DDDS

Nurse

Consultation

Resource

Guide

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
NURSE CONSULTATION RESOURCE GUIDE
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FORWARD

This Nurse Consultation Resource Guide is intended to be a teaching/learning tool for nurses working with the Division of Developmental Disabilities Services to provide Nurse Consultation services. At the end of each section there is a verification page where the nurse can verify and the supervisor can confirm that the information has been read by the nurse and all questions have been answered by the supervisor or others. It is also intended to serve as a reference for nurses even after they have completed their orientation.

WELCOME TO CONSULTATIVE NURSING SERVICES

WITH DDDS

Being a Nurse Supporting People with Developmental Disabilities is a one-of-a-kind job!

Each service recipient receiving services from the Division of Developmental Disabilities Services (DDDS) has a team of professionals that provide support. As a nurse you will be a member of that support team, but you will also play many different roles in the lives of the people you support. Health promotion and advocacy, teaching service recipients and those who support them about health conditions and treatments and overseeing the service recipient's general health care are all duties you will perform as a consultative nurse working with DDDS.

You will discover that there are some incomparable duties and issues not common to other nursing positions. As you provide support to service recipients who have developmental disabilities (DD) or intellectual disabilities (ID), it is important to remember that some issues and concerns are unique to the ID/DD population and others, while not unique, may affect the people you work with at different ages or in different ways than those in the general population. This manual is designed to provide an overview of the typical consultative services a nurse will provide.

This introductory section will provide information about some common health care issues that may challenge the service recipients you support. For example, some people may do things that upon first observation seem to be a behavioral issue. However, it is often the case that there is an underlying health problem causing the behaviors and resolution of the health problem can very often resolve issues around behavior as well. *Whenever a service recipient begins to exhibit behaviors that have not been evident before, or when there is a sudden increase in challenging behaviors, issues of health should be the first thing considered.* It is sometimes the case that people with developmental disabilities are not able to use spoken words, or to articulate, what is wrong or where it hurts. Therefore, the support team, and in particular the nurse, must look first at possible underlying health issues. Issues related to health should be ruled out and/or treatment delivered, in conjunction with any type of behavior support plan, especially those that are restrictive in nature.

"Diagnostic Overshadowing"

Diagnostic overshadowing occurs when the presence of one diagnosis interferes with the detection of other diagnoses. Diagnostic overshadowing can seriously affect the service recipients you support. Malignant or rapidly evolving conditions can cause great harm if undiagnosed.

People living with developmental disabilities have sometimes been deprived of needed treatment and even compassion because their illness has been seen through the lens of their disability. It is often a tendency of medical professionals to attribute signs and symptoms of other illnesses to a service recipient's developmental disability, when in fact there are other causes. Because many in the healthcare profession do not understand developmental disabilities, they may not understand that illness can manifest in different ways for people who have developmental disabilities. *People with disabilities often show symptoms in a way that is different from the "typical" symptoms seen in the general population.*

In fact, for many years it was thought that people with developmental disabilities could not possibly have mental illness, perhaps could not even have the same feelings, as the typical population. This "diagnostic overshadowing" — the tendency to let the developmental disability diagnosis block recognition of other illness — still lingers. When a service recipient acts in uncharacteristic or even dangerous ways, it is still all too often viewed as "misbehavior", not as a possible symptom of an undiagnosed medical or mental illness.

As a nurse working to support people with developmental disabilities, it will be necessary for you to remind others in the healthcare profession that there are only certain and very specific signs and symptoms associated with a developmental disability. *Anything that is not specifically a result of a service recipient's developmental disability should be thoroughly examined.*

Health Care Basics for People Who Have Developmental Disabilities

The "FATAL FIVE"

People with disabilities of all kinds have unique concerns when it comes to their health. Healthcare Professionals must be aware of "The Fatal Five" in order to provide comprehensive supports to people living with disabilities. The "Fatal Five" include aspiration, constipation/bowel obstruction, dehydration, seizures, and infection/sepsis. GERD is also important to watch out for as it can lead to more serious health issues and complications if it's left untreated.

Aspiration

Aspiration is a common problem among people who have difficulty swallowing or "dysphagia". Aspiration is the most common cause of death in group care settings and institutional settings for persons with IDD. Aspiration means that food or fluids that should go into the stomach go into the lungs instead. When material goes into the lungs it can cause aspiration pneumonia. Aspiration pneumonia can worsen quickly if not properly identified and treated. Aspiration pneumonia can result in death. The nurse must become familiar with the signs and symptoms of aspiration and aspiration pneumonia.

Common signs of dysphasia and/or aspiration are:

- Coughing before or after swallowing
- Excessive drooling, especially during meals
- Pocketing food inside the cheek
- Choking on certain foods, for example bread
- Nose running or sneezing while eating
- Trouble chewing
- Trouble swallowing certain types of food or liquids
- Taking a very long time to finish a meal

- Getting tired while eating
- Refusal to eat certain foods or finish a meal
- Complaining of something caught in the throat
- A gurgling voice during or after eating or drinking
- Excessive throat clearing after eating
- Repeated episodes of choking, frequent colds, pneumonias or “allergies”
- Unexplained weight loss
- Unexplained fevers that come and go
- Coughing when lying flat or sitting up quickly from a reclined position

It may take some time for symptoms of **aspiration pneumonia** to become apparent. Aspiration pneumonia can quickly get worse if it is not properly diagnosed and treated. *Aspiration pneumonia can be life-threatening and should be considered an emergency.*

Common signs and symptoms of aspiration pneumonia:

- Frequent cough - foul-smelling mucus or phlegm - may contain pus or streaks of blood.
- Sputum greenish in color and the person may cough up frothy fluid.
- Shortness of breath/noisy breathing.
- Heartbeat or breathing may seem faster than normal.
- Fever or chills accompanied by sweating.
- Pain in the chest while coughing or when taking a deep breath.
- Trouble swallowing
- Feeling as if something is stuck in their throat.
- Confusion, dizziness, faintness, unusually upset or anxious.

Keep a close watch for any symptom of aspiration or aspiration pneumonia and educate direct support staff about what to watch for and what to do if they see the signs. If necessary, implement a formal plan of monitoring and reporting until the condition has resolved.

Constipation/Bowel Obstruction

Constipation is defined as infrequent bowel movements or difficult passage of hard, dry stool. Constipation occurs when stool passes through the large intestine too slowly. When stool stays in the intestine too long, the intestine removes too much water, the stool becomes hard and dry. Severe constipation can result in serious complications including fecal impaction and bowel obstruction. Fecal impaction is when hard, dry stool is in the large intestines and cannot pass. Fecal impaction can be life threatening. Constipation is a condition that often goes unrecognized because people with disabilities may not be able to indicate when they are not feeling well until it poses a major health problem.

Bowel obstruction is the most common cause of PREVENTABLE death in community settings. A bowel obstruction is a serious problem that happens when the bowel becomes blocked in either the large or small intestine. It's also known as an intestinal obstruction. A bowel obstruction may be a partial blockage or a complete blockage of the small or large intestines and requires immediate medical attention. A bowel obstruction can be fatal if not treated in time. A pseudo-obstruction is when there are symptoms of a bowel obstruction but nothing physically blocking it. It can happen because of problems with the gastrointestinal muscles or with the nerves that control them.

The normal length of time between bowel movements varies widely from person to person. Some people have bowel movements three times a day; others, only one or two times a week. However, going longer than three days without a bowel movement is too long. After three days, the stool or feces become hard and more difficult to pass.

If a person is diagnosed with constipation, or has a history of impaction/bowel obstruction, or is at a high risk for elimination concerns because of another diagnosis, medication or treatment or is exhibiting symptoms, the nurse will instruct the service recipient and/or his or her support staff what symptoms to watch for and how to record bowel eliminations (it is <u>not</u> mandatory to track bowel movements for every service recipient supported residentially or by nurse consultation). The nurse will ensure a plan of care is developed specific to the service recipient's needs to address prevention measures and treatment plan. This will be documented on the Medical Alert form and the Significant Medical Conditions document. The nurse will also instruct staff as to when/how to report changes or concerns and when to seek immediate emergency treatment. When instruction is provided to staff the nurse should document this activity in a T-log.

Common causes of bowel obstruction may include:

- Part of the bowel is twisted, closing it off and keeping anything from passing through, also called bowel strangulation
- Inflammation
- Intussusception
- Scar tissue or hernia
- Tumor or other growth
- Damaged blood vessels
- Narrowing of the intestine caused by diverticulitis or inflammatory bowel disease
- Fecal impaction or constipation
    - Common causes of constipation may include:
    - Inadequate fluid intake
    - Inadequate fiber in the diet
    - A disruption of regular diet or routine (for example, while traveling)

- Inactivity or immobility
- Eating large amounts of dairy products
- Stress
- Resisting having bowel movements (sometimes results from pain due to hemorrhoids)
- Overuse of laxatives (stool softeners) which can weaken bowel muscles
- Hypothyroidism
- Neurological conditions such as Parkinson's disease or multiple sclerosis
- Antacid medicines containing calcium or aluminum
- Medicines (especially narcotics, antidepressants, or iron pills and the use of multiple medications with constipating side effects)
- Depression
- Eating disorders
- Irritable bowel syndrome
- Pregnancy
- Colon cancer

Symptoms of bowel obstruction may include:

- Severe pain in the belly
- Severe cramping sensations in the belly
- Vomiting
- Reluctance to eat
- Bloating
- Feelings of fullness or swelling in the belly
- Loud sounds from the belly
- Feeling gassy, but being unable to pass gas
- Constipation
    - Signs and symptoms of constipation may include:
    - Fewer bowel movements than usual
    - Postures that indicate the person is withholding stool (standing on tiptoes and then rocking back on the heels of the feet, clenching buttocks muscles, other unusual “dancelike” behaviors. Such postures can sometimes be mistaken as attempts to “push”)
    - Abdominal pain and cramping
    - Painful or difficult bowel movements
    - Hard, dry, or large stool
    - Stool in the person’s underwear
    - Refusing to eat or drink
    - Spending a lot of time on the toilet
    - Liquid runny stools
    - Nausea

Dehydration

People with disabilities, in particular older adults, have an increased chance of becoming dehydrated because they may:

- Not drink enough.
- Have kidneys that do not work well.
- Choose not to drink because of an inability to control the bladder (incontinence).
- Have stomach and bowel disorders that cause fluid to move through the body too quickly.
- Have a physical condition which makes it:
  - Hard to drink or hold a glass.
  - Difficult or painful to get up from a chair.
  - Painful or exhausting to go to the bathroom.
  - Hard to talk or communicate to someone about symptoms.
  - Necessary to take medication that increases urine output.

Anytime someone you support has an illness that causes high fever, vomiting, or diarrhea, you should instruct direct support staff to watch closely and report to you ANY symptoms of dehydration.

Symptoms of mild to moderate dehydration include:

- Dry, sticky mouth
- Sleepiness or tiredness
- Thirst
- Decreased urine output (eight hours or more without urination)
- Few or no tears when crying
- Dry skin
- Headache
- Constipation
- Dizziness or lightheadedness

Symptoms of severe dehydration (a medical emergency):

- Extreme thirst
- Irritability and confusion
- Very dry mouth, skin and mucous membranes
- Lack of sweating
- Little or no urination — urine that is produced is dark yellow or amber

- Sunken eyes
- Dry skin that lacks elasticity and doesn't "bounce back" when pinched into a fold
- Low blood pressure
- Rapid heartbeat
- Rapid breathing
- No tears when crying
- Fever
- In serious cases, delirium or unconsciousness

Seizure Disorder (Epilepsy)

Seizures of all types are caused by disorganized and sudden electrical activity in the brain. About 2 in 100 people in the United States will experience an unprovoked seizure once in life. A solitary seizure doesn't mean someone has a seizure disorder (epilepsy). At least two unprovoked seizures are generally required for diagnosis of a seizure disorder.

Causes of seizures can include:

- Abnormal levels of sodium or glucose in the blood
- Brain infection, including meningitis
- Brain injury
- Brain problems that occur before birth (congenital)
- Brain tumor (rare)
- Choking
- Drug abuse
- Epilepsy
- Fever
- Head injury
- Heart disease
- Heat illness (heat intolerance / heat exhaustion / heat stroke)
- High fever
- Illicit drugs, such as angel dust (PCP), cocaine, amphetamines
- Kidney or liver failure
- Low blood sugar
- Poisoning
- Stroke
- Toxemia of pregnancy
- Uremia related to kidney failure
- Very high blood pressure (malignant hypertension)
- Venomous bites and stings
- Withdrawal from alcohol after drinking a lot frequently

- Withdrawal from certain drugs, including some painkillers and sleeping pills
- Withdrawal from benzodiazepines (such as Valium)

It may be difficult to tell if someone is having a seizure, especially if you are not yet familiar with the person and his or her typical way of being. Some seizures may only cause a person to have staring spells and may go unnoticed. Specific symptoms depend on what part of the brain is involved and they can occur suddenly.

Symptoms of Seizure may include:

- Brief blackout followed by period of confusion (can't remember a period of time)
- Changes in typical behavior such as picking at one's clothing
- Drooling or frothing at the mouth
- Eye movements
- Grunting and snorting
- Loss of bladder or bowel control
- Mood changes such as sudden anger, unexplainable fear, panic, joy, or laughter
- Shaking of the entire body
- Sudden falling
- Tasting a bitter or metallic flavor
- Teeth clenching
- Temporary halt in breathing
- Uncontrollable muscle spasms with twitching and jerking limbs

Symptoms may stop after a few seconds or minutes or continue for 15 minutes. They rarely continue longer.

A person may have warning symptoms, sometimes called an "aura," before seizures, such as:

- Fear or anxiety
- Nausea
- Vertigo
- Visual symptoms (such as flashing bright lights, spots, or wavy lines before the eyes)

All direct support staff who work with a service recipient who has a seizure disorder are required to receive specific training related to the person's seizures and the proper care and reporting of events. However, you should advise/remind direct support professionals to call 911 (or the local emergency number) if:

- This is the first time the person has had a seizure.
- A seizure lasts more than 5 minutes or as otherwise directed.
- The person does not awaken or return to typical behavior after a seizure.
- Another seizure starts soon after a seizure ends.

- The person had a seizure in water.
- The person is pregnant, injured, or has diabetes.
- There is anything different about a seizure compared to the person's usual seizures.
- As outlined in the person's Seizure Rescue Medication protocol (as applicable).

Seizure Rescue Medication Guidelines

- Seizure rescue medications are given to stop prolonged seizures and clusters of increased seizure activity
- There must be a healthcare provider's order for any seizure rescue medication a service recipient is to receive. The prescriber must also complete the Seizure Rescue Medication Order Form. The order form will be reviewed at each subsequent appointment. The Seizure Rescue Medication Order Form is to be reviewed and a new form completed at least annually by the prescribing practitioner.
- Staff are only permitted to administer seizure rescue medications by the routes as outlined in the Delaware Board of Nursing's Limited Lay Administration of Medication (LLAM) course. If any other routes of administration are ordered (such as injection) a nurse would be required to administer.
- The Seizure Rescue Medication Order Form must be attached to the Risk section of the service recipient's Person-Centered Plan (PCP) and included on his/her Significant Medical Conditions form and the Medical Alert form.
- Once a new order is received from a healthcare provider, the Seizure Rescue Medication Order Form must be faxed to the Consultative Nurse on the same day the order is received.
- The Consultative Nurse must complete on-site training within two (2) business days of receiving the prescription for a seizure rescue medication.
- The Consultative Nurse will review the order, medication, and MAR when he/she performs the on-site training session. The Consultative Nurse will attach the training outline and staff Sign-In-Sheets with the Seizure Rescue Medication Order Form in the Risk section of the service recipient's PCP.
- Staff expected to administer seizure rescue medications will receive instruction on the administration as part of the LLAM Initial training and also during the annual recertification process. Only LLAM trained staff may administer any seizure rescue medications by LLAM approved routes of administration.
- The seizure rescue medication must always be taken with the service recipient when they are out of his/her home. A copy of the current prescriber's order must accompany the medication at all times.
- Staff must document all seizures and the administration of seizure rescue medication in the appropriate sections of the client data management system and Medication Administration Record according to LLAM guidelines.

Infection/Sepsis

An infection is the invasion and growth of germs in the body. The germs may be bacteria, viruses, yeast, fungi, or other microorganisms. Infections can begin anywhere in the body and may spread all through it. Sepsis is an extreme response to an infection and is a silent killer. The body sends a flood of chemicals into the bloodstream to fight the threat. This causes widespread inflammation which, over time, can slow blood flow and damage organs. Sometimes sepsis can be life-threatening, especially if it moves to its later stages -- severe sepsis or septic shock. Every hour that passes without treatment raises death risk by 10%.

Causes of infection can be:

- Bacteria or several infectious agents invading the bloodstream and spreading throughout the body
- Virus
- Protozoa or parasites
- Fungal organisms
- Open Wound
- Pneumonia
- Urinary Tract Infection

Symptoms of infection may include:

- Fever (this is sometimes the only sign of an infection)
- Chills and sweats
- Change in cough or a new cough
- Sore throat or new mouth sore
- Shortness of breath
- Nasal congestion
- Stiff neck
- Burning or pain with urination
- Rapid pulse
- Low blood pressure

Symptoms of sepsis may include:

- Rapid breathing and heart rate
- Shortness of breath
- Confusion or disorientation

- Extreme pain or discomfort
- Fever, shivering, or feeling very cold
- Clammy or sweaty skin

****It is also critically important to watch for Gastroesophageal Reflux Disease.****

Gastroesophageal Reflux Disease (GERD)

Gastroesophageal reflux disease (GERD) occurs when stomach acid frequently flows back into the tube connecting the mouth and stomach (esophagus). This backwash (acid reflux) can irritate the lining of the esophagus. Many people experience acid reflux from time to time. GERD is mild acid reflux that occurs at least twice a week, or moderate to severe acid reflux that occurs at least once a week. Although GERD itself isn't a life-threatening condition, it can lead to more serious health issues and complications if it's left untreated. Long-term GERD can lead to esophagitis which is the irritation and inflammation the stomach acid causes in the lining of the esophagus. Stomach acid is very irritating to the lining of the esophagus and can cause long-term damage. Over time, a painful ulcer can develop. Bleeding of the esophagus is a common long-term complication of GERD.

Causes of GERD:

- Frequent acid reflux
    - Common causes of acid reflux may include:
    - Eating large meals or lying down right after a meal
    - Being overweight or obese
    - Eating a heavy meal and lying on the back or bending over at the waist
    - Snacking close to bedtime
    - Eating certain foods, such as citrus, tomato, chocolate, mint, garlic, onions, or spicy or fatty foods
    - Drinking certain beverages, such as alcohol, carbonated drinks, coffee, or tea
    - Smoking
    - Pregnancy
    - Taking aspirin, ibuprofen, certain muscle relaxers, or blood pressure medications

Risk factors for GERD may include:

- Obesity
- Bulging of the top of the stomach up into the diaphragm (hiatal hernia)
- Pregnancy

- Connective tissue disorders such as scleroderma
- Delayed stomach emptying
- Smoking
- Drinking certain beverages often such as alcohol or coffee
- Eating certain foods often such as fatty or fried foods
- Certain medications such as aspirin

Symptoms of GERD may include:

- A burning sensation in the chest (heartburn), usually after eating, which might be worse at night
- Chest pain
- Difficulty swallowing
- Regurgitation of food or sour liquid
- Sensation of a lump in the throat
- Chronic cough
- Laryngitis
- Shortness of breath or new or worsening asthma
- Disrupted sleep

Developmental Disability and Co-Morbidity

Some disabilities are more frequently associated with co-morbid conditions (i.e., cerebral palsy with vision impairment). Clinicians must be aware of the likelihood of these co-morbidities and recognize that cognitive and communication difficulties can present barriers to accessing health care. When a service recipient has significant communication difficulties, whether due to cognitive, social, or physical limitations, additional communication skills and strategies will be required of the nurse to ensure good communication with the person, and where appropriate, family members and/or direct support staff.

Clinicians should not let the developmental disability distract from or overshadow other health problems.

Many of the service recipients you support will have multiple diagnoses and multiple disabilities. Still others will acquire disabilities in later life, including sensory, psychiatric, musculoskeletal, and neurological disabilities. These can have a significant impact on the service recipient and need to be addressed within the context of the person's life.

It's important for a nurse working with DDDS to have an understanding of the different types of disabilities, conditions which co-exist, and those that occur earlier or at an increased rate in people who have developmental disabilities.

Different diagnoses and the estimated rate at which they occur in people with developmental and intellectual disabilities:

Co-morbid Conditions	**Estimated Rate of Occurrence in People with Developmental/Intellectual Disability (DD/ID)**
Autism Spectrum Disorders	75%
Attention Deficit Hyperactivity Disorder	4 to 11%
Disorders of the brain due to General Medical Conditions	Seizure Disorder – 15 to 30%, Motor impairments – 20 to 30%, Sensory Impairments – 10 to 20%
Schizophrenia	Similar rates in persons with and without DD/ID
Mood Disorders, e.g., Depression	Under-diagnosed in persons with developmental/intellectual disability; estimated to occur at a rate equal to or greater than those without DD/ID
Anxiety Disorders	25% in outpatient samples
Posttraumatic Stress Disorder	Significantly under-diagnosed in people with developmental/intellectual disabilities
Obsessive-compulsive Disorders	Difficult to differentiate from self-injurious, self-stimulatory, or stereotypic behaviors associated with other disorders
Eating Disorders	Developmental/intellectual disability is a predisposing factor for eating disorders such as Pica

Disability Types

There are many types of disabilities, such as those that affect a person's:

- Hearing
- Vision
- Movement
- Thinking
- Remembering
- Learning
- Communicating
- Mental health
- Social relationships

Disabilities can affect people in different ways, even when one person has the same type of disability as another person. Some disabilities may be hidden or not easy to see. When working with people who have disabilities, fundamental principles that guide good practice include clearly focusing on and respecting the person, an awareness of the impact the person's

disability has on their lifestyle and the need to employ the same standards of care that apply to people without a disability.

People who have disabilities can and do have the full range of medical conditions that affect people without disabilities, and they require access to appropriate services. This includes access to the full range of preventive health services such as smoking cessation, nutritional and other community-based health initiatives.

Understanding the Difference between Developmental Disability and Intellectual Disability

Developmental Disability

The term developmental disability refers to a chronic disability that is attributable to a cognitive or physical impairment that begins before an individual reaches the age of 22. People with developmental disabilities have atypical neurological development which results in challenges in some or all of the following domains: 1) cognition, 2) sensory processing, 3) fine and gross motor skills, 4) seizure threshold and 5) behavior and mental health. Strengths and challenges in each of these areas need to be assessed for each individual. These disabilities can include intellectual disability, cerebral palsy, epilepsy, autism, and closely related conditions that require similar treatment. Developmental disabilities can result in limitations in three or more areas of major life activities:

- capacity for independent living
- economic self-sufficiency
- learning
- mobility
- receptive and expressive language
- self-care
- self-direction

Intellectual Disability

Intellectual disability is a disability characterized by limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 22.

Intellectual functioning—also called intelligence—refers to general mental capacity, such as learning, reasoning, problem solving, and so on.

One way to measure intellectual functioning is an IQ test. Generally, an IQ test score of around 70 or below indicates a limitation in intellectual functioning. Other considerations include:

- Significant limitations in intellectual functioning, which means a full-scale IQ standard score of approximately 2 (or more) standard deviations below the mean as measured with an appropriately normed, standardized test of intelligence.
- Significant limitations in adaptive behavior, which means a standard score of approximately 2 (or more) standard deviations below the mean measured with an appropriate and standardized test of adaptive behavior in one or more of the following domains: conceptual, social, or practical skills.
- Onset of both of the above limitations during the developmental period, which means that significant limitations in both intellectual functioning and adaptive behavior in the individual have manifested before the age of 22.

Adaptive Behavior

Adaptive behavior is the collection of conceptual, social, and practical skills that are learned and performed by people in their everyday lives.

- Conceptual skills—language and literacy; money, time, and number concepts; and self-direction.
- Social skills—interpersonal skills, social responsibility, self-esteem, gullibility, naïveté (i.e., wariness), social problem solving, and the ability to follow rules/obey laws and to avoid being victimized.
- Practical skills—activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of the telephone.

Standardized tests can also determine limitations in adaptive behavior.
(Source: American Association on Intellectual and Developmental Disabilities www.aaidd.org)

The most common syndromes associated with intellectual disabilities are autism spectrum disorders (ASD), Down syndrome, Fragile X syndrome and Fetal Alcohol Spectrum Disorder (FASD). Genetic conditions (Down syndrome and Fragile X syndrome), problems during pregnancy (mother consuming alcohol while pregnant), complications at the time of birth, health problems such as whooping cough, measles or meningitis and exposure to environmental toxins like lead or mercury can all cause intellectual disabilities.

Down Syndrome and Alzheimer's Dementia

People with Down Syndrome are more likely than the general population to develop Alzheimer's dementia and at an earlier age. This table shows the percentage of people with Down Syndrome who develop dementia at different ages:

Age	Percentage with clinical signs of dementia.
30's	2%
40's	10-15%
50's	33%
60's	50-70%

Dementia is characterized by the progressive deterioration of mental abilities, behavioral changes, and a decline in skills. Symptoms of dementia can be subtle and develop slowly and are often wrongly attributed to the disability. Early signs may not be apparent because caregivers will often "compensate" for the person by guiding and prompting them, or by filling gaps in their speech.

Some early symptoms that may occur in people with Down Syndrome & Alzheimer's Dementia

- Forgetfulness (loss of short-term memory, but intact long-term memory)
- Confusion (e.g., putting clothes on the wrong way)
- Slowing down (e.g., in walking / eating / speaking)
- Speech & language changes (e.g., repetitive questioning)
- Changes in sleep (e.g., night-time wandering)
- Loss of skills (e.g., using stereo / phone)
- Problems socializing (e.g., becoming more reclusive)
- Increased obsessions (doing things over & over again)
- Altered personality (e.g., less outgoing)
- Problems with balance (e.g., unsteady walking)
- Emotional difficulties (e.g., unexplained crying / screaming)
- Visual hallucinations
- Unexplained body aches & pains

Developmental Disability and Depression

- One person out of five suffers from depression at some point in their lives. People with developmental disabilities suffer from depression at least as often as people without developmental disabilities.
- Depression decreases a person's ability to enjoy life.
- Depression can lead to poor health.
- It can be hard to recognize signs of depression in someone with developmental disabilities, especially if they do not communicate well.
- There may be people with developmental disabilities who need help for depression, but do not get help because they are unable to communicate how they feel.

There are different types of depression:

Major depression interferes with everyday life. This kind of depression can change how people sleep, eat, and feel about themselves. Major depression can also make it hard for a person to concentrate, work, socialize, or enjoy life events. A person may suffer from major depression once, get better, and never become depressed again. But many people feel depressed on and off for their whole lives. Without help, major depression can lead to heart disease, alcohol or drug abuse, and suicide.

Dysthymia is less severe than major depression, but Dysthymia can still keep a person from feeling well and meeting the challenges of everyday life. Dysthymia also tends to last longer than major depression.

Bipolar Disorder (manic-depressive illness) often makes a person change very rapidly, from feeling depressed and doing very little, to feeling very happy and having a very high level of activity (mania). Bipolar disorder affects how people act and think and can lead people to make bad decisions. Bipolar Disorder can occur along a spectrum of severity and symptoms.

Seasonal Affective Disorder (SAD) causes a person to feel very sad during times of the year when there is less natural sunlight—in the winter, for example. People with Seasonal Affective Disorder normally feel better in the spring and summer.

How can you tell when someone you support has depression?

The people you support may or may not be able to talk about their moods or explain that they feel sad. It is important for you to pay attention to any changes in a service recipient's behavior. If the service recipient has limited verbal communication skills, to know that they feel depressed, you must observe what they do. The following table lists some symptoms of depression you might observe in people who have developmental disabilities:

Symptoms	**What You Might Observe**
Depressed (sad) mood	Cries or moans for long periods of time Seems to cry without reason Smiles or laughs less than usual Has a sad facial expression Complains often
Acting out more often than usual	Has an angry expression Increased verbal agitation or aggression Increased physical agitation or aggression Tries to injure self
Acting tired / not having any energy	Spends more time sitting or lying down Has trouble getting out of bed in the morning

Symptoms	What You Might Observe
Sleeping more or less than normal	Sleeps more than 11 hours a night Takes long naps or naps frequently Wakes up earlier than usual Has trouble falling asleep Wakes up in the middle of the night
Changes in weight or appetite	Refuses to eat or eats more than usual Sudden increase or decrease in weight Steals food Is disruptive at mealtimes
Losing interest in activities	Doesn't participate in favorite activities Doesn't seem to enjoy activities Spends more time alone than usual Refuses most work or social activities that they normally enjoy
Acting worried, troubled or very slow to respond	Doesn't sit down Paces or walks rapidly Stops talking or talks more slowly than usual Moves very slowly
Talking about death or suicide	Talks about people who have died Threatens to kill self Shows a strong interest in violent movies or television shows
Feeling worthless	Statements like “I'm no good for anyone.” Spends more time alone Pushes other people away
Finding it hard to think or concentrate	Can't focus on work or activities Is easily distracted Has memory loss Doesn't get as much done at work Has trouble taking care of self

These are examples of some of the things that may lead to depression.

Life Event	Examples
Loss	The death of a loved one Breaking up with someone or getting a divorce Losing a job Loss of a favorite staff member
Stress	Being the victim of abuse Being the victim of a crime Having problems with friends or family Problems with money Problems at work or in school Drug or alcohol abuse
Loss of control due to physical or other limitations	Long term illness or injury Needing assistance from others Loss of independence Loss of self-confidence Feeling a lack of control over one's own life
Social limitations	Difficulty expressing oneself Finding it hard to get a job or earn money Having difficulty making friends Social isolation
Past trauma	Bullying Early childhood trauma Community or disaster trauma Physical or sexual abuse or assault Verbal or emotional abuse Sexual Severe illness or injury Being the victim of a crime

If you believe a person you support is depressed …

Generally, a service recipient should see their doctor if they experience symptoms of depression for longer than two weeks or if symptoms are serious enough to disrupt their daily routine. Changes in behavior related to depression (for example, eating or sleeping less, forgetting to take medication, etc.) may have serious effects on a service recipient's health. It's important for you to act quickly if you think a person you support is depressed.

- Encourage the service recipient to talk to you. Help them to explain how they feel. Ask about what is happening in their life. Pay attention and be supportive. Take what they say

seriously; be careful not to dismiss any of the feelings they describe. Be alert for any signs that they may be thinking of hurting themselves (for example, talking about death).

- If the service recipient does not use speech to communicate, watch them more carefully and instruct direct support staff to do the same. Document symptoms or changes in behavior. Note when the changes first appeared. Report anything that has changed recently in the person's life.
- Make an appointment with the service recipient's primary doctor. Some physical conditions and some medications can cause symptoms similar to depression. A doctor will be able to rule out physical or medical causes. He or she may recommend a visit to a psychiatrist or psychologist.

Post-Traumatic Stress Disorder (PTSD)

People who experience disabilities are more likely than people without disabilities to be abused physically, emotionally, or sexually. The CDC published a report in 2020 stating that people with disabilities are 5 times more likely than the general population to experience "frequent mental distress" as a result of current and previous traumatic experiences.

Traumatic responses occur when action is not effective. When neither resistance nor escape is possible, the human system of self-defense becomes overwhelmed and disorganized. Each component of the ordinary response to danger tends to persist in an altered and exaggerated state after the actual danger is over. Traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition, and memory. Traumatic events may also sever these typically integrated functions from one another. The traumatized person may experience intense emotion without clear memory of the event or may remember everything in detail but without emotion. They may find themselves in a constant state of irritability without knowing why. Traumatic symptoms tend to become disconnected from their source and to take on a life of their own.

"Trauma" can be any life event that leads to a trauma response in the service recipient. It is highly personalized to the person experiencing the event. Traumatic events may include one or more of the following:

- Separation from primary relationships at an early age
- Frequent moves between residential placements
- Institutionalization
- Physical, verbal, emotional abuse or neglect
- Loss of parent, sibling, or significant other
- Significant medical problems/procedures
- Extended hospitalization / institutionalization
- Community/disaster/terroristic events

In the past, people with developmental disabilities have experienced service-related trauma in the name of "treatment." The following list are examples of practices now prohibited by DDDS, but may be things experienced in the past by the people you support:

- Time out / Isolation / Seclusion
- Physical, chemical, or mechanical restraint
- Facial screening (covering the face)
- Ammonia or other noxious or aversive substances

Symptoms of PTSD may include:

- Unexplained episodes of anger or rage
- Inexplicable episodes of screaming, throwing things or destruction of property
- Reactions seeming out of proportion to the situation (people who have an out of proportion reaction to moderately stressful situation may have had something worse happen to them in the past that is stirred up by the event)
- Abrupt physical assault (often toward people they like)
- Extreme fear of people they know and trust at times
- Calling someone they know by a different name
- Appearing unfocused, not "with it"
- Sometimes behaving like they are somewhere else
- Dissociative experiences (detachment from physical and emotional reality)

Trauma Informed Care (TIC) *(source: http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html)*

Trauma-Informed Care (TIC) is an approach in the human service field that assumes that an individual is more likely than not to have a history of trauma. Trauma-Informed Care recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life, including the lives of service staff.

On an organizational or systemic level, Trauma-Informed Care changes organizational culture to emphasize respecting and appropriately responding to the effects of trauma at all levels. Similar to the change in general protocol regarding universal precautions, Trauma-Informed Care practice and awareness becomes almost second nature and pervasive in all service responses. Trauma-Informed Care requires a system to make a paradigm shift from asking, "What is wrong with this person?" to "What has happened to this person?"

The intention of Trauma-Informed Care is not to treat symptoms or issues related to sexual, physical, or emotional abuse or any other form of trauma but rather to provide support services in a way that is accessible and appropriate to those who may have experienced trauma. When service systems operating procedures do not use a trauma-informed approach, the possibility for triggering or exacerbating trauma symptoms and re-traumatizing individuals increases.

Re-traumatization

Re-traumatization is any situation or environment that resembles an individual's trauma literally or symbolically, which then triggers difficult feelings and reactions associated with the original trauma. The potential for re-traumatization exists in all systems and in all levels of care: individuals, staff, and system/organization.

Re-traumatization is often unintentional. There are some "obvious" practices that could be re-traumatizing such as the use of restraints or isolation, however, less obvious practices or situations that involve specific smells, sounds or types of interactions may cause individuals to feel re-traumatized.

Re-traumatization is a significant concern, as individuals who are traumatized multiple times frequently have exacerbated trauma-related symptoms compared to those who have experienced a single trauma. Individuals with multiple trauma experiences often exhibit a decreased willingness to engage in treatment.

Re-traumatization may also occur when working with individuals who have history of historical, inter-generational and/or a cultural trauma experience.

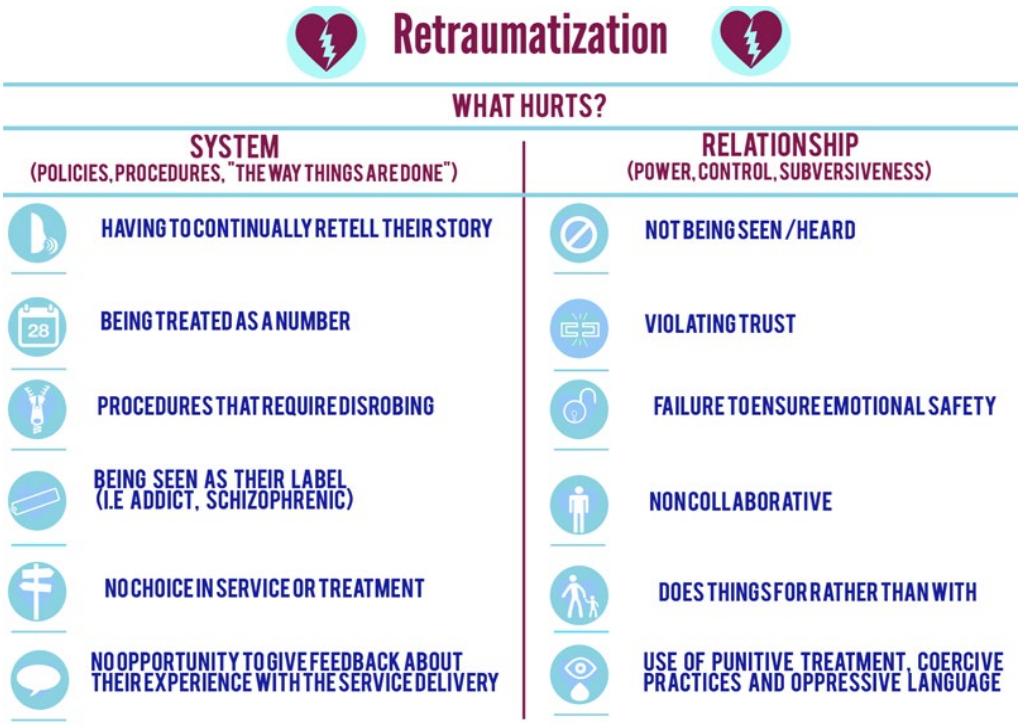

Chart by the Institute on Trauma and Trauma-Informed Care (2015)

Introduction

Section Name	Date Read/Completed	Initials
Welcome to Nurse Consultation		
Diagnostic Overshadowing		
HealthCare Basics for People who Have Developmental Disabilities		
The “Fatal Five”		
Developmental Disability and Co-Morbidity		
Disability Types		
Understanding the Difference Between Developmental Disability and Intellectual Disability		
Adaptive Behavior		
Down Syndrome and Alzheimer’s Dementia		
Intellectual/Developmental Disability & Depression		
Post-Traumatic Stress Disorder (PTSD)		
Trauma Informed Care (TIC) and Re-traumatization		

I, _____, have read and understood the
(print name)
information provided in this section of the DDDS Nurse Consultation Resource Guide. I have had an opportunity to consult with my supervisor and/or his/her designee and my questions have been answered.

_____ _____
Nurse’s Signature Date

_____ _____
Signature of Nurse Supervisor / Designee Date

Section 1 – NURSING ASSESSMENTS

The Electronic Comprehensive Health Assessment Tool (ECHAT)

The Electronic Comprehensive Health Assessment Tool (ECHAT) is an in-depth Comprehensive Nursing Assessment. This is an online tool that assesses a service recipient's current symptoms and health history and calculates overall activity level. A summary is produced when the ECHAT is completed. A preliminary ECHAT is completed by the nurse prior to admission into a provider-managed residential setting, reviewed and updated with any new or additional information within 30 days after admission, and updated as necessary, but at least annually (within 364 days of the previous one) to reflect changes in the service recipient's health condition. The ECHAT must be in 'Approved' status to be considered completed. Do not leave the ECHAT in Pending status. In the rare event of Nurse Consultation provided to a service recipient who does not live in a provider-managed residential setting, the ECHAT should be finalized within 30 days of the service referral and updated as necessary, but at least annually. The ECHAT must minimally be reviewed/updated annually and submitted in conjunction with the person-centered plan meeting date. The goal of this assessment is to proactively identify healthcare and medical needs and to assist the nurse to adhere to Best Practice. It is the expectation that the nurse will provide appropriate follow-up and recommendations to the team to help address any health concerns.

Significant Medical Conditions Form

This form provides a summary of the service recipient's support needs related to their individual diagnoses, a record of immunizations, health screenings, pharmacy and physician contact information, and current medications. This is intended to be a "quick reference" guide for UAPs or other staff who need easy access to the service recipient's current medical information without needing to go into the electronic record system.

The Significant Medical Conditions (SMC) document is to be completed by the nurse for every service recipient who receives Nurse Consultation services upon admission, attached to the appropriate section of the person-centered plan per the Rights and Responsibilities for the DDDS Person-Centered Plan Process guidance, and updated at least annually (within 364 days) or as changes occur. A new date must be entered on the most current SMC to show that it was updated. It must be scanned into the person centered plan by the nurse before the previous one expires. The SMC is used to document each of the service recipient's conditions, provide a summary of risk assessments, and share information that direct support staff need to know in order to support the service recipient with his or her health care needs. To avoid anyone other than the consultative nurse making changes to this attachment, he/she will save the document in PDF format. Residential and day providers will typically print the SMC out to have on hand for staff.

The consultative nurse will keep this document up to date as the service recipient's health status warrants in order for staff to always have the most current information available. When changes occur mid-year, revisions should be marked with a new date and added to the person centered plan. A T-log marked as a high priority status should also be entered into the service recipient's electronic client data management system record. This will ensure all staff are informed about the revised supports for the service recipient. The nurse shall email a PDF copy of the original/revised health supports to the service recipient's day program provider.

Fall Risk Assessment

An additional component of the comprehensive Nursing Assessment or ECHAT is the completion of a Fall Risk Assessment tool. The purpose of this screening is to identify service recipients who are at risk for falls, to protect them from injury and to promote safety. The Fall Assessment tool must be updated any time there are changes in status, but minimally at the same time the ECHAT and SMC is completed/updated, which is upon admission and in conjunction with the service recipient's annual person-centered plan meeting. The nurse should review Fall Management Healthcare Protocol #3 for nursing responsibilities. This protocol can be located in the DDDS website. For any service recipient scoring a 10 or above or

receiving anticoagulant therapy (including aspirin), development of an individualized fall prevention plan is required within 30 days of the completed assessment.

Aspiration Risk Assessment

Aspiration is a major health issue that is more common in-service recipients who have a developmental disability than in the general population. It can lead to severe morbidity and even death. An Aspiration/Choking Risk Assessment is completed with the goal of effectively identifying service recipients who are at risk and provides support staff with interventions to manage safe eating practices. Aspiration and Choking Healthcare Protocol #1 is available for review of nursing responsibilities and can be located in the DDDS website. This assessment is to be completed at the time of admission, annually in conjunction with the service recipient's annual person-centered plan meeting, if there is a change in health status or if risks are identified. Requirements are outlined in the protocol for scores indicating a moderate or severe risk.

Medical Alert Form

The Medical Alert Form is completed for every service recipient receiving Nurse Consultation services. All potentially life threatening, or medically significant health issues are to be documented on this document. If the service recipient does not have any identified life threatening or medically significant health issues "NONE" should be documented on the form and filed as outlined. The Medical Alert Form is completed upon admission, updated at the time of the annual person-centered plan meeting, and updated as changes occur. This form is printed on bright green paper and filed in the front of the Medication Administration Record if living where one is used. If the residential provider utilizes the EMAR, the Medical Alert Form should be attached to the Medication History module and a physical copy printed out and stored at the house with the medications. In a shared living home, the form is filed in the front page of the Shared Living Provider (SLP) notebook. A copy must also be sent by the nurse to the service recipient's day service program. Please refer to Medical Alert Form Guidelines below for additional information.

MEDICAL ALERT FORM - GUIDELINES

- Completed for every service recipient receiving Nurse Consultation services. All potentially life threatening, or medically significant health issues are to be documented on this document. These may include but are not limited to: aspiration risk; fall risk; seizures; order for Diastat or other seizure rescue med; history of bowel obstruction; significant allergies; cardiac issues; asthma or pain management concerns.
- If a service recipient does not have any potentially life threatening or medically significant health issues "NONE" should be documented on the form and filed as outlined.

- Must be kept updated by the nurse as conditions warrant.
- Completed form must be printed on bright green paper to be more visible and easier to locate.
- Completed form must be filed in the front of the hard-copy medication administration record (MAR), attached to the Medication History module if the residential provider utilizes the eMAR and printed out and stored with the medications in the home, or in the front of the Shared Living Provider notebook.
- Copy of the completed form must also be sent to day service provider.
- Form is to be reviewed as needed, but minimally each year at the time of the person-centered plan review meeting.

Nurse Consultation Provider's Responsibility for the Person Centered Plan (PCP)

1. Completes and attaches the Fall Risk Assessment, Aspiration Risk Assessment, Significant Medical Conditions (SMC), and Medical Alert form to the appropriate section of the service recipient's person centered plan in the State Oversight account in the electronic client data management system. If the service recipient is in the Moderate to High risk the assessment must be attached to the RISK section of the PCP document along with the SMC and Medical Alert. If the service recipient is in the Low risk category, the assessment should be attached to the "Documents Checklist" at the bottom of the PCP.

2. Completes and attaches the ECHAT to the Documents Checklist in the service recipient's PCP in the State Oversight account.

3. Completes the Professional Services section of the service recipient's PCP in the State Oversight account. This is a list of the medical practitioners for the service recipient and contact information. Ensures this section stays up to date and accurate during routine reviews.

4. Completes and attaches the completed Self-Administration of Medication Assessment to the "Documents Checklist" in the service recipient's PCP in the "Other Supporting Documents" location (specify in document description field as Self-Administration of Medication Assessment) when applicable. Completes and attaches the completed Self-Administration of Medication Approval form to the Documents Checklist in the service recipient's PCP in the "Other Supporting Documents" location when applicable.

    a. Documents in the PCP- "Discussion Record" section if the service recipient was assessed and not approved for Self-Administration of Medication with the corresponding date with the reason for that the person was not approved.

****Please note the Nursing Care Plan section in the electronic client data management system is not currently used for Nurse Consultation Services.**

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Medical Alert

Any time there is a medical emergency call 911 immediately.

Name: _____ DOB: _____ Date: _____

Medical Concerns	Symptoms	Response

Name of Nurse: _____Signature of Nurse: _____

The purpose of this form is to identify medical concerns that may be fatal or have serious consequences. Examples are Dehydration, Aspiration, Seizures, Constipation/History of Bowel obstruction, Diet modifications, Cardiac conditions, Asthma, Pain management and serious Allergies. It is to be placed in the individuals MAR.

******THIS FORM IS TO BE USED IN CONJUNCTION WITH THE NURSING ASSESSMENT/ELP and SIGNIFICANT MEDICAL CONDITIONS. YOU ARE STILL RESPONSIBLE FOR ALL OF THE MEDICAL INFORMATION PRESENTED IN THESE ADDITIONAL DOCUMENTS.***

Section 1 – **Nursing Assessments**

Section Name	Date Read/Completed	Initials
Electronic Health Assessment Tool		
Fall Risk Assessment		
Aspiration Risk Assessment		
Significant Medical Conditions Form		
Medical Alert Form		
Medical Alert Form Guidelines		
Nurse Consultation Provider's Responsibility for the Person Centered Plan (PCP)		

I, _____, have read and understood the
(print name)
information provided in this section of the DDDS Nurse Consultation Resource Guide. I have had an opportunity to consult with my supervisor and/or his/her designee and my questions have been answered.

_____ _____
Nurse's Signature Date

_____ _____
Signature of Nurse Supervisor / Designee Date

Section 2 – Service Provider Health Education

Health Promotion

The World Health Organization (WHO) published the International Classification of Functioning, Disability and Health (ICF) in 2001, with updates posted annually on their website. The ICF provides a standard language that you should use when discussing a service recipient's health or when teaching. This will help accurately track health, functioning, activities, and factors in the environment that either help or create barriers for service recipients. It is important for you to use and teach the correct terminology to the people you support, family members and direct support staff. The following terms and definitions were taken from the World Health Organization's (WHO) International Classification of Functioning, Disability and Health (ICF):

Health Conditions - refers to illness, disease, disorder, injury or trauma. The condition is usually a diagnosis. For example, autism spectrum disorders, spina bifida, and traumatic brain injury are health conditions.

Body Structure - refers to a part of the body. For example, heart, legs, and eyes are body structures.

Body Functions - describe how body parts and systems work. For example, thinking, hearing, and digesting food are body functions.

Functional Limitations - difficulty completing a variety of basic or complex activities that are associated with a health problem. For example, inability to move one's legs is a functional limitation.

Activity - refers to a task or action. For example, eating, writing, and walking are activities.

Activity Limitations - difficulty a person may have in doing activities. For example, not being able to brush one's teeth or open a medicine bottle are activity limitations.

Participation - being involved and fully participating in society. This means being included in all aspects of a communities' political, social, economic and cultural life.

Participation Restrictions - difficulty a person may have taking part in life situations.

Environmental Factors - things in the environment that affect a person's life. For example, technology, support and relationships, services and policies are environmental factors.

Personal Factors - relate to the person, such as age, gender, social status, and life experiences.

DDDS Training Requirements

Every employee of DDDS and contracting agencies is required to complete a series of trainings designed to provide an orientation to DDDS and explain the function of DDDS and Delaware Health and Social Services (DHSS) in the lives of people who have developmental disabilities. These trainings also provide instruction to staff to assist them to appropriately support people and to help them stay safe.

Basic training requirements for staff employed by DDDS and contracting agencies are outlined in the division's training policy which can be found on the Policy page of the DDDS website.

Recommended Preventative Screenings/Immunizations

- On an annual basis, the consultative nurse shall assess the service recipient's status and eligibility for immunizations. Eligibility is based on:
    - Age
    - Immunization status (e.g., persons previously unimmunized or due for immunization according to the DDDS's Minimal Vaccination Guidelines).
    - Presence of a medical condition and other indications.
    - Place of residence (e.g., neighborhood home is considered a long-term care facility).
    - Any known history of an allergy or reaction to an immunization.
- At least annually, the service recipient's healthcare provider will be requested to review the recommended adult immunization schedule.
- At a minimum, service recipients should be offered the following immunizations on the CDC recommended schedule:
    - Influenza
    - Tetanus
    - Covid vaccine/booster
- The service recipient's healthcare provider will make the final determination of immunization eligibility and discuss the need for any immunizations with the service recipient and/or his/her guardian/surrogate decision maker. The healthcare provider will order the administration of such as deemed appropriate.
- When an immunization is administered the date and type of immunization will be recorded in the immunization section of the service recipient's electronic client data management system.
- If a service recipient/guardian/surrogate decision maker declines any of the recommended adult immunizations as outlined here or as ordered by his/her healthcare provider, a Routine Adult Immunization Declination Form will be completed and

attached to the Person Centered Plan (PCP) in the Documents Checklist section. If any other type of written correspondence is received documenting the declination it must be attached to the Routine Adult Immunization Declination Form and attached as outlined above.

- Any recommended and or ordered immunization(s) that is declined will be reviewed at least annually during the annual planning meeting with the service recipient/guardian/surrogate decision maker. If the recommended vaccination(s) is still declined a new Routine Adult Immunization Declination Form must be signed and attached to the PCP.

Section 2 – **Service Provider Health Education**

Section Name	Date Read/Completed	Initials
Health Promotion		
DDDS Training Requirements		
Recommended Preventative Screenings/Immunizations		

I, _____, have read and understood the
(print name)
information provided in this section of the DDDS Nurse Consultation Resource Guide. I have had an opportunity to consult with my supervisor and/or his/her designee and my questions have been answered.

_____ _____
Nurse's Signature Date

_____ _____
Signature of Nurse Supervisor / Designee Date

Section 3 – MEDICATION & HEALTH REVIEW

Guidelines

The nurse is responsible for reviewing and auditing the medication and health records, MAR, and orders for all service recipients on their assigned caseload each month. Reviewing medical documentation and monthly medication records for service recipients in Shared Living is done each month as appointment documentation and monthly medication records are received and when Quarterly Reports are due. The Medication and Health Review is completed for each person who lives in a neighborhood home in the electronic client data management system. All Medication and Health Reviews must be entered into the electronic client data management system as an ISP Clinician Report within 14 days of the day the nurse completed the audit. During the Review, the nurse should be looking for all the items listed on the Medication and Health Review ISP, including reviewing the previous months' completed reviews to make sure the residential team has responded and followed up on all previously identified unresolved issues. Medication and Health Reviews for residents of neighborhood group homes (NGH) and community living arrangements (CLA) require a response from the residential program manager within 14 days from the date the nurse enters the review in the electronic client data management system. If no response is received from the program manager after 14 days, the nurse should reach out directly to the program manager to request a response, following up with the residential director/coordinator or supervisor if no response is received from the program manager and document the outreach in a T-log.

Shared Living Progress Reports/Audits

The nurse is responsible for contacting the Shared Living Provider (SLP) at least once a month, either by phone, email or in person. Texting is not an acceptable method of monthly contact with the SLP. The nurse must enter a T-log in the electronic client data management system to document the monthly contact and provide a summary of the conversation. The nurse must also make two home visits annually for those service recipients that are level 0-2 per the

assessment tool and a minimum of quarterly home visits for those service recipients that are level 3 and above that reside in a Shared Living home. During the home visit the nurse will verify that medications in the home match current health care practitioners' orders, are kept in a secure location and that the service recipient's medications are not mixed with medications of other household members. Medications that are considered "controlled medications" must be securely double locked. More visits may be necessary depending on the needs of the service recipient and at the discretion of the nurse. All contacts will be documented in T-log in the electronic client data management system in the DDDS-DE provider level account (do not use the SLP-DE provider level account).

Every time the SLP takes a service recipient to the doctor or dentist, they must take with them a *Medical Appointment Information Record* (MAIR) and/or a *Dental Appointment Information Record* (DAIR) form. Every month the SLP will send the nurse forms for the previous month. It is the nurse's responsibility to enter the information into the electronic client data management system: Scan the document and save it in the service recipient's file in the DDDS-DE provider level account. Enter the electronic client data management system in the DDDS-DE account and go to "Appointments" module in the Health Tracking section. Fill in each area. Attach the scanned document to the appointment screen. When you are finished, be sure to click on submit. If there are any medication changes, go to the "Medication History" module and either click on "New" to enter new medications or click on "Search" and enter the service recipient's name and status (check "In Prep" and "Approved") then "Search". You may then select the medication you need to change and enter the changes. You can go to the other modules and enter weights and vital signs if they are available. This information will then be available when you do the Quarterly Report for the service recipient. Once finished with the form, send the original to Health Information Management (HIM).

If there is any type of incident with a service recipient in Shared Living, the provider is to call DDDS staff. If it is medically involved, they should contact the nurse and give full details. Such incidents might be a fall, a seizure or a medication error. After determining if any follow up care is needed, the nurse is required to notify the support coordinator. The nurse or the support coordinator, depending on who received the initial information from the SLP, will then complete a General Event Report (GER) and a Seizure report (if the incident was a seizure) in the electronic client data management system: Under GER click on new and fill out the report completely and submit it. In the Health Tracking section, you will find the Seizure report. Click on this and answer questions as reported to you, then submit.

The nurse is also responsible for tracking other health issues for the service recipient in Shared Living in the electronic client data management system by entering information obtained from the MAIR into the Health Tracking module. Information such as weight, blood pressure,

seizures, immunizations, and glucose can be tracked for the Quarterly Report. The nurse must complete a Quarterly Report for each service recipient on their caseload in Shared Living. This can be done by setting up a list of required information in the report section: In the Health Tracking section, click on the "Health Care Report" module, select "New" and then on the next screen select the information to be included in the report, the three-month time frame for the report based on calendar quarters, and the service recipient. Select "Generate". The report will appear, at this time you will name the report according to the month and year – for example "January-March 2023 Quarterly Report." There is a section for comments at the bottom where the nurse should enter an information summary on how the service recipient's health was during the quarter and any follow-up needed by the SLP. If there are any issues this is where the nurse will document them. Save the report again. You may then go back to the report and choose to send the report via S-Comm to the day program or the Guardian. After completing the Quarterly report, bill for the time and make a t-log entry stating that it has been done and can be found in the Health Tracking Reports.

SLPs are required to fill out a *"Shared Living / Respite Monthly Medication and Tube Feeding Record."* This form is to be completed monthly, signed by the SLP, and submitted to the nurse by the 10th of the month for the previous month. For example, January's form would be due by February 10th. The form must list each medication the service recipient is receiving, the dosage and how many times a day it is given. There are also columns for number of refills left and when it was refilled last. If a service recipient is receiving tube feedings, that information must be completed as well. Once this is received, the nurse will reconcile the medications with those currently listed in the electronic client data management system adding any new medications into the electronic client data management system or changing/updating the meds in the electronic client data management system so that it is an accurate list. Enter the Monthly Medicaid and Tube Feeding Record into electronic client data management system in the DDDS DDDS-DE provider level account. Scroll down to the Medication History module in the Health Tracking section. Click on "Search" and follow directions as above. When the medication list comes up, compare each medication on the list to the one from the provider. Everything that does not match must be investigated for new orders or changes that have not been reported. If the nurse is unable to identify the cause of the discrepancy, the health care provider must be called for clarification. After all medications are reconciled, both sides and all pages of the Monthly Medication and Tube Feeding Record must be scanned into the electronic client data management system as a new Appointment as an attachment.

Any time a SLP is not meeting contractual requirements, such as missing appointments for the service recipient or not turning in paperwork, it must be documented. If the nurse does the review and finds that appointments are behind schedule, the provider must be contacted and notified of the need for improvement. This must be documented in the electronic client data

management system via T-logs as well as by notifying the service recipient's Support Coordinator and Shared Living Coordinator. Any delay of care/neglect concerns must be reported to the DDDS Office of Incident Resolution through the web-based portal available on the DDDS Website main page https://dhss.delaware.gov/dhss/ddds/.

Shared Living Provider Notebook

The SLP notebook is put together by the DDDS Shared Living Coordinator. The nurse provides a copy of the annual nursing assessment. If the service recipient has a diagnosis that warrants a Medical Alert Form, the nurse will provide that to be placed in the notebook as well.

Neighborhood Home/Community Living Arrangement (CLA) Audit

The nurse is responsible for reading T-logs and General Event Reports (GER) in the electronic client data management system for everyone on their assigned caseload as close to daily as possible. This will give the nurse an idea what is going on with the service recipients in his/her caseload on a day-to-day basis. Neighborhood homes/CLAs must be visited in person. At the visit each service recipient's medications, health record, and MAR are reviewed. The most common issues found in the review of the home are related to medications. The staff working in neighborhood homes are required to complete a Delaware Board of Nursing approved medication administration course called Limited Lay Administration of Medications (LLAM) to learn how to assist service recipients with their medications. The staff member who takes the service recipient to the appointment might not be the one assisting with the medication; therefore, the order and label instructions need to be very clear and specific, leaving no room for guessing or requiring staff to make a "judgement call" about when or whether to give the med or not. Pharmacy labels must match the order exactly as written. The label and prescription/order must also match the MAR. Any LLAM trained staff should be able to help with the medication and do it correctly based on the label. While still at the doctor's office the following must be verified:

1. Staff should make sure they can read / understand the orders before leaving the office.
2. Medication orders must be specific. Orders may not contain the word "or" as in "1 or 2 tablets"; or give choices such as "4 to 6 hours". Orders may not be general, such as "give for pain" but must specify where or what type of pain for which the medication is prescribed (i.e. "Give two tabs every 6 hours for headache.")
3. Orders for topical medications must specify where to apply i.e. "to rash in diaper area" or "to wound on bottom of right foot", etc.
4. If the medication should be taken at a specific time or with/without food, it must be written on the script and MAR.

5. Prescriptions cannot say PRN without explanation. The parameters must be clear so that everyone understands them and assists with the medication/treatment the same way, i.e. “apply ointment twice daily to groin area as needed for rash” or “take 1 tablet for constipation after 3 days of no bowel movement.”
6. When medicines are discontinued, staff must assure that there is a written order to discontinue a medicine for their records. The MAR must be updated to indicate the medication has been discontinued and should not be given.

When reviewing medications, remember:

1. Everything MUST match. The order must match the label and must also match the MAR.
2. Every open medication must have a start date indicated on it somewhere.
3. If a medication is loose and not bubble packed, it must have a count sheet and it must be counted in accordance with current policies and guidelines.
4. If it is bubble packed, check from the start date to the current date and verify that all doses have been given and signed off.
5. If meds have not been given for some reason, they should be indicated on the MAR, make sure the reason is documented on the MAR.
6. Controlled medications must be double locked and counted at every shift change with two staff completing and documenting the count.
7. Check the Over-the-Counter medication order form (OTC) for each service recipient for appropriate PRN medications and start dates. This form must be signed by the healthcare provider yearly. Check that all ordered OTC medications are available in the home. Check start dates on all medications.
8. Ensure that any topical medications are stored separately from oral medications.
9. Check every medication for expiration dates (including all OTC medications) to be sure no expired meds are in the home.
10. If a doctor prints signed office notes electronically and they include medications, *it is considered an order.* If the doctor’s list does not match the current list of medications, document it on the monthly medication and health audit and immediately notify the residential provider. The residential provider program/house manager will need to resolve the discrepancy, usually by contacting the doctor’s office to verify which list is correct and getting the current order corrected in writing, if necessary. Only a nurse is allowed to take verbal orders.

When the nurse is in the home and finds an ongoing medication error, it must be addressed before he/she leaves. If no one is in the home the nurse must contact someone starting with the residential provider program/house manager and working up the agency’s chain until

someone is able to assist. Any medication error discovered must be reported by the nurse to the DDDS Office of Incident Resolution within 24 hours.

After reviewing the medications, the nurse then reviews the electronic client data management system. The comprehensive nursing assessment including all risk assessments, Significant Medical Conditions, and Medical Alerts are checked for any changes that need to be made. The nurse then moves on to the "Appointment" module of the electronic client data management system. Check each medical specialty appointment for any new visits and to see if a visit should have been made and wasn't. Confirm any new orders have been transcribed and ordered correctly. The nurse should document in the electronic client data management system any contact with service recipients, health care providers, HCBS provider staff, or other DDDS staff related to service recipients on his/her caseload.

The nurse uses the "Medication and Health Review ISP" in the electronic client data management system for each service recipient on their assigned caseload. In the "ISP Data" module, the nurse selects "New", then the correct program (usually the home address, ie. BayView 1 or State Street), then the service recipient name, and then selects "Medication and Health Review." When it opens, the next step is to select the date and "Next" then enter the time. The location is service recipient's home. The service provider must be changed; it will not accept your name at this point unless you work for the same provider agency. Select "other" from the drop-down list; if your name is not found, enter your name in the box provided. For each category following, the nurse must select "yes", "no", "N/A" or "action." Comments can be written in the area provided. Every box must have a selection made or the report cannot be completed. There must be a comment at the end or the report cannot be completed. This is where the details of what needs to be done by the house manager should be entered, along with the 14-day due date. After completing the report, hit "save" then at the top of the page select "create report." On the next screen select the appropriate medication and health review and click "next", then select the correct date as the start and end dates. When the report comes up, name it by the month and year and save again. Then select "back to report" from the top of the page and you will be able to send the report via S-Comm to the residential provider program/house manager.

Residential Provider Response

The residential provider is required to review the report and respond to the nurse by the specified date, typically within 14 days from the date the report was finished. The nurse should receive an S-Comm notification that the response is ready in the electronic record. At that time, he/she should check to see that all concerns have been addressed. If all concerns have not been addressed the nurse should follow up with the residential program/house manager to find out what the plan of action is, and if concerns are not followed up by the time the next monthly

medication and health review is conducted the concerns should be documented on the review again and escalated to the residential supervisor and/or reported to DDDS as appropriate.

Coordination, Advocacy, Monitoring of Appropriate Follow-Up & Resolution of Identified Clinical Needs

The residential provider is responsible for helping the service recipient to select health care providers and dentists if they are not already actively seeing one. They must help the service recipient choose from those approved by their insurance. Insurance is always the primary pay source, and Medicaid is the "payer of last resort." DDDS does have some contracted dental/optometry/nutrition providers that can be used if the service recipient's needs exceed what is covered by insurance, and the service recipient doesn't have funds to pay out of pocket for care. The nurse does not typically schedule the appointments. The staff at the service recipient's home are the ones that know what fits into their schedules the best. The nurse also does not routinely attend appointments but may under special circumstances. These circumstances may be a potential new diagnosis of a significant medical condition, any serious condition which the provider feels they need help understanding, a condition which is not improving, etc. After appointments, the residential provider is responsible for scanning the MAIR, DAIR, PAIR, all pages of office notes, discharge instructions, lab orders, testing orders, results, prescriptions copies, etc. into the electronic client data management system along with any lab and radiology reports. The nurse will review these as they come in as he/she does with those received from the SLPs. It is the nurse's responsibility to advocate for the service recipient if he/she feels there may be an alternative treatment, or the service recipient has increased physical needs. If anything stands out from any report, the nurse should contact the residential provider to discuss it with them and determine if any further action is needed. This may be a need for an immunization, a referral to see a specialist, need for more frequent blood pressure checks, teaching needs for providers related to a new diagnosis or treatment – Ex: with a new diagnosis of diabetes staff need to understand the Glucometer as well as Hyperglycemia and Hypoglycemia.

Referrals to Medical Specialists

Physicians may refer people to medical specialists at any time. However, if the service recipient is insured by Medicaid, the support team can elect to refer the service recipient to a specialist for care as well, provided there is a medical need and the provider accepts Medicaid as payment. In-network providers are preferred whenever possible.

List of Contracted Professionals/Funding Guidelines

DDDS maintains a current list of professionals with whom they contract to fund services after Medicaid coverage is exhausted (i.e. dental, optometry, nutrition). Contact the Assistant Director of Community Services overseeing clinical services to obtain a copy of this list and guidelines for funding.

Dental Services

When dental care is neglected, it can lead not only to tooth decay and gum disease, but to other significant health problems as well. This protocol outlines responsibility to ensure that service recipients get appropriate and fiscally responsible dental care.

Most service recipients have Medicaid funded dental coverage. Medicaid and any other insurance coverage must be exhausted prior to requesting funding support through any contract the Division holds with private dental providers. However, the Division does maintain some contracts with private dental providers that can be accessed to fund medically necessary dental services that are outside of what is funded through insurance coverage. A Division contract manager is assigned to over-see contracted dental services so as to maximize funds and provide support to as many people who need it as possible.

The Medicaid Managed Care Organization (MCO) care team can help service recipients and their support teams locate dental providers who accept Medicaid coverage. The Division will not routinely fund dental services by a dental provider who does not accept Medicaid or the service recipient's other insurance coverage. All effort must be made to locate a dental provider that accepts the insurance coverage of the service recipient. Additionally, service recipients may be responsible to contribute to the cost of their dental care outside of insurance coverage before the Division contract funds can be utilized.

The nurse should review the Dental Appointment Information Record (DAIR) as soon as possible after each dental visit and be familiar with the service recipients dental care needs. The Division dental contract manager may request supporting documentation from the nurse to substantiate the need for recommended dental treatment plans submitted to the Division for funding consideration.

The nurse may be responsible for teaching the service recipient and/or his or her support staff how to provide proper dental care. Attached to this protocol are training tools the nurse might utilize.

Section 3 – **Medication and Health Review**

Section Name	Date Read/Completed	Initials
Guidelines		
Shared Living Medication Logs		
Shared Living Progress Reports/Audits		
Shared Living Provider Notebook		
Neighborhood Home/ Community Living Arrangement (CLA) Audit		
Residential Provider Response		
Coordination, Advocacy, Monitoring of Appropriate Follow Up and Resolution of Identified Clinical Needs.		
Referrals to Medical Specialists		
List Of Contracted Professionals/Funding Guidelines/Dental Services		

I, _____, have read and understood the
(print name)
information provided in this section of the DDDS Nurse Consultation Resource Guide. I have had an opportunity to consult with my supervisor and/or his/her designee and my questions have been answered.

_____ _____
Nurse's Signature Date

_____ _____
Signature of Nurse Supervisor / Designee Date

Section 4 – Admission to and Transfer of Residential Services

Admission from Community/Family Home

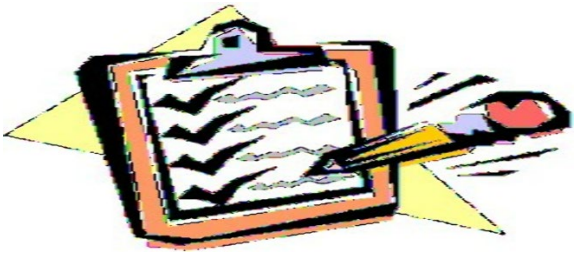
<u>Nurse's responsibilities when a service recipient is admitted to Residential Services:</u>

- Attend Transfer Planning Conference (TPC) Meeting (Usually 30 days prior to admission); also attend pre TPC if scheduled. If service recipient has a targeted case manager, ask them for caregivers contact information prior to the TPC. Call caregivers and ask them to bring to TPC the following (if possible): medical records; most recent physical exam documentation; list of current medications; immunization record; and proof of a two-step tuberculin skin test or interferon-gamma release assay test (IGRA) performed within 30 days of the move in date (prior or post) for neighborhood group homes and community living arrangements, or within 6 months prior to the move in date for shared living placements. If a two-step tuberculin skin test or IGRA has not been performed according to these timelines, advise caregivers to begin the testing process now, as it is required.
- Take RN TPC Checklist in this document below, Annual Physical Exam form, OTC, release of information, and blank MAIR/DAIR/PAIR to the meeting.

Obtain the following information from transferring nurse, parents, and/or caregivers.

1. Vital Statistics (weight, height, usual BP and pulse, etc.)
2. Diagnoses and medical history including communicable diseases
3. List of current medications (dosage, frequency, prescribing physician) and copies of medication orders/prescriptions (usually available from the filling pharmacy if the caregiver does not already have copies available.)
4. Current physician's addresses and phone numbers and any scheduled or needed appointments. Discuss if there is a need to establish any new practitioners.
5. Immunization information- inform caregiver/provider that 2 step tuberculin skin test or IGRA is required in accordance with the timelines described above
6. Copy of most recent physical exam (completed within the last year). If most recent physical was more than a year prior, inform caregiver that a new physical will need to be obtained prior to admission.
7. List of adaptive Equipment (how maintained, repair information)
8. Nursing Assessments and person-centered plan (if one is in place or has been developed)
9. Discuss need for Physical, Occupational and Speech Therapy assessments and Audiology
10. Discuss supports the service recipient needs for medical procedures (i.e. antibiotics prior to dental appointments, conscious sedation, etc.)
11. Discuss who will sign consent forms for medical/dental procedures. (This should be either the service recipient or their legal guardian for routine consents. A surrogate decision maker can be appointed under Del. Code Title 16, chapter 25, for situations when a physician declares the service recipient lacks capacity to sign consent at that particular moment in time.)

Individuals must have a current physical or comprehensive medical exam, current immunization record, 2- step tuberculin skin test or interferon-gamma release assay test, current medication orders and OTC form completed in accordance with the timelines above.
Ask caregivers to bring as much medication as possible as well as prescriptions for all medications on the day of admission (at least a 2-week supply of medication). Prescriptions can typically be obtained through the filling pharmacy if the caregiver doesn't have copies of the current prescriptions.



Nurse's Responsibilities Day of Admission

(Documentation requirements assume that the service recipient's record has been migrated to the residential provider's account in the electronic client data management system on the day of admission. If the record is not yet available on the day of admission, the documentation requirements must be met within two business days of the record becoming available in the residential provider's account.)

- Complete Fall and Aspiration Assessments, attach and document in a T-log and attach to the PCP if it is available or send to the Support Coordinator to attach. *Emergency placement assessments must be done within 48 hrs.*
- Review medical documentation
- Ensure appointments that are immediately needed are scheduled
- Count medications, complete medication transfer form, complete count sheet form for any medication not in bubble packs (neighborhood homes/CLAs only), document by T-log
- Obtain copies of prescriptions/orders and ensure house manager or SLP sets up pharmacy account and turns in prescriptions to be filled. For Shared Living Providers, review expectations that monthly medication logs are due to the nurse on the 10th of every month for the previous month (ex. March med log is due by April 10th).
- Ensure proper storage of medication.
    - In a neighborhood home/CLA, each service recipient's medication should be labeled and separated from housemates and all medications locked. Controlled substances must be doubled locked. Internals must be separate from externals. When possible and practical, all medications should be requested in "bubble packs".
    - In an SLP's home, medications for service recipients should be kept separately from other medications in the home, and medications for 2 or more service recipients are to be separated by service recipient and locked in a cabinet. Internals and externals are separate.
- Review MAR and treatment record for accuracy

- Start Health Records in electronic client data management system. Draft a preliminary E-CHAT assessment record to be updated within 30 days of placement

- **<u>Day of Move In Checklist- Neighborhood Home/CLA (*Emergency placement done within 48 hrs)*</u>**

- ☐ Complete fall and aspiration assessment day of move in or within 2 business days if the record is not available the day of move in
- ☐ Ensure medications are counted, medication transfer forms are completed (transfers only), count sheets started on any medications not bubbled packed
- ☐ Ensure proper storage of medications
- ☐ Review MAR and treatment record for accuracy
- ☐ Ensure residential providers schedules appointments that are immediately needed
- ☐ Ensure Health Records are started in electronic client data management system or within 2 business days if the record is not available the day of move in

<u>Nurse's responsibilities within 30 days of move in</u>

- Ensure residential provider has scheduled needed medical appointments
- Ensure copies of physical exam form, OTC, current prescriptions, and current immunization record are in SLP notebook (for SLPs only) and uploaded to the electronic client data management system, obtain copies for nurse's record. (Annual physical, OTC, current prescriptions, current immunization record, vision exams, and dental cleanings scanned into the electronic client data management system; Neighborhood home/CLA residential-agency responsibility; SLP- nurse responsibility)
- Ensure baseline assessments are scheduled (OT/PT, Speech, Audiology, GYN) as needed
- Complete and send nutritional evaluation to Registered Dietician for all new admissions, document by T-Log
- Ensure appointments for needed immunizations including Flu, Covid, Tetanus within the last 10 years, and any others indicated are scheduled.
- Complete the E-CHAT Nursing Assessment, risk assessments, Significant Medical Conditions, Med Alert, document in the electronic client data management system. If service recipient is new to the Division, complete a Nursing Assessment. If the

service recipient has a Nursing Assessment from a previous placement, it should be updated at this time.

- Ensure baseline tuberculin screen documentation has been obtained as described above.

30 Day Post-Move In Checklist

- ☐ Complete E-CHAT Nursing Assessment and attend 30-day meeting, document in the electronic client data management system.
- ☐ Complete and send nutritional evaluation to Registered Dietician for all new admissions, document by T-Log
- ☐ Ensure needed medical appointments are scheduled
- ☐ Ensure copies of physical exam, OTC, current prescriptions/ physician's orders are in electronic client data management system, give SLP copies for SLP notebook, and keep copies for nurse's record. (All MAIR/DAIR forms scanned into electronic record)
- ☐ Ensure baseline assessments are scheduled (OT/PT, Speech, Audiology, GYN) as needed
- ☐ Ensure appointments for needed immunizations including Hep B, Flu, Covid, Tetanus within the last 10 years, and any others indicated are scheduled.

Planned Placement Transfer Checklist

The Nursing Transfer Procedure listed below must be followed when transferring a service recipient from one residential placement to another or from one Nurse Consultation provider to another Nurse Consultation provider.

- Prior to the transfer planning conference/clinical transition review (TPC/CTR) the transferring nurse shall review the medical components of the electronic client data management system and is responsible for updating any issues.

- The following must be completed as part of the final nurse review:

  - ✓ Physical - current or is scheduled
  - ✓ Medical Appointments - current or are scheduled

- ✓ Medication orders correspond with MAR/ Monthly Med Logs, and medication labels
- ✓ Health care provider orders for all medical equipment and for current diet
- ✓ Document in T-log that all ordered testing has been completed or scheduled
- ✓ Update or complete a Transfer Planning Conference Checklist listing dates and times of upcoming appointments for the receiving nurse
- ✓ Ensure E-CHAT Nursing Assessment, Fall Risk and Aspiration Risk assessments, Significant Medical Conditions and Med Alert contains all current and relevant information
- ✓ E-CHAT Nursing Assessment, Fall Risk and Aspiration Risk assessments, Significant Medical Conditions, and Med Alert must be updated if person-centered plan meeting is scheduled one month or less after the transfer
- ✓ Shared Living Provider (SLP) Notebook contains updated/current medical information.
    - ❖ SLP Notebook must minimally include:
        - o E-CHAT Nursing Assessment
        - o Significant Medical Conditions
        - o Medical Alerts
        - o Fall Risk Assessment
        - o Aspiration Risk Assessment
        - o MAIR/DAIR/PAIR and medication orders
        - o OTC
        - o Completed Annual Physical Exam form or visit summary from physician that contains all information on the Annual Physical Exam form
        - o Information about required medical procedures, etc.
        - o Medication Side Effects Sheet from pharmacy, physician, or printed from web
        - o Immunization Record
        - o Miscellaneous Data Record (seizures, falls, etc.)
        - o Current Diet Order and guidelines

Section 4 – **Admission and Transfers**

Section Name	Date Read/Completed	Initials
Admission From Community/Family		
Day Of Admission Checklist		
30 Day Post-Admission Checklist		
Planned Placement Transfer Checklist		

I, _____, have read and understood the
(print name)
information provided in this section of the DDDS Nurse Consultation Resource Guide. I have had an opportunity to consult with my supervisor and/or his/her designee and my questions have been answered.

_____ _____
Nurse's Signature Date

_____ _____
Signature of Nurse Supervisor / Designee Date

Section 5 – Limited Lay Administration of Medication

Limited Lay Administration of Medication (LLAM)

Guidelines

Medication Administration in neighborhood homes and CLAs is typically handled by direct support staff who have completed the Limited Lay Administration of Medication (LLAM) course regulated by the Delaware Board of Nursing. Direct support staff who have completed LLAM are known as Unlicensed Assistive Personnel (UAP). All providers of Nurse Consultation must observe a LLAM course to be aware of LLAM limitations and guidelines and their attendance at the LLAM course must be documented.

In order to administer medication to a service recipient being supported by the Division of Developmental Disabilities Services (DDDS), Unlicensed Assistive Personnel (UAP) must successfully complete all sections of the **DDDS Limited Lay Administration of Medication (LLAM) course.**

Qualifications for Participants in the LLAM course:

- 18 years old or older

- Current CPR certification
- Read, write and speak English
- Competency in basic math *(addition, subtraction, metric, apothecary)*

It is the employer agency's responsibility to complete "Participant Prerequisite Checklist" form acknowledging that all prerequisites have been met by participant prior to attending the LLAM course. The checklist form will be signed by the employer agency representative and either emailed to the ddds_opd_questions@delaware.gov Resource Mailbox or brought to the LLAM course by the attending participant. The checklist form will be returned to the employer agency via the LLAM class participant, along with the letter of completion, to be kept in the employee file.

Completion of the initial LLAM course required of all newly hired staff consists of:

- Attend 2 *(two)* classroom days for minimum of 8 *(eight)* hours and pass a written exam with passing score of 85% or better
- Successful Demonstration of 10 *(ten)* Supervised Field Medication Passes*
  - Will be completed within 60 days of 1st day of class date
  - **During the federal Public Health Emergency associated with Covid-19, the requirement to complete 10 Supervised Field Medication Passes was temporarily lifted. UAPs who have successfully completed the LLAM course and exam may administer medications. The federal Public Health Emergency expires 5/11/23 and the Division's CMS Appendix K authority expires 11/1/23. The 10-field pass requirement will be reinstated for all UAPs completing LLAM after 10/31/23. UAPs who completed LLAM training during the federal Public Health Emergency will not need to go back and complete 10 field passes.*

A "Letter of Completion" will be issued to each participant once the classroom portion of the course is completed but is only valid after 10 *(ten)* medication passes have been successfully completed (* *see above*) and signed by the agency supervisor/designee. The "Letter of Completion", the "Participant Prerequisite Checklist" and the corresponding completed "10 Supervised Field Medication Pass Observations" will be maintained in the employee file at the employing agency. Staff are not authorized to pass medications to DDDS service recipients until these 3 documents (* *see above)* are signed and dated as indicated.

Failure to successfully complete all of the requirements of the program within the specified time frame of 60 days will require the participant UAP to re-take the two *(2)* day program before administering medications to individuals of DDDS.

If participant fails either the skill session(s) or exam, he/she may retake the session or exam one *(1)* time. The test retake should be completed no later than 10 business days following the

initial exam. A 30-minute review with a qualified LLAM instructor must take place prior to retaking the exam. If the participant fails a second time, he/she will be required to repeat the full two-day course after 6 months with recommendations from his/her supervisor that he/she is prepared to retake the course.

If a LLAM trained UAP commits two medication errors within a six *(6)* month time frame, he/she must repeat the entire LLAM training program including five *(5)* Supervised Field Medication Pass Observations before resuming LLAM duties.

It is the agency's responsibility to monitor the number of medication errors and to take appropriate steps as outlined by this curriculum.

Thereafter, the LLAM trained UAP will renew annually:

- Attend one *(1)* Full classroom day *(6 hours)* and pass a written exam with passing score of 85% or better

LLAM trained UAP's are required to renew their status annually by successfully demonstrating competency in the LLAM process with no errors. A letter of completion will be issued after successful renewal of competencies and exam with passing score of 85% or better.

LLAM trained UAP's are required to verify current CPR status (Participant Prerequisite Checklist).

Annual renewals should be scheduled every 11 months, which allows time for the participant to retake any requirements that he/she did not successfully complete during the first attempt before his/her LLAM authorization expires. The employer agency must monitor LLAM expiration dates for their staff. Any UAP whose LLAM training has expired will not be authorized to administer medications to DDDS service recipients. ** *During the federal Public Health Emergency associated with Covid-19, DDDS extended LLAM authorizations for UAPs who remain in good standing, which is defined as less than 2 med errors in a 6-month timeframe. During the federal Public Health Emergency, UAPs in good standing do not have to recertify annually. The federal Public Health Emergency expires 5/11/23 and the Division's CMS Appendix K authority expires 11/1/23. After 10/31/23, UAPs will need to fully recertify in LLAM by their previous annual date. (For example, a UAP who was authorized in LLAM on February 1, 2020, and remains in good standing, will need to recertify in LLAM by February 1, 2024.)*

If renewing participant fails either the skill session(s) or exam, he/she may retake the session or exam one *(1)* time. If the participant fails a second time, he/she will be required to repeat the full two *(2)* day course after six *(6)* months with recommendations from his/her supervisor that he/she is prepared to retake the course.

If a LLAM trained UAP commits two medication errors within a six *(6)* month time frame, he/she must repeat the entire LLAM training program including five *(5)* Supervised Field Medication Pass Observations before resuming LLAM duties.

It is the agency's responsibility to monitor the number of medication errors and to take appropriate steps as outlined by this curriculum.

Classroom Key Points:

- Class size limited to 1:20 student ratio.
- Must present Photo I.D. when entering class.
- Bring prerequisite checklist.
- Bring LLAM course workbook.
- If more than 10 minutes late for class, staff will need to be rescheduled.
- If the trainee needs to leave the classroom early for any reason, the class will need to be rescheduled.

LLAM Instructor Qualifications

- **New Instructor Requirements:**
  - Active Delaware or compact state RN license in good standing.
  - One year of clinical nursing experience, including experience in medication administration.
  - At a minimum, observation of the presentation and successful completion of the core curriculum and any eligible program specific module to be taught.
  - Presentation of at least one component of the core curriculum and any eligible program specific module to be taught with observation by a qualified instructor. Documentation of observation must be completed on the Limited Lay Administration of Medications (LLAM) Instructor Monitor Form and provided to the eligible program.
  - Once the above requirements have been completed, the nurse must submit the following documentation to the DDDS LLAM Program Coordinator:
    - A copy of his/her RN license
    - Resume
    - A copy of the class voucher to verify class attendance
    - Limited Lay Administration of Medications Instructor Monitor Form
    - Letter of Recommendation from his/her supervisor
  - When the DDDS LLAM Program Coordinator determines all requirements have been met, a letter will be issued to the RN recognizing him/her as an approved instructor to teach Limited Lay Administration of Medication (LLAM) course that has been approved

for the Division of Developmental Disabilities Services programs. The nurse must meet all requirements as outlined by the Delaware Board of Nursing to continue with his/her instructor status.

- **Current Instructor Requirements:**
  - Qualified instructors must present a minimum of one core curricula and eligible program specific module per year. If an instructor fails to present in a single year, that instructor must again complete the core curriculum and any eligible program specific module before s/he will be deemed a qualified instructor.

A list of all LLAM instructors will be maintained by the DDDS LLAM Program Coordinator and submitted annually to the Delaware Board of Nursing as part of the Limited Lay Administration of Medication (LLAM) Annual Report.

Field Medication Passes (**see above*)

The observed field medication passes are designed to give the UAP trainee the opportunity to practice the application of the information that they have learned in the classroom. The field pass is an exercise for the UAP trainee and serves as an opportunity for the authorized observer to share his/her knowledge and expertise with the trainee.

A medication pass is defined as administering or assisting with the administration of medication(s) during one *(1)* medication pass time regardless of how many service recipients at this time were provided medication. A trainee can only receive credit for the completion of one medication pass at a time with no exceptions. Ten *(10)* supervised medication passes are required because the purpose of supervised passes is to help the trainee become familiar with the entire medication process from start to finish, with no errors.

> ***For Example,*** the 3-11 shift with 4 PM and 8 PM medication administration times would provide the opportunity for two *(2)* observation passes to be completed.

The employer agency is responsible for ensuring that there is a system in place to monitor the ongoing performance and supervision of the field medication passes occurring in all of its programs.

If the LLAM trained UAP trainee fails to correctly carry out any one *(1)* step of the medication pass, the medication pass is considered unsuccessful and must be repeated correctly at another time after reviewing the steps of the medication process.

In the event that a LLAM trained UAP transfers from one agency to another, five *(5)* medication passes are required to demonstrate competency. Staff are not authorized to pass medications to DDDS service recipients until the five *(5)* medication passes are completed and documented on the Supervised Medication Pass Observation form. LLAM renewal will continue as required, on a yearly basis, from the date of the last renewal.

- **The authorized observer is:**
  - An employee with the Division of Developmental Disabilities Services (DDDS) or a DDDS contractor with a minimum of two *(2)* years of experience. These individuals shall have no history of medication errors over the past one *(1)* year and shall be current in all criteria for LLAM trained UAP's from the Limited Lay Administration of Medication (LLAM) course; or
  - A supervisor with DDDS or a DDDS contractor, at least at a Program Manager or Program Coordinator level with a minimum of six *(6)* months of experience. These individuals shall also be current in all criteria for LLAM trained UAP's from the Limited Lay Administration of Medication (LLAM) course; or
  - A nurse who currently holds a valid state of Delaware nursing license, has attended the two-day Limited Lay Administration of Medication (LLAM) course through DDDS and has worked within the DDDS system for a minimum of three *(3)* months.

There is mutual responsibility between the authorized observer and the trainee. Extreme caution and care will be made to ensure the service recipient's safety during the process of medication administration. A medication error could be considered neglect, resulting in criminal investigation, charges, and or fines.

The LLAM trained UAP may:

- Participate solely within the confines of the core curriculum and any applicable program eligible module.
- Administer medication without assessing the appropriateness or effectiveness of the prescribing practitioner's medication order.
- Administer only injectable emergency medications pursuant to the core curriculum.

The LLAM trained UAP may not:

- Administer medications through a feeding tube, including nasogastric, gastrostomy, or jejunostomy tubes.
- Be a held responsible for assessing pharmacy accuracy either by identifying the appearance of the medication or assessing proper medication dosing for medications released by the pharmacy.

Documentation:

All eligible programs must maintain a monthly LLAM medication error report, retained on site and readily available for inspection at all times. Send to DDDS LLAM Program Coordinator by the 5th of the month for the preceding month.

All eligible programs must provide an Annual Report to DDDS for review. This annual reporting period is July 1st to June 30th and must be received by the DDDS LLAM Program Coordinator no later than July 14th.

The DDDS Service Integrity and Enhancement will confirm that all required documentation as described in the above mentioned LLAM trained UAP criteria are present during audits, as evidence of the authorization to assist without direct supervision during the administration of medications.

A copy of the monthly error report is sent by the DDDS LLAM Coordinator to DDDS Service Integrity and Enhancement by the 5th of the month.

A copy of the annual report is sent by the DDDS LLAM Program Coordinator to the Delaware Board of Nursing by August 1st.

Pharmacy Label Changes and Verbal Orders

ONLY an RN or another licensed healthcare professional is permitted to change a pharmacy label and then only with orders from a physician or other individual legally permitted to prescribe medications. An RN is permitted to create a pharmacy-type label when the pharmacy is not able to label a medication that they did not fill. The created label must match the current doctor's order for the medication.

ONLY an RN is allowed to accept verbal orders from a physician or other individual legally permitted to prescribe medications. The verbal order should be transcribed onto the MAR exactly as it is given to the nurse, and a written order must be obtained as soon as possible.

Section 5 –Limited Lay **Administration of Medications**

Section Name	Date Read/Completed	Initials
Limited Lay Administration of Medication (LLAM) Training Program		
Pharmacy Label Changes and Verbal Orders		

I, _____, have read and understood the
(print name)
information provided in this section of the DDDS Nurse Consultation Resource Guide. I have had an opportunity to consult with my supervisor and/or his/her designee and my questions have been answered.

_____ _____
Nurse's Signature Date

_____ _____
Signature of Nurse Supervisor / Designee Date

Section 6 – Policies, Protocols and Forms

DDDS POLICIES

Approved and active DDDS policies can be found on the Policy page of the DDDS website https://dhss.delaware.gov/dhss/ddds/ddds_policy_main.html . Although all DDDS policies apply to all DDDS and contracting agency staff at all times, there are some policies that are of particular interest to clinical staff and MUST be reviewed by the nurse upon hire. In this section, an overview of the most relevant policies for nurses is provided.

Abuse & Neglect

This policy outlines the standardized procedures for responding to allegations of abuse, attempted suicide, neglect, mistreatment, financial exploitation and significant injury. Standardized procedures are established by this policy for reporting, investigation and follow-up. ALL DDDS staff and contractors who have reason to believe that any type of aforementioned abuse has occurred are required to take the following measures:

- Take action to treat, protect and comfort the service recipient(s) involved
- Ensure that victims of alleged sexual assault are examined by a Sexual Assault Nurse Examiner (SANE) at the hospital as soon as possible after the alleged assault
- Contact police to report criminal activity and protect the crime scene as necessary
- Report events to the regional Office of Incident Resolution Administrator (OIRA) through the web reporting portal available on the DDDS website (middle of the main page).
- Make a verbal report to the Division Health Care Quality (DHCQ) by calling the 24-hour toll free number: 1-877-453-0012

Consent for Elective Surgery

For service recipients who do not have the ability to give informed consent (as specified in Title 16 Del. C. §5530 – 5531) for elective medical or dental treatments, the DDDS has established the "Consent for Elective Surgery by Division Director/Designee" policy. This policy establishes standards and procedures for obtaining informed consent from the Division Director or designee for service recipients without a guardian or surrogate decision maker who are receiving residential services from DDDS and/or contracting agencies. The Consent for Elective Surgery form is completed by the Consultative Nurse and sent, along with consent forms, to the designated DDDS contact.

Cannabis and Cannabis Derivative Products (Guidance)

This guidance document provides an overview of cannabis and cannabis derivative products that are currently legal under state law in Delaware, or under federal law, and when/where/and by whom they can be used in DDDS provider-managed settings.

Death of an Individual

When a person receiving services from DDDS dies, there is a standardized process which must be followed. These procedures are outlined in the Death of an Individual Policy. It is the responsibility of the DDDS Support Coordinator to coordinate burial plans with the service recipient's family. However, there are some specific things the nurse must do when someone dies. According to this policy, the nurse must be notified when a person receiving services dies, whether in the care of a residential agency, a shared living provider or other in-patient facility. Within one (1) business day of receipt of notice, the Nurse Supervisor or designee (designee is typically the nurse consultant) MUST:

- Secure and audit all of the service recipient's medications, both prescription and non-prescription

- Document findings in a T-log. If there is a discrepancy, explain it to the best of his or her knowledge in the documentation
- Consult with the Office of Incident Resolution Administrator (OIRA) to determine if there is any on-going investigative activity related to the death
- If there is ongoing investigative activity related to the death, transfer unused medications to the OIRA. The nurse must document the transfer of this evidence on the Medication Chain of Evidence form (attached to this policy)
- If there is no investigative activity related to the death, the nurse will dispose of any unused medications in accordance with policy, in the presence of a witness, and document this activity in a T-log

HIPAA and Confidentiality

Maintaining confidentiality is not only a legal requirement, but is also the basis for all relationships, as well as respect of personal privacy. DDDS will conform to all applicable requirements set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, including Electronic Health Care Transaction, Privacy, Confidentiality, and Health Data.

This policy is to be used as a supplement to DHSS Policy Memorandum Number 5.

Human Rights Committee

This policy specifies the elements and operations of the DDDS Human Rights Committee (HRC). The purpose of the Human Rights Committee (HRC) is to review: complaints of rights violations made by DDDS service recipients and completed investigations that determine whether a service recipient's rights were violated; rights restrictions included in a Behavior Support Plan; rights restrictions necessary for a medical or safety-related reason not related to a behavior support need; and to advise and make recommendations to the DDDS Director of Community Services to ensure that the human rights of DDDS service recipients are protected.

Tuberculin Screening for Home and Community Based Service Recipients Guidance

The purpose of this guidance is to provide guidance to Authorized Providers of the Division of Developmental Disabilities Services (DDDS) regarding tuberculosis screening and testing requirements for DDDS eligible service recipients living in a provider-managed residential setting, in accordance with federal and state regulations.

DDDS Home and Community Based Waiver Standards

The purpose of the Standards is to ensure that providers understand the expectations of the Division regarding the operation of each HCB waiver service, including the desired experience of the service recipients they support. These are the Standards against which they will be

monitored and held accountable by the DDDS Service Integrity Program Evaluators and the Office of Incident Resolution. Nurse Consultation is an HCB waiver service.

PROTOCOLS & GUIDELINES

In addition to the policies that govern the activities of DDDS and its affiliate agencies, DDDS has developed for use a series of protocols that provide information about best practices in nursing as they relate to providing support to people who have developmental disabilities. In this section, an overview of the current DDDS protocols for nursing is provided. The nursing protocols can be found on the DDDS website https://dhss.delaware.gov/dhss/ddds/nursing_forms.html .

Aspiration and Choking Healthcare Protocol #1

This protocol sets forth guidelines for assessing people who may be at risk of aspiration or choking, as part of their comprehensive Nursing Assessment/ECHAT. Service recipients receiving nurse consultation services are assessed upon entry to a residential placement and at least annually thereafter at the time of their person centered plan review, or whenever circumstances warrant an updated assessment.) The nurse is responsible for completing this assessment. Service recipients who have a change in health status must be assessed any time during the year the need is present.

Enterostomy Tube Management Healthcare Protocol #2

People are generally prescribed an enterostomy tube (a medical device placed into the stomach or small intestine via a surgical procedure) for feeding, hydration or receiving medication. For these people, proper care and maintenance is critical. The Delaware Board of Nursing has advised DDDS that Shared Living Providers can be considered to have the same eligibility to participate in providing this type of care as any other eligible family member. LLAM UAPs in provider-managed residential settings (outside of the Shared Living program) ARE NOT allowed to provide any enterostomy related care.

The Shared Living Provider must be a licensed Registered Nurse or a Licensed Practical Nurse. Shared Living Providers who are not nurses but are “grandfathered in” because they have supported service recipients with enterostomy tubes for several years must evaluated by a Home Health Agency nurse annually as to their ability to provide appropriate care. The provider’s capability, interest, resources, etc. will be evaluated to determine their ability to meet the needs of the service recipient.

To provide this type of support to a service recipient in a Shared Living residential placement, the Shared Living Provider MUST:

- Possess a current Shared Living Medication Administration training completion certificate and one year experience assisting with medications

- Possess a current CPR and First Aid certification
- Demonstrate the ability to count and record respiratory and pulse rates
- Successfully complete a Feeding, Hydration, General Knowledge, and/or Medication Assistance via Enterostomy Tube return demonstration (as appropriate to the service recipient's support needs) using the appropriate Competency Evaluation Tool (all forms attached to this protocol). The competency evaluation must be completed by a Home Health Agency nurse, form completed, and then attached to the person centered plan by the Support Coordinator
- Repeat the return demonstration each year with the Home Health Agency nurse.

The nurse will provide training to the Shared Living Provider about the use and care of the enterostomy tube. The training must contain the following components:

- General overview of how the administration of medication through the enterostomy tube relates to Shared Living Medication Administration.
- Purpose of the enterostomy tube
- Overview of different kinds of enterostomy tubes
- Overview of the different methods of tube feeding (bolus, continuous, intermittent)
- The importance of clean technique and how to clean equipment
- Proper maintenance of enterostomy tubes
- General positioning issues as well as positioning relative to the service recipient's specific needs
- Overview of the signs and symptoms of problems with enterostomy tubes
- How to prepare different forms of medications for use with the enterostomy tube
- Consideration of residual check maintenance
- Safe management and storage of formula and equipment
- Completed Enterostomy Tube Information Form specific to the service recipient's support needs (attached to this protocol)
- Service recipient-specific training relative to all of the above including on-site return demonstration by a registered nurse, verified with the Competency Evaluation Tool (attached to this protocol)

Fall Management Healthcare Protocol #3

The Fall Management Protocol outlines procedures for identifying service recipients who may be at risk for falls and for helping to keep them safe and protect them from injury.

When a service recipient enters residential services a Fall Risk Assessment will be completed by the nurse as part of the pre-admission process. The Fall Risk Assessment is repeated annually to coincide with the person-centered plan meeting, and anytime it is warranted due to a change in the service recipient's circumstances. If a service recipient is determined to be at risk for falls, a fall prevention plan, specific to the service recipient, will be a part of the annual Comprehensive Nursing Assessment (ECHAT, Significant Medical Conditions, Med Alert, and

related annual assessments) related to the person-centered plan. Fall prevention plans include, at a minimum; needed education, physical, medical and environmental factors.

All falls, whether witnessed or discovered, shall be documented in a GER in the electronic client data management system and reviewed by the assigned nurse. An important step in reviewing the fall is trying to determine why the person has fallen. At the nurse's request, an assessment by a physical/occupational therapist may be ordered by the health care provider.

Any fall that requires medical care beyond first aid must be reported within 24 hours as significant injury incident through the web-based incident reporting portal on the DDDS website by the residential provider or day service provider.

Nutrition Management Healthcare Protocol #4

The purpose of this protocol is to effectively and efficiently promote and monitor nutritional health and safety for people receiving services.

A. A Registered Dietician (RD) will complete a Nutritional Assessment on all service recipients upon admission to a provider-managed residential setting.

B. Annually, a nutritional screening will be performed by the nurse for all service recipients. The screening will be part of the Electronic Comprehensive Health Assessment Tool (E-CHAT). During this review, if the nurse deems it necessary, a referral to a RD will be completed.

C. A service recipient can be referred to the RD for re-assessment anytime if the nurse deems the service recipient's health status warrants. Also, at the request of the service recipient, family, guardian, or health care provider, the nurse can complete a referral to the RD

D. Nutritional status will be discussed with the service recipient, their advocates/family, and other support team members at the time of the person-centered plan meeting. Outcomes of that process shall be documented in the person-centered plan.

Self-Administration of Medication Healthcare Protocol #5

The Self-Administration of Medication Protocol has two objectives. The first is to provide a way to assess the skill and ability of service recipients ready to administer their own medication independently, and the second is to guide service recipients wishing to learn how to administer their own medications or medical treatments.

When a service recipient expresses a desire to be able to administer their own medications, or a member of his or her support team makes the determination that the service recipient may be capable of administering their own medications, a meeting with the support team must be held to discuss the assessment and training process.

The nurse will complete the Self-Administration of Medication Assessment Form (attached to this protocol) to determine the service recipient's readiness and ability to administer their own medications. If the nurse's assessment concludes that the service recipient has the skills necessary for this task, a self-medication training program will be implemented.

For service recipients able to administer their own medications, the nurse will include information in the ECHAT indicating "supports needed for taking medication" and describing what parts the service recipient does, what parts of the process must be completed by staff and how this process is monitored. This information should also be included in the person-centered plan.

The nurse must complete a new Self-Administration of Medication Assessment form to coincide with the service recipient's annual person-centered plan meeting, or whenever there is a decline in skills for the service recipient. The completed assessment must be scanned into the electronic client data management system and saved as an attachment to the person centered plan.

OTHER HEALTHCARE GUIDELINES

Seizure Rescue Medicine Guidelines

Recently, new seizure rescue medicines have been introduced into seizure management protocols for service recipients diagnosed with seizure disorder or related diagnoses. Diazepam rectal gel (also known as Diastat) remains the most frequently prescribed seizure rescue medicine and is a medication that comes in a pre-packaged rectal delivery system and is used to stop prolonged seizures and clusters of increased seizure activity. It works much more quickly than oral medications and is much easier to give than IV diazepam. It has been shown to begin having an effect in as little as 5 – 15 minutes. Diazepam rectal gel and nasal medication is approved for use by LLAM unlicensed assistive personnel (UAP- direct support staff who have successfully completed a LLAM course and remain in good standing). Prior to beginning use of diazepam, all UAPs who might need to assist with it, as well as the service recipient and his or her guardian or other authorized advocate, must be instructed in its use. Consent of the use of diazepam will be obtained by the prescribing healthcare professional, if required.

Newer seizure rescue medications include nasal seizure rescue medications. The medication is administered through a nasal spray applicator directly into the nostrils of the person having a seizure. The physician must outline instructions for the specific use of the nasal diazepam, in the same way they must for any PRN medication. The physician's order must detail when to administer (symptoms that must be present), exactly how much to administer, what to do after administration if the seizures do not stop or there is a change in breathing, behavior, or worrisome condition, and any follow-up treatment required after successful administration of the medication.

As medication options continue to improve and progress, there are likely to be other seizure rescue medications added to the list of options available for people. The Seizure Rescue Medication Protocol should be followed in all instances to ensure UAPs are well-trained for how to respond to any service recipient prescribed these medications.

The Seizure Rescue Medication Order Form must be completed by the prescribing healthcare professional for any service recipient prescribed a seizure rescue medication to be potentially administered by a UAP. This form must be signed by the prescribing practitioner every year and is considered a doctor's order. This form is to be uploaded into the electronic client data management system and reviewed by the nurse as soon as possible after the appointment. Within 2 business days of receipt of the order for a seizure rescue medication, it is the responsibility of the nurse to ensure that all program sites (residential, day program, etc.) receive on-site training. Any event that requires a seizure rescue medication to be administered to the service recipient by a UAP, and any associated follow-up care, must be documented thoroughly in the electronic client data management system.

Lithium Guidelines

Lithium is often used in the treatment of bi-polar disorder. The full effect of the drug can be seen by 2 to 3 weeks after beginning use. Regular monitoring is necessary to ensure adequate serum levels and minimize the risk of toxicity. Different preparations of Lithium may vary widely so the same brand of Lithium should always be prescribed. Care should be taken, and additional monitoring is necessary if changing between brands or between tablets and liquid is necessary.

Lithium toxicity is not uncommon in individuals with developmental disabilities. Signs of toxicity include:

- Blurred vision
- Increased gastrointestinal disturbances
- Muscle weakness
- Drowsiness
- Sluggishness
- Ataxia (a lack of muscle coordination which may affect speech, eye movements, the ability to swallow, walking, picking up objects and other voluntary movements)
- Coarse tremor
- Lack of coordination
- Dysarthria (trouble with speaking which can affect eating or breathing)
- Confusion
- Convulsions
- Any sudden change in status should be considered as a possible effect from lithium toxicity and medically evaluated immediately

Lithium should never be discontinued abruptly without consulting the prescribing doctor.

Sunscreen and Thickening Agents Guidelines

Questions were recently raised regarding Limited Lay Administration of Medication (LLAM) procedures and requirements pertaining to the use and application of sunscreen and thickening agents that are added to liquids.

After consultation with the Delaware Board of Nursing (BON) it has been determined that neither sunscreen nor thickening agents need a healthcare provider's order and do not need to be recorded on the Medication Administration Record (MAR). Any DSP (with proper training) can apply sunscreen or prepare liquids using a thickening agent. LLAM trained Unlicensed Assistive Personnel (UAPs) are not the only staff who may assist with these products. Sometimes providers request a healthcare provider's order for thickening agents for insurance coverage purposes, to avoid requiring a service recipient to pay out-of-pocket. This practice may continue. It still does not need to be on the MAR, according to the BON.

REQUIRED FORMS

This section contains a brief description of medical appointment and assessment forms. Most of these forms can be found on the DDDS website: https://dhss.delaware.gov/dhss/ddds/nursing_forms.html They can also be found attached to the various policies to which they pertain. Although this section does not describe all the forms a nurse may be required to utilize, it provides an overview of the most common forms and their use.

Annual Physical Examination (APE) Form

Typically referred to as the "Physical", this form is to accompany the service recipient to his/her medical provider to be completed prior to residential service admission and/or each year at the service recipient's annual physical examination appointment. It must be completed by the service recipient's medical provider or designee. As with other appointment forms, this form can be signed by the medical provider and a printed visit summary may be attached as the appointment documentation. However, according to the HCBS Provider Standards, this form, NS 206, is mandatory and must be reviewed and signed by the healthcare provider to document that demographically appropriate healthcare screenings were considered and advised for the service recipient. This completed form and attachments must be uploaded by the residential provider into the electronic client data management system in the service recipient's health record in the Appointments section.

Aspiration/Choking Risk Assessment

This form is completed by the nurse prior to a service recipient's admission to residential services, and annually in preparation for the service recipient's person-centered plan update. This form may be completed as needed when a risk is identified and/or the service recipient's health status changes. See the Aspiration and Choking Healthcare Protocol #1.

Controlled Substance Count Sheet

Because of the potential for abuse, regulations require that all medications in Schedules II – V (controlled medications) be double locked and counted (reconciled) at every shift change by the oncoming and outgoing staff. The Controlled Substance Count Sheet is the record of how many controlled medication units should be on the premises at any given time. If the residential setting uses the electronic medication administration record (EMAR) available in the electronic client data management system, the controlled substance count may be maintained in the EMAR but must still be counted and signed at every shift change by the oncoming and outgoing staff.

Dental Appointment Information Record (DAIR) Form

This form should be taken with the service recipient each time s/he visits the dental care provider and is completed by the dental care provider at the time of the visit. This form should be completed each time the service recipient sees their dental care provider (every six months or as recommended by the provider). As with other appointment forms, this form can be signed by the dental provider and a printed visit summary may be attached as the appointment documentation. This completed form and attachments must be uploaded by the residential provider into the electronic client data management system in the service recipient's health record. While it is best practice to use this form, a printed visit summary that contains all the same information is acceptable.

Fall Risk Assessment Form

This form is completed by the nurse prior to a service recipient's admission to residential services, and at least annually in preparation for the service recipient's person-centered plan update. This form may also be completed more often in response to an identified need (2 or more falls) or as health status changes. See the Fall Risk Management Healthcare Protocol #3.

Medical Appointment Information Record (MAIR) Form

The Medical Appointment Information Record (MAIR) should accompany the service recipient to every physician's appointment and is completed by the physician or other health care practitioner at the time of the visit. This form serves as a record of the visit and of recommendations made by the physician. Page 2 of this form is a Medical Appointment Checklist that outlines for staff accompanying the service recipient the reason for the visit, symptoms present, how long the symptoms have been present, what has been done for these symptoms in the past. It also provides staff a set of questions to ask the practitioner before leaving the office. It may also list medication orders, equipment orders, lab orders and referrals that need to be viewed in order to ensure all follow ups are completed. As with other appointment forms, this form can be signed by the medical provider and a printed visit summary may be attached as the appointment documentation. This completed form and attachments must be uploaded by the residential provider into the electronic client data management system in the service recipient's health record. While it is best practice to use this form, a printed visit summary that contains all the same information is acceptable.

Medication Count Sheet

All loose medications not in bubble packs require the use of a Medication Count Sheet. This form enables staff to record the number of units on hand, how many were administered at any given time, and the number of units remaining. Discrepancies must be reconciled as soon as they are discovered. If the residential setting uses the electronic medication administration record (EMAR) available in the electronic client data management system, the loose medication count may be maintained in the EMAR but must still be counted when the medication is

received from the pharmacy, and each time the medication is administered and the count recorded either in the EMAR if used, or on a physical count sheet.

Medication Form for Leave/Vacation

When a service recipient is going on vacation or some other type of leave from their Neighborhood Home, CLA, or Shared Living Provider's home, a Medication Form for Leave/Vacation should be completed. This form serves to document the number of medication units that were sent with the service recipient, and the number of medication units that were returned with the service recipient. It can also be used to provide specific instructions regarding medications or medical treatments. If the residential setting uses the electronic medication administration record (EMAR) available in the electronic client data management system, the Medication Form for Leave/Vacation should be scanned and attached to the service recipient's Medication Review module. The medication administration can be entered in "bulk" in Detail Mode with a comment to see the attachment in the Medication Review section of the EMAR for verification.

Nutrition Referral Form

When a service recipient has a need for nutritional consultation, either due to weight loss/gain or a specific illness or condition, a Nutrition Referral form is completed and forwarded to a Registered Dietician under contract with DDDS. The RD will evaluate the service recipient for whom the referral was made and develop a nutritional plan or set of guidelines to help assure that the service recipient receives adequate support around their specific nutritional requirements. See the Nutrition Management Healthcare Protocol #4.

Psychiatric Appointment Information Record (PAIR) Form

Similar to the MAIR, the Psychiatric Appointment Information Form (PAIR) must accompany the service recipient to every psychiatric visit and be completed by the psychiatrist or psychologist treating the service recipient. It will outline medications the service recipient receives, recommended treatments or procedures and necessary follow-up appointments. As with other appointment forms, this form can be signed by the psychiatric provider and a printed visit summary may be attached as the appointment documentation. This completed form and attachments must be uploaded by the residential provider into the electronic client data management system in the service recipient's health record. While it is best practice to use this form, a printed visit summary that contains all the same information is acceptable.

Over the Counter Medication (OTC) Form

Each service recipient receiving residential services must have in their record a completed Over the Counter Medication (OTC) form. The form must be updated at least once a year by the service recipient's health care provider. This form is used to indicate what

medications/treatments the health care provider prescribes for the treatment of relatively minor health issues such as headache, slight fever and minor abrasions. This form provides instruction as to how to monitor the use of these medications/treatments and when to seek further assistance from a medical professional. This completed form and attachments must be uploaded by the residential provider into the electronic client data management system in the service recipient's health record.

Section 6 – **Policies, Protocols and Forms**

Section Name	Date Read/Completed	Initials
DDDS Policies		
Protocols & Guidelines		
Required Forms		

I, _____, have read and understood the
(print name)
information provided in this section of the DDDS Nurse Consultation Resource Guide I have had an opportunity to consult with my supervisor and/or his/her designee and my questions have been answered.

_____ _____
Nurse's Signature Date

_____ _____
Signature of Nurse Supervisor / Designee Date

Section 7 – Nurse's Role on the Support Team

No matter what type of meeting you may be attending, your primary responsibility is to ensure that the person you are supporting receives the quality healthcare they want and need. In this section is a listing of some of the different types of meetings the consultative nurse may be asked to attend or for which the nurse will be asked to provide input.

Person Centered Plan

The person centered plan is the State's plan of care for each person receiving services from DDDS. The purpose of the person centered plan is to provide information to support team members about the type of life the service recipient wants to live, what they want to achieve, and the services and supports the service recipient wants and needs to be successful. The person centered plan also outlines Medicaid-funded services and community supports. The person centered plan must be updated at least annually and requires the input of all the support team members.

As part of the annual planning process, the consultative nurse must complete the necessary assessments, and the Comprehensive Nursing Assessment/ECHAT, SMC, Med Alert and assessments in advance of the person centered plan meeting so that the results of the assessments can be included in planning. The Fall Risk Assessment and the Aspiration Risk Assessment must be completed annually for every service recipient, other assessments such as the Self-Administration of Medication Assessment are completed as appropriate to the service recipient's support needs during the pre-planning phase of the annual person centered plan. In the Comprehensive Nursing Assessment/ECHAT, the nurse will clearly describe the service recipient's health issues and what supports are needed, while taking into consideration the service recipient's expressed preferences, goals and life-style choices.

At the person centered plan meeting, it is also the nurse's responsibility to make sure that whatever other supports are enacted for the service recipient, they take into account what the service recipient needs in order to be healthy and well. For example, the service recipient might express a desire to get a job. It would then be the nurse's responsibility to inform the

service recipient and the team about possible supports that might be needed relative to healthcare while the service recipient is at work. If the service recipient has Diabetes, the nurse may suggest that there needs to be a mechanism in place to monitor their blood sugar at work and to make sure they eat every 3 – 6 hours as recommended by the physician or the nutritionist.

Team Meetings

It is required that each service recipient supported by DDDS have an annual (within 365 days) person centered plan meeting. For many people, this is all that is necessary. For others, it may be necessary for the support team to meet more regularly due to on-going issues. A service recipient may have a change in circumstances that will necessitate more regular meetings until it is resolved, or they may develop new or worsening medical conditions that require closer monitoring by the team. At team meetings, it is the nurse's responsibility to inform the team as to the best practices in health care for the service recipient as well as how health issues and concerns may impact planning and resolution efforts. The paperwork required for each team meeting will differ depending on the issues.

Emergency Team Meetings

If an emergency arises, it may be necessary for the support team to meet as a whole to address the issue. Some of the types of events that might necessitate an emergency team meeting include accident or sudden illness, significant injury, involvement with law enforcement or admission to or discharge from an in-patient treatment facility. Whatever the reason for the emergency meeting, the nurse's responsibility will be to inform the planning process relative to the specific health concerns of that particular service recipient and to ensure that best practice with respect to health care is incorporated into planning efforts.

Transfer Planning Meetings

When a service recipient is transferring into a residential placement, or between residential placements, it is the nurse's responsibility to make sure that all assessments are completed as required and that planning efforts and activities include consideration for the unique health care needs of the service recipient. It is also the nurse's responsibility to ensure arrangements are made for continuity of care so that all health concerns are continually monitored and supported throughout the transition process.

The duties of the nurse will vary depending on where the service recipient may be coming from and the type of residential placement into which they may be moving.

When a service recipient is transferring from one nurse consultation provider agency to another, it is the responsibility of the transferring nurse to ensure that all assessments and other currently requirement and due documentation are completed prior to the transfer. The transferring and receiving nurses shall meet to discuss the service recipient's support needs and

current documentation prior to the transfer. This discussion shall be documented in the electronic client data management system.

Facility Discharge Meetings

When a service recipient is being discharged from an in-patient facility, the nurse should attend the discharge meeting. Nurses have a unique perspective in the team process and will be able to ensure that plans are in place to address health concerns throughout the process of moving out of the facility. The nurse's responsibility includes making sure that staff who will be receiving the service recipient into their new environment have adequate instructions to continue providing quality health care to the service recipient as well as ensuring that needed items will be available for the service recipient (i.e., medications, medical equipment, treatments, therapies, etc.).

Attending Medical Appointments as Appropriate

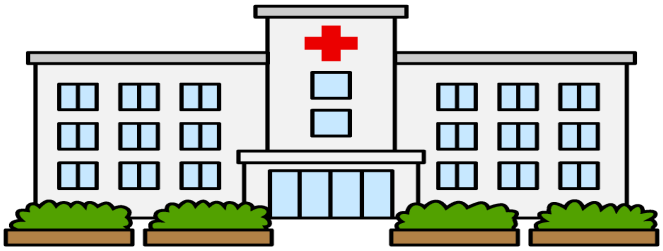
In the majority of cases, the service recipient's residential support staff will accompany them to medical appointments. Staff members are required to provide the correct form depending on the type of appointment and ask the health care practitioner to complete it for the service recipient's record. Following the appointment, the form (or forms) will be added to the service recipient's record in the electronic client data management system by the residential provider (or BA if the BA accompanied the service recipient to a psychiatric appointment). Any printed visit summaries from the appointment should be added to the service recipient's electronic client data management system record, as well. The nurse should review these forms as soon as possible after the appointment to ensure there are no contradictions in terms of care or medications/treatments. Please remember that signed appointment records or visit summaries that contain a list of prescribed medications are considered orders. If there is a change in medications, the nurse must ensure the MAR/EMAR has been correctly changed during the next medication and health review. If there is confusion between medication orders, or a medication appears to be transcribed incorrectly on the appointment record or visit summary, the medication order must be verified with the health care practitioner and a corrected written order obtained as soon as possible, if necessary.

Some of the forms the nurse can expect to see added to the record following appointments are:

Medical Appointment Information Record (MAIR)
Psychiatric Appointment Information Record (PAIR)
Dental Appointment Information Record (DAIR)

When a service recipient is dealing with a complex medical issue, it may be necessary for the nurse to accompany them to the appointment along with the support staff. Direct support staff members may not be knowledgeable about a particular condition, diagnosis or treatment and may require the expertise of the nurse to fully understand what the health care practitioner is

asking them to do in terms of support. It may also be that there is some discrepancy in the care or treatment the service recipient is receiving that may warrant the nurse attending the appointment. Earlier in this Manual there was an explanation of "diagnostic overshadowing". Remember, this is the tendency of health care practitioners to overlook symptoms caused by other conditions and attribute them instead to the service recipient's developmental disability. Many direct support staff members are not able to have these types of discussions with the practitioner and may require the assistance of the nurse.



Hospital and Nursing Home Visits

When a service recipient you support is admitted to a hospital or nursing home, until and unless they are discharged from DDDS services, the nurse should visit within the first 48 hours or within 2 working business days of admission (if the facility allows an in-person visit) and then speak to the treatment team at least weekly to stay informed about the service recipient's condition and any medications or treatments they are receiving. Daily phone contact by the nurse should also occur when the service recipient is in an acute care setting; if facility will not communicate due to HIPAA then daily contact with team member (DSP/PM, SC, MCO) should occur. All contact with the service recipient and the hospital staff should be documented in a T-log and case note in the electronic client data management system. "Diagnostic overshadowing" is a genuine threat to the health and well-being of people with developmental disabilities and extreme care should be taken to assure that significant symptoms are not attributed to the service recipient's disability instead of to a new or worsening health issue. Hospital and nursing home staff probably will not know the service recipient very well and may not be familiar with intellectual or developmental disabilities in general. Your visit could mean the difference between something being taken into account or being dismissed. Visiting the service recipient regularly while they are an in-patient will also assist you with discharge planning when the time arrives as well as providing reassurance and comfort to the service recipient by the presence of a familiar person with whom they have an established relationship. It may also be beneficial since the consultative nurse may understand how best to explain procedures and side effects to the service recipient. Any contacts with or on behalf of the service recipient while they are inpatient are billable as Nurse Consultation service, as long as they remain active waiver participants.

Section 7 – -**Policies, Protocols and Forms**

Section Name	Date Read/Completed	Initials
Person Centered Plan		
Team Meetings		
Emergency Team Meetings		
Transfer Planning		
Facility Discharge Meetings		
Attending Appointments as Appropriate		
Visits to the Home and Day Program		
Hospital and Nursing Home Visits		

I, _____, have read and understood the
(print name)
information provided in this section of the DDDS Nurse Consultation Resource Guide. I have had an opportunity to consult with my supervisor and/or his/her designee and my questions have been answered.

_____ _____
Nurse's Signature Date

_____ _____
Signature of Nurse Supervisor / Designee Date

Section 8 – The Electronic Client Data Management System Record

DDDS is currently contracted with Therap to maintain the electronic client data management system used by DDDS and contracted providers to maintain records of people receiving services. In order to access the records of a service recipient, you must be given electronic "permission" or access by an Administrator.

Some of the terms that will help users better understand Therap are:

Dashboard/First Page:

This is the page that comes up after you log in. It contains all the Modules (i.e. T-Logs, GERs, case notes, and ISPs) that you are allowed to access and work on. It also notifies you of what you need to open/read/respond to since the last time you were logged in. You can switch between the Dashboard and First Page view. The Dashboard groups relevant modules in tabs making it easier for you to browse, while the First Page is a one-page display of all the modules you have access to.

Case Notes:

Consultative providers shall use the statewide case note template assigned for RN services called “Nurse Consultation Service Documentation-Provider” for billable service documentation and shall select the appropriate services provided in the attached Questionnaire and select the correct billing tier from the dropdown options in the case note template. The RN must select the appropriate billing tier based on their credentials when creating billable service documentation in the electronic client data management system. Providers must have systems in place to ensure that Nurse Consultation services are documented and billed correctly and at the appropriate tier based on the RN who provided the service. At least one service documentation “billable note” must be maintained for service delivered each day the service is billed.

Individual Demographic Form (IDF):

This document contains a comprehensive overview of the service recipient including demographics, program history, allergies, contacts, insurance information, and other aspects necessary to assist the service recipient such as required levels of support, dietary guidelines, mobility guidelines etc.

Emergency Data Form (EDF):

EDF is the portable version of the IDF that includes the most immediately necessary information for an emergency such as diagnoses, insurance information, and emergency contacts.

T-Log:

T-Logs are a way to document thing specific to the service recipient. They can be used to record anything from daily activities, the monitoring of injuries, contacts, behavioral concerns, to general information. This allows for extensive sharing of information with the neighborhood home/program direct support professionals, management and program coordinators, nurses, support coordinators, Investigators, etc. The information in T-Logs will only be available to those who have been granted access to it. Information can be pulled up by DDDS oversight staff, as needed. A T-Log also allows all users to view when others have read it. T-logs should not be used to communicate between staff or team members, unless it is an issue that directly relates to the service recipient whose record the T-logs are attached to.

General Event Reports (GER):

GER is an incident report that can include injury, medication error, restraint, death, or the “other” category which may include things such as a service recipient going to the emergency room, etc. Also included within GERs is the Witness Report used to gather further information about a given event from additional staff members who were present, and the Emergency Behavior Intervention Strategy (EMBIS) form that is completed when a restraint or unplanned

restrictive procedure is used in working with the service recipient. This may include the use of prescribed psychotropic PRNs.

Secure Communication (S-Comm):

This is the secure intra-agency email system within Therap that all users can access to both send and receive messages in a secure, HIPAA compliant way. It can be used to e-mail anyone who is an active user in the system. You may also group people into User Groups for convenience in messaging as well as organizing folders system to store received messages. You can also view who has read any messages that you have sent.

Health Tracking (HT):

Health Tracking keeps track of any data that refers to a service recipient's medical status including appointments, vital signs, height/weight, seizure activity, medication history, and intake/elimination, among others.

The Health Tracking application is a group of modules that record various aspects of a service recipient's health status. Reports can be generated based on this data. The Medication History Module is included in Health Tracking and is the working document used to configure or create the electronic medication administration (EMAR) record, also available in Therap. The State is working to implement use of the EMAR statewide.

Administrators at the agency will need to assign appropriate "permissions" to grant users access to particular features of the Health Tracking application. Following is a list of available health tracking modules. The nurse will use the ones that apply to the individual s/he is working with.

Appointments Module
Blood Glucose Module
Height and Weight Module
Immunization Module
Infection Tracking Module
Intake and Elimination Module
Lab Test Result Module
Medication History Module
Menses Module
Report Module
Respiratory Treatment Module
Searching the Forms
Seizures Module
Skin and Wound Module

Electronic Medication Administration Record (EMAR):

The electronic Medication Administration Record (EMAR) module provides users with a tool to effectively and easily track medications administered to a service recipient. With EMAR, users can schedule and add comments to medications and treatment records and export the EMAR reports with current medications and treatments on a monthly grid.

Medication History:

The Medication History module is accessed through the Health Tracking tab on the Therap Dashboard. The Medication History module is used to document prescriptions, PRN and OTC meds and treatments; house medication orders; link to general drug information, compound components, and side effects; log prescriber and pharmacy information; and document diagnosis information. The information input in the Medication History module will pull over into the electronic Medication Administration Record (if used) and Therap operates a pharmacy interface so information can be added to the Medication History module directly from the pharmacy.

Individual Medical Information:

Individual Medical Information section contains the service recipient's Diagnosis record, Advance Directives which is used to document treatment preferences and designate a surrogate decision-maker and Allergy Profile to document a service recipient’s allergy information in detail.

Section 8 – **The Electronic Client Data Management System**

Section Name	Date Read/Completed	Initials
Dashboard		
Case Notes		
Individual Demographic Form (IDF)		
Emergency Data Form (EDF)		
T-logs		
General Event Report (GER)		
SComm		
Health Tracking		
Electronic Medication Assistance Record (EMAR)		
Medication History		
Individual Medical Information		

I, _____, have read and understood the
(print name)
information provided in this section of the DDDS Nurse Consultation Resource Guide. I have had an opportunity to consult with my supervisor and/or his/her designee and my questions have been answered.

_____ _____
Nurse's Signature Date

_____ _____
Signature of Nurse Supervisor / Designee Date

Service Guidelines and Billing Guidance

Provider Reimbursement and Billing:

Nurse Consultation is a Medicaid funded service. The reimbursement methodology was designed by the Division with the expectation of a 1:1 staff- to-service recipient ratio. The maximum number of annual billable 15-minute units for each service recipient are documented on the designated Service Authorization form and indicated as Funding Level (1 through 4). Funding Level is based on a standard Assessment of Need for Clinical Nursing Services conducted annually by a Division Registered Nurse III or Nurse Supervisor based on interviews, historical records, other assessments/evaluations, and documentation. The Funding Level determines how many units per month/year the Nurse Consultation provider can bill for services provided to and for the service recipient. (Monthly units/task breakdown units are a recommended average and are flexible within the funding year based on task need.) The funding year coincides with the service recipient's annual Person-Centered Plan date.

A mid-year Funding Level re-assessment may be requested when the support needs of the service recipient exceed the current Funding Level. This may be due to a life changing event or increased nursing support needs that were not anticipated at the time of the annual assessment. Requests for mid-year Funding Level reassessment are processed through the Support Coordinator/Community Navigator assigned to the service recipient. The Support Coordinator/Community Navigator will submit a Request for Assessment of Need for Clinical Nursing Services to the Division Nurse Supervisor to have the service recipient reassessed. Once the service recipient has been reassessed and level determined, the Support Coordinator/Community Navigator will inform the Nurse Consultation provider of the results and, if appropriate, a new Funding Level Service Authorization will be sent to the Nurse Consultation provider. It is important to note that the Nurse Consultation provider cannot directly make the request to the Division Nurse Supervisor and cannot participate in the reassessment.

To bill for Nurse Consultation services, the service provided must be consistent with the service description in the approved Medicaid 1915c HCBS Lifespan Waiver (waiver). All DDDS waiver services must be prior authorized by DDDS and entered into the Delaware Medicaid Enterprise System (DMES) by DDDS. A prior authorization is issued to the Nurse Consultation provider for each service recipient the provider is authorized to support. It is not permissible to bill for services that are not authorized, or for services that fall outside of the waiver service description. The prior authorization created for each service recipient indicates the maximum amount that can be billed for a specified period of time. It is not a guarantee of payment for the entire amount authorized. Claims may only be submitted for hours of Nurse Consultation services actually provided and supported by service documentation. Billing for services not actually provided or billing contrary to the established reimbursement methodology approved

in the DDDS waiver would be considered an overpayment by Delaware Medicaid or CMS. If they were to audit such claims, it would likely result in a recoupment. If CMS were to determine that the overbilling was purposeful, the Office of Inspector General of the U.S. DHHS has the authority to sanction the provider, which would result in their exclusion from participation in the Medicaid and Medicare programs for a period of 5 years (see regulatory citation below).

24 CFR §1003.102 Basis for civil money penalties and assessments.

> (a) The OIG may impose a penalty and assessment against any person whom it determines in accordance with this part has knowingly presented, or caused to be presented, a claim which is for….
>
> > (1) An item or service that the person knew, or should have known, was not provided as claimed, including a claim that is part of a pattern of practice of claims based on codes that the persons knows or should know will result in greater payment to the person than the code applicable to the item or service actually provided.

Nurse Consultation is reimbursed on a tiered rate system, based on the credentials and qualifications of the Registered Nurse (RN) providing the service. RN credentials shall be uploaded by the provider employer and be maintained in the DDDS learning management system (LMS) to support the provider's ability to bill at the correct tier level for each RN providing Nurse Consultation service. Credentials must be uploaded to the LMS prior to the provider submitting claims for services provided by the RN. IDD experience requirements will be evidenced by a completed and signed Nurse Consultation RN Attestation form that is uploaded to the LMS with other credentials. All RNs must also meet the additional experiential criteria outlined in the DDDS Lifespan 1915c Waiver. The tiers and associated credentials/qualifications are:

Tier	Credentials/Qualifications	Procedure Code	Modifier
Tier One	Current Delaware Registered Nurse license	T1001	U1
Tier Two	Current Delaware Registered Nurse license with two or more years Intellectual/Developmental Disability (IDD) experience	T1001	U2
Tier Three	Current Delaware Registered Nurse license with two or more years	T1001	U3

	Intellectual/Developmental Disability (IDD) experience **and** national certification with specialty in Intellectual/Developmental Disability (IDD)		

DDDS shall issue annual service authorizations for every Nurse Consultation service recipient with all annual billable 15-minute units, as determined by the assessed Funding Level, available to be used by the provider in any of the three tiers. The RN must select the appropriate billing tier based on their credentials when creating billable service documentation in the electronic client data management system. Consultative providers shall use the statewide case note template assigned for RN services called "Nurse Consultation Service Documentation-Provider" for billable service documentation and shall select the appropriate billing tier from the dropdown options in the case note template. Consultative providers must create a "Therap Service Authorization" for every service recipient that allocates the annual 15-minute units to the most appropriate tiers based on the credentials and qualifications of the RN(s) working with the service recipient. Units can be assigned to multiple tiers if multiple RNs may work with the service recipient. Providers must have systems in place to ensure that Nurse Consultation services are billed correctly and at the appropriate tier based on the RN who provided the service.

Service Documentation:

Records must be maintained in one or more documents, to detail the provision of service to a service recipient, consistent with the service recipient's Person-Centered Plan. At least one service documentation "billable note" must be maintained for each service delivered for each service day. Documentation must be recorded in the electronic client data management system and must be kept in a manner as to fully disclose the nature and extent of services delivered which include, at a minimum:

- Type of Service;
- Date of Service;
- Place of Service;
- Name of Individual receiving service;
- Progress the individual made toward goals expressed in the Plan of Care;
- Medicaid ID number of the individual receiving service;
- Name of Provider;

- Signature (may be electronic) or initials of the person delivering the service (if signature and corresponding initials are on file with the provider).

Please refer to Appendix D-Documentation Guidance of the DDDS Provider Standards for Home and Community Based Services for further explanation of these requirements.

Providers of DDDS Medicaid covered services must maintain the records necessary and in such form to disclose fully the extent of the service provided, for a period of six years from the date of receipt of payment or until an initiated audit is resolved, whichever is longer. The records will be made available upon request. DDDS may audit provider records, including any source documentation supporting Medicaid claims for DDDS waiver or State Plan Rehab services. The provider agrees to fully cooperate with DDDS during such inquiry.

Billable Activities:

Task Name	Description
Meetings	• Case Transfer Meeting • Transfer Planning Conference (if separate from Case Transfer Meeting) • Intake • Person-Centered Planning and Annual Review Meetings • Support Team Meetings (planned and ad hoc) • HRC for medically necessary restrictive interventions • Family/Legal Guardian/other HCBS Providers/Employer/etc when supports for the service recipient are discussed
Visits/Observations	• Contact with the service recipient in any environment • Visits to the program site to complete medication and health reviews on behalf of the service recipient
Appointments	• Medical or dental appointments as needed • Other appointments with the service recipient pertaining to their medical needs and supports and medications, upon request
Phone/Email/Text	• Phone calls with the service recipient or on behalf of the service recipient pertaining to their medical needs, supports and medications • Emails/email exchange with the service recipient or on behalf of the service recipient pertaining to their medical needs, supports and medications • Text exchange with the service recipient or on behalf of the service recipient pertaining to their medical needs, supports

	and medications. (Monthly contacts for service recipients living in Shared Living must be completed by phone or in person per the waiver)
Assessments	• Comprehensive Health Assessment and all component parts at least annually or more often if needed • Fall Risk Assessment at least annually or more often if needed • Aspiration/Choking Risk Screening and Assessment at least annually or more often if needed • Other assessments or health care protocols necessary to support the service recipient's health based on medical history, diagnosis, or other medical support need
Plan/Report Creation	• Contributions to the Person-Centered Plan • Medical Alert Form at least annually or more often as needed • Significant Medical Conditions at least annually or more often as needed • Quarterly Reports for service recipients in Shared Living per waiver service description • HRC presentation materials • DDDS and DHSS Death Review Report
Training	• Staff/family/other training on medical diagnosis, appropriate supports, follow-up, labs or tests, special data/documentation needed, and treatments as prescribed by health practitioner
Documentation Creation/Review	• Case Notes • ISPs • T-logs • GERs • Reportable Incident/PM46 submission • Behavior Support Plans • MAIRs, DAIRs, PAIRs, CAIRs • Labs • Appointment summaries and physician's orders • Monthly Medication and Health Review completion and review/response of follow-up responses for service recipients living in a Neighborhood Group Home or Community Living Arrangement • Monitor, review, and reconcile Monthly Medication Record and Tube Feeding Form for service recipients living in Shared Living

	• Input information obtained from Shared Living providers into the electronic record such as weight, height, allergies, blood pressure, blood glucose, medications, etc. • Previous assessments/evaluations/plans pertaining to the service recipient's medical supports • Service documentation entered by other support team members • Medication Administration Record Data/Documentation
Other	• Completing all tasks associated with transition from one residential setting to another such as reconciling medications, staff training, obtaining and reviewing necessary documentation such as baseline tuberculosis screen, annual physical, immunizations, ongoing health concerns and treatments, and nutritional referral • Completing all tasks associated with transition from one nurse consultation provider to another such as: completing, obtaining, and reviewing necessary documentation such as baseline tuberculosis screen, annual physical, immunizations, ongoing health concerns and treatments, and nutritional referral; completing Quarterly Reports; completing Medication and Health Reviews, etc prior to transfer • Referrals and associated tasks to health practitioners, specialists, and therapists, for assessment, treatment, and follow up • Time spent obtaining or coordinating letters of medical necessity • Time spent obtaining information and completing Consent for Elective Surgery packets • Nurse Consultation services provided in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community based setting and to preserve the service recipient's functions • In an emergency situation, perform a medical procedure within the RN scope of practice, experience, and proficiency • Providing transportation to the service recipient to a medical or dental appointment (when no other means of transportation is available and in a vehicle in accordance with contract requirements) * • At death of service recipient, collecting medication and ensuring proper disposal

*Travel time to and from visits, meetings, appointments is not billable unless transporting the service recipient

Section 9 –**Service Guidelines/Billing Guidance**

Section Name	Date Read/Completed	Initials
Service Guidelines and Billing Guidance		

I, _____, have read and understood the
(print name)
information provided in this section of the DDDS Nurse Consultation Resource Guide. I have had an opportunity to consult with my supervisor and/or his/her designee and my questions have been answered.

_____ _____
Nurse's Signature Date

_____ _____
Signature of Nurse Supervisor / Designee Date

Section 10 – DDDS Commonly Used Acronyms and Abbreviations

ACRONYM/ ABBREVIATION	What It Means	What It Is/Does
AAIDD	American Association on Intellectual and Developmental Disability	AAIDD (formerly AAMR) is *the* professional association run by and for professionals who support people with intellectual and developmental disabilities.
AAR	Adult Abuse Registry	The Division of Health Care Quality (DHCQ)) maintains a listing of all persons in the State of Delaware who have a substantiated case of abuse, neglect, mistreatment, and/or financial exploitation in their backgrounds
ADA	Americans with Disabilities Act	The Americans with Disabilities Act (ADA) ensures equal opportunity for persons with disabilities in employment, State and local government services, businesses that are public accommodations or commercial facilities, and in transportation. The ADA also mandates the establishment of telephone relay services for people who use TTYs (teletypewriters, also known as TDDs or telecommunications devices for deaf persons)
ADL	Activities of Daily Living	Activities of daily living (ADLs) are the things we normally do in daily living including any daily activity we perform for self-care (such as feeding ourselves, bathing, dressing, grooming), work, homemaking, and leisure
AMI	Asocial Maladaptive Index	An index located within the ICAP
APA	Authorized Provider Application	The application completed by a party or parties interested in contracting with the

		DDDS to provide services to the people it supports.
APS	Adult Protective Services (Division of Services for Aging and Adults with Physical Disabilities)	The Adult Protective Service (APS) Program responds to cases of suspected abuse, neglect, or exploitation of impaired adults. Specifically, the program serves persons who are aged 18 or over, who have a physical or mental impairment, and who are not living in a long-term care facility (for example, a nursing home).
ARC	The ARC of Delaware	The Arc of Delaware is a non-profit organization of volunteers and staff working together to improve the quality of life for people with cognitive disabilities and their families. The ARC is the owner/landlord of many DDDS group homes operated by other provider agencies.
ASD	Autism Society of Delaware	ASD was started in 1998 by a group of families who had common experience with autism. ASD is a group that reaches out to others facing autism, and they work together to improve opportunities for their children. ASD is an advocacy organization that works to connect the autism community together throughout Delaware. ASD is not associated with the national Autism Society
AT	Assistive Technology	Assistive technology includes assistive, adaptive, and rehabilitative devices and equipment. AT can promote greater independence for people with disabilities by enabling them to perform tasks that they were formerly unable to accomplish, by providing enhancements to or changed methods of interacting with the environment to accomplish such tasks.

BSP	Behavior Support Plan	An individualized plan of support written by a Behavior Analyst that instructs staff and others how to respond to certain behavioral issues.
CAR	Child Abuse Registry (also called the Child Protection Registry)	Maintained by the Department of Services for Children, Youth and their Families (DSCYF). A search of the Child Protection Registry will show if [a job or volunteer applicant] is a perpetrator in designated substantiated cases of child abuse or neglect.
CDS (UD CDS)	Center for Disabilities Studies at the University of Delaware	The mission of the Center for Disabilities Studies is to enhance the lives of individuals and families in Delaware through education, prevention, service, and research related to disabilities.
CLA	Community Living Arrangement	Living arrangements in the community that are managed by a provider and usually not a single-family home – i.e., Staffed Apartment, Supervised Apartment
CLASI	Community Legal Aid Society, Inc.	The Disabilities Law Program is a special project of CLASI and is designated by the Governor as the Protection and Advocacy agency in Delaware.
CM/TCM	Case Manager/Targeted Case Manager	An individual assigned to assist a person receiving services from DDDS to coordinate services and benefits
COR	Consumer (Client) Oriented Record	A written record maintained at the home which contains health and other information about each individual. This is not required as most of the information is maintained electronically in the client data management system, but some residential providers still maintain a hard copy record.

CN	Community Navigator (Case Manager)	A case manager from the contracted agency that provides targeted case management to service recipients living in the community.
CP	Cerebral Palsy	Cerebral Palsy is a group of disorders associated with developmental brain injuries that occur during fetal development, birth, or shortly after birth. It is characterized by a disruption of motor skills, with symptoms such as spasticity, paralysis, or seizures.
CS	Community Services	The DDDS Unit that provides oversight and support to DDDS service recipients who live in the community or community-based settings.
DART	Delaware Authority for Regional Transit	An operating division of the Delaware Department of Transportation. Their mission is to design and provide public transportation services
DATI	Delaware Assistive Technology Initiative	The Delaware Assistive Technology Initiative (DATI) connects Delawareans with disabilities with tools they need to learn, work, and participate in community life safely and independently. DATI's services are available to all residents of Delaware. There are no eligibility limitations, other than Delaware residency.
DD	Developmental Disability	Developmental disability is a term used to describe life-long disabilities attributable to mental and/or physical or a combination of mental and physical impairments, manifested prior to age twenty-two.

DDDS	Division of Developmental Disabilities Services	The Division of the State of Delaware Department of Health and Social Services that provides services and support to individuals with developmental disabilities
DDDSAC	DDDS Advisory Council	A group of concerned citizens selected by the Governor and state legislatures for appointed terms to serve as advisors to DDDS
DHSS	Delaware Health and Social Services	DHSS is the largest cabinet department and the fifth largest employer in Delaware. DHSS employs 35% of all State employees. There are 12 divisions plus the Office of the Secretary within DHSS... - Office of the Secretary - Child Support Enforcement - Developmental Disabilities Services - Health Care Quality - Management Services - Medicaid & Medical Assistance - Public Health - Services for Aging & Adults with Physical Disabilities - State Service Centers - Social Services - Substance Abuse and Mental Health - Visually Impaired - Office of the Chief Medical Examiner
DHCQ	Division of Health Care Quality	The Division of Health Care Quality's mission is to protect residents in Delaware long term care facilities through: Promotion of quality of care, quality of life, safety and security, and Enforcement of compliance with State and Federal laws and regulations

DOE	Department of Education	The Department for the State of Delaware that provides services to individuals and their families in the educational system
DPH	Division of Public Health	DPH includes a wide range of programs and services aimed toward protecting and improving the health of the people who live and work in Delaware
DSAAPD	Division of Services for Aging and Adults with Physical Disabilities	The mission of the Division of Services for Aging and Adults with Physical Disabilities is to improve or maintain the quality of life for Delawareans who are at least 18 years of age with physical disabilities or who are elderly.
DSCYF	Department of Services for Children, Youth and their Families	The Department of Services for Children, Youth and their Families' primary responsibility is to provide and manage a range of services for children who have experienced abandonment, abuse, adjudication, mental illness, neglect, or substance abuse. Its services include prevention, early intervention, assessment, treatment, permanency, and after care.
DSM – V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)	Psychiatric Diagnoses are categorized by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Better known as the "DSM-V," the manual is published by the American Psychiatric Association and covers all mental health disorders for both children and adults. It also lists known causes of these disorders, statistics in terms of gender, age at onset, and prognosis as well as some research concerning the optimal treatment approaches

DVR	Division of Vocational Rehabilitation	DVR's mission is to provide opportunities and resources to eligible individuals with disabilities, leading to success in employment and independent living
EDF	Emergency Data Form	A document contained in the Therap System that records for team use the Emergency Information necessary to support an individual. Includes pertinent health and insurance information and emergency contact information.
EMI	Externalized Maladaptive Index	An index located within the ICAP
FICA	Federal Insurance Contribution Act	A U.S. law requiring a deduction from paychecks and income that goes toward the Social Security program and Medicare. Both employees and employers are responsible for sharing the FICA payments. FICA stipulates that there is a maximum that can be allocated to Social Security, while there is no maximum on what can go toward Medicare.
GAC	Governor's Advisory Council (for Exceptional Citizens)	Provides leadership to improve the lives of exceptional citizens of Delaware of all ages through advice and advocacy.
GER	General Event Report	A document contained in the Therap System that is used by team members to report events that are noteworthy or require follow-up. Replaces the DDDS Incident Report in Therap.
GMI	General Maladaptive Index	An index located within the ICAP
HIM	Health Information Management	The unit in the DDDS that is responsible for overseeing the agency's archived records.

HCB or HCBW or HCBS	Home And Community Based Or Home And Community Based Waiver Or Home And Community Based Services	The Developmental Disability Home and Community Based Waiver Program is administered by the DDDS. Services offered include all regularly covered Medicaid services (hospital, physician, lab, prescriptions) plus special waiver services such as: Targeted Case Management Day Habilitation and other day services Institutional or In-home Respite Care Residential Habilitation
HIPAA	Health Insurance Portability and Accountability Act	The HIPAA law is a multi-step approach that is geared to improve the health insurance system. One approach of the HIPAA regulations is to protect privacy. This is in Title IV which defines rules for protection of patient information. All healthcare providers, health organizations, and government health plans that use, store, maintain, or transmit patient health care information are required to comply with the privacy regulations of the HIPAA law
HOYO	Home of Your Own Program	Provides financing assistance for individuals with disabilities that are income eligible
HRC	Human Rights Committee	A group of concerned citizens who are appointed by the Director of Community Services. The committee reviews suggested rights restrictions (including medically necessary restrictions) prior to implementation to assure they are justified and reasonable. The committee also reviews completed investigations of rights complaints to assure that DDDS and providers are following policy and not

		unnecessarily restricting a service recipient's rights.
ICAP	Inventory for Client and Agency Planning	An assessment tool used by DDDS to determine the support needs of individuals who are eligible for DDDS services, expressed as a number of hours of direct support needed per day for each individual.
ICF/IDD	Intermediate Care Facility/Intellectual/Developmental Disability	A long-term care facility that provides nursing and supportive care to residents with an intellectual or developmental disability on a non-continuous skilled nursing care basis, under a physician's direction.
IDF	Individual Demographic Form	A document contained in the Therap System that records pertinent information about an individual, including name, address, date of birth, next of kin, etc.
IDT or ID Team (Support Team)	Inter-Disciplinary Team	The team of support professionals (usually composed of a Case Manager, Nurse, Behavior Analyst, Residential and Day Program staff) assigned to provide services to an individual. Also called the Support Team.
IEP	Individualized Education Program	Each public-school child who receives special education and related services must have an Individualized Education Program (IEP). Each IEP must be designed for one student and must be a truly *individualized* document. The IEP creates an opportunity for teachers, parents, school administrators, related services personnel, and students (when appropriate) to work together to improve educational results for children with disabilities. The IEP is the cornerstone of a

		quality education for each child with a disability
IMD	Institution for Mental Diseases	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, which includes substance use disorders (SUDs)
IMI	Internalized Maladaptive Index	An index located within the ICAP
IPE	Individual Plan for Employment	This plan is completed by the Division of Vocational Rehabilitation (DVR)
LD	Learning Disabled	Referring to an individual who has a learning disability
LOC	Level of Care	A form completed as part of the Medicaid Waiver application
MANDT	The MANDT System of Behavior Support	A course of instruction that teaches people how to build relationships, have positive interactions, and respond in a crisis situation. The Division's current approved Behavior Support class for staff
MAP25	Comprehensive Medical Report	A form completed as part of the Medicaid Waiver application
MCI (Medicaid number)	Master Client Index	The unique identification number assigned to each individual receiving services from the State of Delaware Department of Health and Social Services
NCI	National Core Indicators	A collaboration among participating state agencies and Human Services Research Institute, with the goal of developing a systematic approach to performance and outcome measurement.

NH – 10	Review and Approval of Level of Care	A form completed as part of the Medicaid Waiver application
OAS	Office of Applicant Services	The Office of Applicant Services provides individuals and/or families with information about and assistance with applying for services from the DDDS
OBSS	Office of Business Support Services	The fiscal office of DDDS
OBRA	Omnibus Budget Reconciliation Act/	In 1987, President Ronald Reagan signed into law the first major revision of the federal standards for nursing home care since the 1965 creation of both Medicare and Medicaid 42 U.S.C1396r, 42 U.S.C. 1395i-3, 42 CFR 483. The landmark legislation changed forever society's legal expectations of nursing homes and their care. Long term care facilities wanting Medicare or Medicaid funding are to provide services so that each resident can "attain and maintain her highest practicable physical, mental, and psycho-social well-being."
OMB	Office of Management and Budget	The Office of Management and Budget was established July 1, 2005. This office supports State agencies to best utilize state assets, including people, land, facilities and financial resources.
OT	Occupational Therapy	Occupational Therapy is the "use of productive or creative activity in the treatment or rehabilitation of physically, cognitively, or emotionally disabled people" (American Heritage Dictionary).
PASRR	Preadmission Screening and Resident Review, part of the Federal Omnibus Reconciliation Act of 1987, also referred to as the Nursing Home Reform Act	PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care and ensures all applicants the most appropriate setting for their needs (in the community, a

		nursing facility, or acute care settings. This federally mandated program determines whether persons with mental illness or an intellectual/developmental disability and/or a related condition are appropriate for admission to or continued residence in Medicaid certified nursing facilities and whether they require specialized services
PCA	Personal Care Attendant	A person specifically employed or designated to help an individual with a disability with daily living needs.
PCP	Person Centered Plan	A person centered plan, developed with the person receiving services, his/her family or guardian and other individuals providing support, that outlines in detail the individual's preferences, individual support needs, and lifestyle choices
PIC	Parent Information Center (of Delaware)	The Parent Information Center of Delaware, Inc, (PIC) is a statewide nonprofit organization and is Delaware's only federally mandated Parent Training and Information Center designated by the US Department of Education to provide support to families of children and youth with all disabilities from birth to age 26.
PM 46	Policy Memorandum #46	Policy Memorandum #46, Issued by the Department of Health and Social Services. This document defines "abuse, neglect and mistreatment", and instructs staff about the professional obligation to report.
PPD	Purified Protein Derivative (The test used to detect Tuberculosis)	The tuberculosis skin test (also known as the tuberculin or PPD test) is a test used to determine if someone has developed an immune response to the bacterium that causes tuberculosis (TB).

PRC	Placement and Review Committee	The committee in DDDS whose responsibility it is to maintain a data base for individuals seeking residential services of available vacancies with approved residential service providers
PROBIS	Peer Review of Behavior Intervention Strategies Committee	A committee comprised of the DDDS BA Supervisors, a DDDS RN, DDDS Senior BA, and a provider PROBIS Delegate (rotating) who review and approve Behavior Support Plans prior to implementation and on an annual basis.
PSR	Personal Spending Record	The document used to track the use of an individual's funds in a residential setting.
PT	Physical Therapy	Physical Therapy provides services to individuals and populations to develop, maintain and restore maximum movement and functional ability throughout the lifespan.
QIDP	Qualified Intellectual Disabilities Professional	A Qualified Intellectual Disabilities Professional is someone who has specialized training in supporting people with developmental disabilities (mental retardation)
SIE	Service Integrity and Enhancement	A DDDS Unit that provides oversight and monitoring of community-based services.
SND	Support Needs Document	A document contained in the Therap System that records an individual's health & safety support needs. Types: General, Residential, Day Program, Work Center or Individualized Services. Many individuals will have more than one completed based on their current supports.
SSDI/OASDI	Social Security Disability Insurance / Old Age Survivors & Disability Insurance	Social Security Disability Insurance / Old Age Survivors & Disability Insurance pays benefits if you are "insured," meaning that you (or someone responsible for

		you) worked long enough and paid Social Security taxes.
SSI	Supplemental Security Income	Supplemental Security Income (SSI) is a federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people, who have little or no income; and it provides cash to meet basic needs for food, clothing and shelter.
ST	Speech Therapy	Speech Therapy addresses speech production, vocal production, swallowing difficulties and language needs.
OPD	Office of Professional Development	The Office of Professional Development (OPD) is responsible for administration of the statewide training program for staff employed by or contracted with DDDS
THERAP	THERAP Services, LLC	THERAP Services is a web-based service organization that provides an integrated solution for documentation and communication needs of agencies providing support to people with disabilities, especially developmental disabilities.
T-Log	THERAP Log	A document contained in the Therap System that is used by team members to communicate with one another about every day events
UCP	United Cerebral Palsy	United Cerebral Palsy (UCP) is the leading source of information on cerebral palsy and is an advocate for the rights of persons with any disability. The UCP mission is to advance the independence, productivity and full citizenship of people with disabilities through an affiliate network.

Ukeru	Ukeru Systems by Grafton	A behavior intervention program approved for use in Delaware that utilizes a trauma-informed “hands-off” approach with no physical restraints. Blocking pads may be used in this program.

Section 10 – **DDDS Commonly Used Acronyms and Abbreviations**

Section Name	Date Read/Completed	Initials
DDDS Commonly Used Acronyms and Abbreviations		

I, _____, have read and understood the
(print name)
information provided in this section of the DDDS Nurse Consultation Resource Guide. I have had an opportunity to consult with my supervisor and/or his/her designee and my questions have been answered.

_____ _____
Nurse’s Signature Date

_____ _____
Signature of Nurse Supervisor / Designee Date