DEVELOPMENTAL DISABILITIES ADMINISTRATION
RESIDENTIAL HABILITATION CENTER
STANDARD OPERATING PROCEDURE

TITLE: INTERDISCIPLINARY TEAM: NURSING FACILITY 103.3

PURPOSE

To establish responsibilities of the interdisciplinary team.

SCOPE

This policy applies to all employees who serve as a member of an interdisciplinary team for a client who resides in a nursing facility at a Residential Habilitation Center (RHC).

POLICY

A. For each client residing in a nursing facility, the RHC must establish a team of professionals that work cooperatively as members of the client's.

B. The interdisciplinary team must include:

1. The client;
2. The client's family or guardian; and
3. RHC facility staff.

C. The interdisciplinary team may include personnel from:

1. A school;
2. An organization that supports the client's specific needs; and
3. The preadmission screening and resident review (PASRR) team.

D. The interdisciplinary team may include professionals with expertise necessary to meet the client's specific needs, such as:

1. Physical development;
2. Health;
3. Nutritional status;
4. Sensorimotor development;
5. Affective development;

6. Speech and language development;
7. Auditory functioning;
8. Cognitive development;
9. Vocational development;
10. Social development;
11. Adaptive behavior; and
12. Independent living skills.

E. The interdisciplinary team must include:

1. The attending physician;

2. A registered nurse with responsibility for the client;

3. A nurse aide with responsibility for the client;

4. A member of food and nutrition services staff;

5. To the extent practicable, the participation of the client and the client's representatives; and

6. Professionals and support staff from disciplines and service areas suggested by the care area assessment, and the client's individual preferences.

F. Each member of the interdisciplinary team is responsible for working directly with the client and completing assessments to obtain and document current and accurate information.

G. Each client has an individual plan of care developed by the interdisciplinary team which includes a person-centered care plan to meet the client's needs, training programs, supports, and preferences.

PROCEDURES

A. The client's role in the interdisciplinary team

1. The client is the most important member of the interdisciplinary team and is the focal point of the planning and decision-making process.

2. To the best of their ability, the client must be:

    a. Consulted and considered in all decisions affecting the client and their care, thus creating a person-centered individual plan of care; and

    b. Included in the interdisciplinary team meetings to participate in the decision making process.

B. The family or guardian’s role in the interdisciplinary team

1. The client’s family or guardian advocates for the client and works with the interdisciplinary team to provide services that support the client to live as independently as possible.

2. The client’s family or guardian is encouraged to:

   a. Participate in the interdisciplinary team process;

   b. Provide input that helps determine the client’s needs;

   c. Provide input for plans to meet the client’s needs;

   d. Participate in decision-making;

   e. Review and sign informed consent forms;

   f. Notify other interdisciplinary team members of concerns, wishes, and objections; and

   g. Advocate for the client’s appropriate placement.

C. The case management personnel’s role in the interdisciplinary team

1. The case management personnel manages the interdisciplinary team process, which includes:

   a. Scheduling and facilitating interdisciplinary team meetings;

   b. Ensuring appropriate members are present at each meeting;

   c. Encouraging participation by all members;

   d. Resolving issues and conflicts within the team;

   e. Maintaining contact with the client’s family, guardian, non-health related outside agencies;

   f. Facilitating discussions about change in status and documenting changes in status; and

   g. Documenting the need for restrictive procedures and facilitating a review by the Human Rights Committee.

2. The case management personnel manages the client's individual plan of care, which includes:

   a. Writing the individual plan of care;

   b. Distributing the individual plan of care to the remaining interdisciplinary team members;

   c. Training staff to implement the individual plan of care;

   d. Ensuring all assessments are complete and included in the individual plan of care;

   e. Monitoring data and program implementation; and

   f. Revising the individual plan of care during regularly scheduled review, or more often if needed.

3. The case management personnel coordinates plans with outside services such as:

   a. PASRR assessors;
   b. Specialized service providers;
   c. Regional case managers; and
   d. School personnel.

D. **<u>The interdisciplinary team's responsibilities</u>**

1. All members of the interdisciplinary team must participate in the client's assessments by:

   a. Completing testing and observation of the client in all program areas;

   b. Providing accurate, updated, and thorough annual assessments;

   c. Reviewing documents and providing hands-on assistance to the client as required throughout development; and

   d. Documenting for the Human Rights Committee whether the client needs restrictive procedures

2. All members of the interdisciplinary team must help develop the client's person-centered service plan or individual plan of care by:

   a. Attending annual individual plan of care meetings;

   b. Providing input about the client's strengths, needs, preferences, and

training goals and objectives;

c. Collaborating with other disciplines to develop a comprehensive care plan that improves the client's functional abilities to the extent possible;

d. Implementing recommendations by the PASRR assessment;

e. Monitoring the client's goals and objectives through monthly observations, data collection, and analysis;

f. Recommending necessary care plan changes; and

g. Monitoring the client's person-centered care plan for appropriateness.

3. All members of the interdisciplinary team must:

a. Communicate openly and clearly with each other while being open to new suggestions and ideas;

b. Meet after comprehensive and quarterly assessments, and any time concerns arise or there is a significant change in the client's status;

c. Understand the client's individual plan of care and the rationale behind the training programs and service care plans;

d. Strive to eliminate or minimize restrictive programs, activities, and procedures using risk-risk or risk-benefit analysis. For more information about restrictive procedures, see DDA 5.14, *Positive Behavior Support,* and DDA 5.15, *Restrictive Procedures.*

AUTHORITY

42 CFR 483.21(b)	*Comprehensive Care Plans*
42 CFR 483.21(b)(2)(i)-(ii)	*Care Plan Timing and Revision*
42 CFR 483.24(c)	*Activities*
Chapter 71A RCW	*Developmental Disabilities*

DEFINITIONS

Case Management Personnel means Case Manager Resource Nurses, Patient Care Coordinators, Habilitation Plan Administrators, and Health Care Coordinators.

Comprehensive assessment means an assessment of a resident's needs, strengths, goals, life history, and preferences using the resident assessment instrument (RAI) required by CMS.

Individual plan of care means a person-centered comprehensive care plan that describes a client's needs, supports, and preferences.

Interdisciplinary team means a group of people who collaborate to develop and implement a client's individual plan of care.

SUPERSESSION

None.

Approved: /s/ Deborah Roberts
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