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Navigating a Plan of Care for the Developmentally Disabled Adult

The Medical-Surgical Nursing Certification Board (MSNCB) is a professional organization whose mission is to validate excellence in medical-surgical nursing. MSNCB administers the Certified Medical-Surgical Registered Nurse (CMSRN®) and Certified in Care Coordination and Transition Management (CCCTM) certification programs because certification is the recognized path for registered nurses to build and demonstrate commitment, confidence, and credibility. Certification provides an added credential beyond licensure. It demonstrates, by examination, that the Registered Nurse adheres to specialized nursing standards and has acquired a core body of specialized knowledge in their practice or specialty. The topic of this article is part of the comprehensive examination given by MSNCB. The following scenario and questions offer an example that potential certificants may use to test their knowledge. For more information about MSNCB, visit www.msncb.org.

Autism and Mental Retardation

Disabled persons have varying needs depending on the severity of condition. While special education is available through age 21, families may face challenges as the disabled person ages. Parents may face uncertainty over the future of their children. At the age when other young adults are leaving for college and seeking independence from their parents, the disabled adult faces unique obstacles. Depending on the degree of physical and mental function, the disabled adult may require additional years of care and supervision. Disabled adults may not be able to live on their own and/or sustain employment. Disabled persons may require medication, care, and supervision into adulthood (Centers for Disease Control and Prevention, 2016).

The Individuals with Disabilities Education Act of 2004 provides guidelines for special education, including proactive integrated programs for disabled persons at the local, county, and state levels (U.S. Department of Education, 2017). In California, for example, partnerships and collaboration have resulted in unification of county services and academic university programs to assist disabled persons and families (California State University San Bernardio, 2016). While a disabled client and his or her family benefit from available services and resources throughout childhood and adolescence, what happens when the child reaches adulthood? Parents are faced with questions regarding continuity of care, unexpected medical needs or services, and long-term arrangements (e.g., group home placement). A registered nurse (RN) in care coordination and transition management (CCTM®) must be able to help the parent navigate the system by developing an individualized plan for smooth transition.

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Case Study

Mr. Burns, age 54, has a 19-year-old son Jacob. The boy's mother lives in a neighboring state and has no contact with the family. Jacob has severe autism and mental retardation. He attends a special education program at a local high school. Jacob has undergone various medication changes as he has grown. He is of medium build, 5 feet 10 inches tall, and weighs 185 pounds. According to his father, Jacob has had a weight gain of 20 pounds in the last 6 months.

Mr. Burns' mother Joanne, age 78, has resided with the family for the last 10 years. Joanne has a history of heart disease and rheumatoid arthritis. She is visually impaired. Despite her age, she is quite active and provides after-school care for Jacob. Mr. Burns works full time at a government agency and relies on his mother's support at home.

Jacob has exhibited frequent episodes of aggressive and destructive behavior. His teacher has reported episodes of increased aggressiveness in the classroom. Jacob's most recent outburst at school resulted in the injury of a teaching assistant. The school psychologist has expressed concern over Jacob's behavior, which also has worsened at home. He has been physically aggressive toward his grandmother on several occasions. Mr. Burns has expressed concern over his aging mother's safety. He worries about the future and his ability to provide long-term care for Jacob. No other family members live in the area.

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Questions

1. Because Jacob has exhibited a new onset of behavioral aggression, he may need additional intervention. When meeting with the family, the RN should do which of the following FIRST?
   a. Arrange a medical appointment for Jacob.
   b. Identify and review Jacob's current medications.
   c. Initiate a team meeting with school staff.
   d. Arrange a meeting with a behavioral therapist.

2. Because Mr. Burns questions his ability to provide further care for his adult son, the RN in CCTM may consider using which of the following tools to assess his current hardship and coping?
   a. CAGE-AID
   b. Modified Caregiver Strain Index
   c. KATZ Index of Independence
   d. Psychosocial Assessment Tool

3. The RN in CCTM can empower the Burns family to manage future transitions in Jacob's life. This is part of which phase of the nursing process?
   a. Assessment
   b. Evaluation
   c. Plan and Implementation
   d. Diagnosis

4. The RN in CCTM could initiate wraparound services to help Mr. Burns and his family. Based on the information provided, which of the following is the wraparound service of highest priority?
   a. Pharmacy
   b. Behavioral
   c. Community
   d. Medical

5. Which of the following should the RN in CCTM identify FIRST in the advocacy role when collaborating with the social worker to assist the Burns family with care?
   a. An after-school program
   b. A parent support program
   c. In-home care providers
   d. Group home providers

6. For effective teamwork and collaboration, the RN in CCTM should act as a coach for the Burns family if faced with the following barrier:
   a. Unclear or blurred roles
   b. Communication challenges
   c. Unclear processes or guidelines
   d. Unavailability or change of members

Answers with Rationale

1. B – A complete nursing assessment is needed, to include medication review and reconciliation. Because the patient has demonstrated increased behavioral aggression, the RN should review all prescriptive medications as well as any over-the-counter drugs, herbals, or supplements that could interact with the current medication regime (Haas, Swan, & Haynes, 2014). While all other choices are reasonable, the RN in CCTM first should conduct a medication reconciliation.
2. B – The Modified Caregiver Strain Index is a 13-question tool designed to measure strain related to care provision. This tool is helpful in identifying families who would benefit from more comprehensive assessment of the caregiving experience (Haas et al., 2014). Mr. Burns is expressing his concerns openly, but the RN should determine his level of strain. The RN in CCTM may consider administering the index to Jacob's grandmother because she also has been providing care.
3. C – The planning and implementation phase includes assisting the patient and caregivers with the education and skills needed to manage future transitions. The RN in CCTM must help patients and families communicate their needs to others. Because Jacob cannot self-manage, the family needs the skills to manage future care needs and transitions as he ages (Haas et al., 2014).
4. B – Wraparound service is a holistic, intensive, individualized care plan designed to meet the needs of caregivers and family unit to address a range of life areas. It includes formal services and interventions, as well as community services and assistance provided by friends, families, and case workers (Haas et al., 2014). Behavioral services include treatment options such as medication modification. While pharmacy and community services may seem reasonable, the escalating behavior should be addressed first. Medical care is not included in the wraparound method. Wraparound services are in addition to the medical services the client is being provided.
5. C – It is important to advocate and negotiate for the client and family, and provide support and assistance with access to appropriate types and level of services (Haas et al., 2014). The Burns family is likely to opt for in-home care provider assistance if programs and services can be provided. The RN in CCTM can collaborate with the social worker to obtain resources and information to best fit the Burns family needs.
6. B – Communication challenges may occur between team members or across sites. Clients and families may not feel comfortable in a setting with multiple team members. An RN in CCTM may need to coach them for active team participation and collaboration (Haas et al., 2014). MSN

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