481—53.8(135J) Interdisciplinary team (IDT). The IDT shall establish a plan of care for each patient and family based on assessments performed by team members.

53.8(1) The interdisciplinary team shall include the:

a. Patient;

b. Hospice patient's family;

c. Attending physician;

d. Medical director;

e. Patient care coordinator;

f. Staff nurse;

g. Social worker;

h. Coordinator of volunteer service; and may include

i. A spiritual counselor and others deemed appropriate by the hospice.

53.8(2) Prior to or on the day of admission, the attending physician and at least one IDT team member shall develop an initial plan based on a preliminary assessment of the patient and family needs.

53.8(3) Within seven calendar days of admission the interdisciplinary team shall assess the needs of the patient and family. A care plan shall be based on these findings.

53.8(4) Within seven calendar days of admission the interdisciplinary team shall meet to develop a comprehensive written plan of care. The plan of care shall:

a. Identify the primary caregiver or an alternate arrangement for care;

b. List the needs of the patient and family;

c. List any intervention planned to meet the needs of the patient and family and the results expected from each intervention;

d. Indicate which team member(s) is responsible for each intervention;

e. Indicate the anticipated frequency of each intervention; and

f. Indicate the prognosis and expected disease process.

53.8(5) The IDT shall monitor and revise the plan of care on a regular basis. The team shall meet weekly and exchange information regarding the needs of the patient and family. Changes in the care plan shall be made when the needs of the patient or family change or when interventions do not result in the expected or intended response.

This rule is intended to implement Iowa Code section 135J.3(5).