HEALTH QUALITY BC

Appropriate Use of Antipsychotics in Long-Term Care

Interdisciplinary Team – Roles and Responsibilities

Role	Responsibility	Appointed Team Member
LTC Home Administrator/Manager	Works with Administrative Leadership to plan, organize, direct day-to-day functions of the care home supporting BPSD and overcome barriers (e.g. physical space issues, implementing changes for residents to improve quality of life).	
Medical Director	Provide physician leadership, resident care and clinical leadership, quality of care, and education to support medication management for BPSD.	
Director of Care (DOC) or Assistant Director of Care (ADOC)	Works with manager to assist with day-to-day coordination, supervision and development of clinical programs supporting BPSD.	
Attending/Most Responsible Primary Care Physician	Initial resident care and support and offers deprescribing strategies and appropriate diagnosis for residents.	
Nurse Practitioner	Initial resident care and support and offers deprescribing strategies and appropriate diagnosis for residents.	
Pharmacist	Assists with medication reviews and educates on effects of medications. Can be the conduit between Most Responsible Physician (MRP) and the resident, caregiver/family. Provide recommendations for deprescribing options.	
Gerontological specialty consults with nurse/geri-psych team, physician	Consult with gerontological specialty local team/physician and/or nursing staff that have a speciality in gerontology-as recognized by a specific course with certification in Gerontology or by the Canadian Nurses Association with GNC designation.	
Clinical Nurse Leader/Clinical Practice Lead or Designate	Point person for this group, helps schedule team huddles/behaviour rounds and monthly assessments. Data collection and monitoring of quality indicators. Oversees RAI assessments and training and brings	

Adapted from: The Long-Term Care Team of the Future.Richard G Stefanacci et al.April 2016.
https://www.hmpgloballearningnetwork.com/site/altc/articles/long-term-care-team-future

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	relevant resident information to the team along with staff training and education (PIECES, UFirst, DementiAbility, GPA, etc). Assists with communication (working with pharmacist on drug utilization reports), non-pharmacological interventions and training implementation, works with social worker and care coordinator with family engagement and communication.	
RN/LPN/RPN	Nurse representative with floor/unit knowledge about residents to provide input on medication administration, monitoring for side effects, behaviour management, informs team on RAI assessment outcomes that are impacting behaviours and medications (e.g. sections E, F, M, pain management, social isolation).	
Health Care Aide(s)	Provides input on behaviour triggers (e.g. meals, bathing) and assists with problem solving for re-direction.	
Care Coordinator	Provides relevant input from care conferences, supports family coordination and leadership support for floors/units.	
Occupational Therapy/ Physiotherapy	Provide recommendations for managing pain and activities for each resident.	
Recreation	Provide recommendations for therapeutic interventions and non-pharmacological approaches to care.	
Social Work	Provide an advocacy support role to families/caregivers to problem solve behaviour triggers.	
Dietician	Provide recommendations on strategies if there are food and/or mealtime related issues or behaviours.	