Individual Quality Review

Section 1. Information Gathering: Document Review

Class Member	On-Site Date	Region	Reviewer	Case Judge

Procedures for Data Collection: Record Review

In advance of the review, you are to have received and reviewed the individual's current ISP, previous ISP and assessments. **Assessments that are not obtained in advance (via digital file or Therap) are to be requested and provided via Document Request Form and/or during the onsite review.** The record review conducted during the review includes the primary record kept in the home.

The record review is intended to be the means to gather readily accessible, useful information about the individual. The information sought in the protocol should be available in the person's current/active/working record. The record review is not intended to be an exhaustive document search. The Reviewer is not required to search the historical/inactive/"dead" records or files for information unless such a search is needed to substantiate a specific issue discovered during the review.

If you cannot find a document or information, complete the Document Request Form as described in the instructions on that document. If, during interviews, knowledgeable staff says the document or record does not exist, note this, along with the name of the person who told you this, in the protocol book.

Prior to the review start date you should have received a copy of the current and previous ISP and all current assessments. You are expected to review this file in advance of the telephone interviews and onsite review. The Reviewer **MUST finish the initial record review and complete the documentation in the protocol booklet prior to proceeding** to the next phase of the protocol. It is the Reviewer's responsibility to acquire the information necessary to complete the protocol.

1. DEMOGRAPHIC/GENERAL INFORMATION

YOU MUST PROVIDE AN ANSWER TO EVERY QUESTION. NO SPACE SHOULD BE LEFT BLANK.

1. Social Security Number	2. Date of Birth	3. Current Age	4. Gender	5. Current Address	6. Telephone	7. Ethnicity
			Choose			Choose If Other, Specify:

8. Preferred Language	9. Method of Communication:	10. Legal Guardian?	Guardian Name & Contact Information
Choose If other, specify:	(e.g., Verbal, signs, gestures, facial expressions, etc.)	Choose	

11. Guardianship Status based on legal documents found in record).	☐ Full (Plenary)	☐ Limited* (Specify)	☐ Competent	☐ Could Not Determine	☐ None: *This person does not have a guardian but the team feels the person needs a guardian*	☐ Power of Attorney* – If yes, date that POA went into effect:

12. Acuity Level: (as identified in the eChat summary): Choose View Nursing Oversight

***Note:** Limited guardianship will state specifically what the guardian has authority to do, such as make financial and medical decisions. Full or Plenary guardianship papers may not specify what authority the guardian has, or may list many general things, such as all financial, medical, treatment, and placement decisions. If the document only states the guardian cannot make decisions for the person regarding marriage, children, and voting, that is NOT a limited guardianship; it is a Plenary Guardianship. Power of Attorney cannot be older than 6 months.*

2. DIAGNOSES

Guidance: Starting with the diagnosis identified in e-Chat, note the specific diagnosis, the document in which it is found, the date of the document and the author and their title. When the table is complete (after all documentation has been reviewed), look for discrepancies; compare with information provided during interviews and use knowledge gained to provide justifications, as appropriate, for the Scoring questions. Indicate in the e-Chat column 'yes' or 'no' if the document does/does not appear in the e-Chat. If you do not find it in e-Chat, list each document where that diagnosis is found. You do not need to list multiple documents in which the same diagnosis was found. List diagnosis from the e-Chat, then add any additional diagnoses found in other documents and cite the document in which it was found. If there is a diagnosis identified in the e-Chat that is not listed in any other documents, list that as well.

DIAGNOSES TABLE

On eChat (Y/N)	Diagnosis	Document	Date	Author/Title

DIAGNOSES TABLE				
On eChat (Y/N)	Diagnosis	Document	Date	Author/Title

3. PROVIDER INFORMATION	
13. Case Management Agency	
14. Living Care Agency	
15. Living Care Arrangement	NOTE DDSD Definitions: If the person lives in their own home with non-paid family but receives personal care/respite services, record that in the "Other Major Provider" information below.. New service titles for individuals who have converted to the new DD Waiver are indicated in parenthesis. ☐ **Family Living:** Services are provided to Participant in a family setting. (Actual family or surrogate foster-type family). ☐ **Independent Living: (Customized In-Home Supports)** More independent environment. Staff support is available when needed and furnished on a planned, periodic schedule. Such intermittent support may occur in a home they share with other family members or non-disabled friends or may occur in their own apartment/home where they live alone or with a peer roommate. ☐ **Supported Living**: Services are provided to an individual or in groups of 4 or less. Service is provided 24 hours with the exception of time spent in education/employment setting.

3. PROVIDER INFORMATION	
	☐ **(Intensive Medical Living):** Similar to Supported Living, but includes a daily nursing visit and expanded support for highly complex medical needs. This service is based upon a higher reimbursement rate for the extra medical oversight, but does not indicate a certain location. Individuals receiving Intensive Medical Living may have roommates that receive regular Supported Living. This rate is also available short term in certain circumstances such as post-hospital stabilization. ☐ **Other:** If a class member is not in a service described above, please check 'other' and describe what type of service the class member is receiving. If Other, please describe:
16. Number of Residences	*Note: This is the number of residences the person has been in the past year, including their current home.*
17. Day/Employment Agency	*Note: List all as needed*
18. Type of Day/Employment program (select all that apply)**:**	☐ **Individual Customized Community Supports:** Individual Customized Community Supports are age appropriate and provided on a one- to-one (1:1) basis. Activities listed in the scope of work are delivered in a manner consistent with the individual's ISP and are provided exclusively in the community. ☐ **Small Group Customized Community Support:** Small Group Customized Community Support is provided in groups of three (3) or less. Activities listed in the scope of work are delivered in a manner consistent with the individual's ISP and are provided exclusively in the community, not in an agency-operated building. ☐ **Group Customized Community Supports:** Within the CCS Group model, there are two (2) categories of service: CCS Group Category 1 and CCS- Group Category 2 Extensive Support. The two categories are based on intensity and nature of individual support needs. Activities listed in the scope of work are delivered in a manner consistent with the individual's ISP and may be provided in an agency-operated building. ☐ **Community Inclusion Aides:** The Community Inclusion Aide provides one-to-one (1:1) personal care services in a community setting for individuals who require assistance with Activities of Daily Living (ADLs) and other health supports as needed and is to be delivered in the community exclusively. This service is provided in conjunction with other CCS services. ☐ **Individual Intensive Behavioral Customized Community Supports:** Individual Intensive Behavioral Customized Community Supports are designed to meet the needs of individuals with extraordinary behavioral needs. Individuals in this group exhibit extraordinary behavioral support needs such as aggressive behavior, property destruction, stealing, self-injury, pica, sexual inappropriateness, frequent emotional outbursts, wandering, and/or substance abuse, that if left unsupported, expose the individual to risk of doing significant harm to themselves or others. Services are provided on a one-to-one basis (1:1) only at times when this level of support is needed. ☐ **Job Development:** Job Development may include, but is not limited to, activities to assist an individual to plan for, explore and obtain Community Integrated Employment. ☐ **Job Maintenance:** Job Maintenance is intended to be used as the long-term supports once funding through vocational rehabilitation or the educational systems have been utilized. Job Maintenance is provided in a one-to-one ratio.

3. PROVIDER INFORMATION

	☐ **Group Community Integrated Employment:** In Group Community Integrated Employment as many as six (6) individuals work in an integrated setting with staff supports on site. Regular and daily contact with non-disabled coworkers and/or the public occurs. Within the CIE Group model, there are two (2) categories of service: CIE Group Category 1 and CIE- Group Category 2 Extensive Support. The two categories are based on intensity and nature of individual support needs. ☐ **Group Community Integrated Employment – Intensive:** In Group Community Integrated Employment – Intensive as many as four (4) individuals work in an integrated setting with staff supports on site. Regular and daily contact with non-disabled coworkers and/or the public occurs. ☐ **Self-Employment:** When an individual elects to start his/her own business, the Community Integrated Employment Provider supports the individual by assisting with the development of a business plan, conducting a market analysis for the product or service and establishing the infrastructure to support a successful business. Self-employment does not preclude employment in the other models. ☐ **Job Aide:** The Job Aide provides one-to-one (1:1) personal care services in an individual integrated employment setting for individuals who requires assistance with Activities of Daily Living (ADLs) during work hours in order to maintain successful employment as job coaching is reduced. This service is provided in conjunction with other CIE services. ☐ **Intensive Community Integrated Employment (ICIE):** ICIE is designed to provide services for individuals who are working in a community integrated employment setting and require more than 40 hours of staff supports per month in order to maintain their employment. ☐ **Other:** If a class member is not in a service described above, please check 'other' and describe what type of service the class member is receiving. If Other, please describe:

19. Other Providers: *(e.g., Behavior Support, OT, PT, SLP, Adult Nursing, etc.)*	**Agency and Name of Provider**	**Service Provided**

Before Proceeding Please Ensure That You Have Answered All of Questions 1-19

Documentation of Relevant Information

The following pages are provided for the Reviewer to record information found in the file that is relevant to the Summary Questions to be answered at the end of the protocol. The Reviewer should be very familiar with the specific questions in the Summary Questions Section prior to reviewing the primary record/case management file. To assist the Reviewer in recording and finding information needed to complete the Summary Questions Section, the following pages have been formatted by subject area with a brief guide to the information to be recorded in each section.

This space is "working paper" for the Reviewer. Information recorded here will be used as evidence to support determinations made in the Summary Questions Section of the

protocol. Record the date and source of any information recorded on these pages. The Reviewer may summarize or paraphrase the information found in the record or may record the information verbatim.

4. ASSESSMENTS

Notes on Assessments: Copies of all current assessments should have been provided with the initial packet of information. If not, they must be requested and, if possible, obtained by the Reviewer. Use this space to record information about assessments indicated as needed but not found, efforts to obtain any missing assessments, and any pertinent information found in the case manager's notes about the assessments. Consider the following types of assessments: history and physical; dental; psychological; behavioral; psychiatric; physical therapy; occupational therapy; living care/residential; vision; hearing; speech language pathology; day/community; employment; Person Centered Assessment; other: i.e., neurological; self-administration of medications; nutritional; Emergency/Urgent Care visits; all Doctor's visits; Hospital Admissions; Out of Home Placements; and Hospice Assessments.

Note assessments completed in the past year:
These assessments are required annually: History & Physical Exam—required for everyone; e-CHAT—required for everyone; Medication Administration Assessment Tool (MAAT) and Aspiration Risk Screening Tool (ARM) are required annually for everyone, Comprehensive Individual Assessment (CIA)—required for everyone.

NOTE: Jackson class members may have a Mealtime Plan, but only if they are low risk for aspiration and they have special dietary/eating needs unrelated to aspiration risk, such as chopped soft for an individual with several missing teeth. If they have additional factor(s) - in addition to aspiration risk - everything should be incorporated into the CARMP and there should not be a separate MTP.

Assessment requirements should be identified in the ISP: Positive Behavior Supports Assessment; Occupational Therapy (OT) Assessment; Physical Therapy (PT) Assessment; Speech Therapy (SLP) Assessment; Vision Exam; Dental Exam; Neurological Exam; Psychiatric Exam; employment/Person Centered Assessment; Aspiration Screens; TEASC, SAFE clinic, and other clinic exams/assessments.

Elements to look for in Annual Physicals

- Medical History including comments regarding changes since the last exam;
- Review of Systems (Doctor reviews all body systems plus anything that the program will call to the Physician's attention)
- Review of Medication;
- Physical Exam of the person;
- Impressions/Plan: identification of what is needed which may include blood work/labs; additional specialty tests, medication change, etc.; and
- Signature and title of individual completing the Physical

Therapy/BSC/Nutrition Assessments should identify:

1. The person's current developmental strengths, preferences, skills and abilities;
2. The person's learning style and support needs in order for the person to be successful;
3. The person's presenting problems, challenges and disabilities;
4. Projected outcomes/goals that the author will do or wants done next ;
5. If this is not the initial assessment, progress from baseline or one point in time to another should be noted.
6. Recommendations for remediation of identified challenges;
7. Recommendations for skill development and/or maintenance of abilities to prevent decline; and
8. Date and author's signature.

ASSESSMENTS TABLE

Link to Nursing Oversight

Date of Previous Assessment	Date of Current Assessment	Specialty	Author, Title	Information/ Recommendations	Evidence that Recs were followed up	Comments & Justifications Regarding Adequacy of Assessment
e.g. 8/16/16	*e.g. 8/18/17*	*e.g. Podiatry*	*e.g. Dr. Scholl's, Podiatrist*	*e.g. Obtain new lifts*	*e.g. Lifts obtained on 10/4/17*	
	05/05/5000	PT Assmt				

ASSESSMENTS TABLE						Link to Nursing Oversight
Date of Previous Assessment	**Date of Current Assessment**	**Specialty**	**Author, Title**	**Information/ Recommendations**	**Evidence that Recs were followed up**	**Comments & Justifications Regarding Adequacy of Assessment**
	05/05/5000	OT Assmt				
	05/05/5000	SLP Assmt				
	05/05/5000	BSC Assmt				
	05/05/5000	Nutrition Assmt				

20. Does this person currently take medications? **Choose**

Note: A list of current medications is to be recorded in Residential Services Provider Interview. Be sure that all current medications are listed prior to the on-site review so they can be checked at the person's home
For questions 21-23, the Reviewer is asked to rate each item as follows: A rating of "0" = No Compliance A rating of "1" = Needs Improvement; few of the indicators are met, many are inconsistently met A rating of "2" = Many Indicators Met, but not all A rating of "3" = Full Compliance A rating of "NA" = Not Applicable, and represents an item that does not apply to the individual being reviewed
21. If Participant is on a neuroleptic medication, is there evidence of involuntary movement screening (AIMS or similar) and follow-up? **Choose**
Notes/Justifications:
22. If needed, is there evidence of ongoing tracking of seizures? **Choose**
Notes/Justifications:
23. If needed, is there evidence of required blood work? **Choose**
Notes/Justifications:

5. PROGRESS/REGRESSION

Notes on Progress/Regression Information. Record information related to the person's progress/growth. This may include information (Supported Living reports Community Access reports, etc.) generated by service providers and/or ancillary providers that were found in the person's record. Use this space to make notes about the type (e.g., data only, data and written summaries) of information found specific to outcomes on the ISP. Include information about growth/progress that may not be specific to outcomes in the ISP. If you find problems such that you will score either a "0", "1" or "2", note those details.

ALSO: List provider reports for the past year which may include but not be limited to: Residential semi-annual progress reports; Day/Employment semi-annual progress reports; BSC semi-annual reports; OT semi-annual reports; PT semi-annual reports; SLP semi-annual reports; Psychiatric visit reports/notes. Nurses are required to provide quarterly reports for people who score a moderate or high on the e-CHAT.

PROGRESS/REGRESSION TABLE

Date of Report	Title of Report *(e.g. PT Semi-Annual)*	Author, Title	Related to what ISP (date) and Outcome (list)	List specific measurable progress or regression, Plans to address the need to maintain functional skills, regression, and Outcomes achieved Use exact quotes from reports when possible	Does Data Verify Information in Progress Report? (Also note Comments & Justifications here)
7/7/7777	PT Semi-Annual				
7/7/7777	OT Semi-Annual				
7/7/7777	SLP Semi-Annual				
7/7/7777	BSC Semi-Annual				
7/7/7777	Nutrition Semi-Annual				

PROGRESS/REGRESSION TABLE					
Date of Report	**Title of Report** *(e.g. PT Semi-Annual)*	**Author, Title**	**Related to what ISP (date) and Outcome (list)**	**List specific measurable progress or regression, Plans to address the need to maintain functional skills, regression, and Outcomes achieved <u>Use exact quotes from reports when possible</u>**	**Does Data Verify Information in Progress Report? (Also note Comments & Justifications here)**

PROGRESS/REGRESSION TABLE					
Date of Report	**Title of Report** *(e.g. PT Semi-Annual)*	**Author, Title**	**Related to what ISP (date) and Outcome (list)**	**List specific measurable progress or regression, Plans to address the need to maintain functional skills, regression, and Outcomes achieved Use exact quotes from reports when possible**	**Does Data Verify Information in Progress Report? (Also note Comments & Justifications here)**

6. THERAPY/BSC/NUTRITION DOCUMENTATION REVIEW

Guidance: *Prior to the interview, reviewers must read the complete file. The following table should be completed.*

Note: The Current and Semi-Annual Dates should auto-populate from the assessment and progress tables. If they do not, try a print preview.

All Documents are to be reviewed in advance of Interviews.	**PT**	**OT**	**SLP**	**BSC**	**Nutrition**
Most Current Assessment Date	**05/05/5000**	**05/05/5000**	**05/05/5000**	**05/05/5000**	**05/05/5000**
Date WDSI were due (ISP implementation date) and Date of document.	Due: WDSI Date: Comments & Justifications:	Due: WDSI Date:	Due: WDSI Date:	Due: WDSI Date:	Due: WDSI Date:
Are the WDSI/Plans related to the current ISP?	☐ Yes ☐ No ☐ N/A Comments & Justifications:	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Are steps to be taken by those implementing the WDSIs clearly written?	☐ Yes ☐ No ☐ N/A Comments & Justifications:	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A

6. THERAPY/BSC/NUTRITION DOCUMENTATION REVIEW

Guidance: *Prior to the interview, reviewers must read the complete file. The following table should be completed.*

Note: The Current and Semi-Annual Dates should auto-populate from the assessment and progress tables. If they do not, try a print preview.

All Documents are to be reviewed in advance of Interviews.	**PT**	**OT**	**SLP**	**BSC**	**Nutrition**
Date Semi-Annual progress report was due and date of report.	Due: Report Date: 7/7/7777	Due: Report Date: 7/7/7777	Due: Report Date: 7/7/7777	Due: Report Date: 7/7/7777	Due: Report Date: 7/7/7777
	Comments & Justifications:				
Does the progress report provide evidence that measurable progress has been achieved, or if the objective is to prevent decline, has functional status been maintained since the previous report?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
	Comments & Justifications:				
Is there documentation of action to address lack of progress or attainment of objectives (e.g. revision of plans or objectives, establishing new objectives, etc.)?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
	Comments & Justifications:				
Compare therapy progress reports to daily notes and data provided for the review. Is the person's progress/performance reflected in therapy reports consistent with the person's performance as indicated in the daily notes and data?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
	Comments & Justifications:				

7. TEAM MEETINGS

Notes on Team Process. Record information found on the frequency of IDT meetings; topics discussed during any IDT meetings; any communication among the IDT members outside of formal meetings including the "topic" of any communication; information about unusual incidents and any IDT follow-up; or any information pertinent to how the team is functioning for this Participant.

Note: The IDT shall consist of: person served, case manager, guardian (if applicable), direct service staff from each provider agency and ancillary service providers (if applicable) such as therapists, nurses, vocational specialists, behavioral support consultant, etc. The team may also include a friend advocate, physician, psychiatrist, psychologist, family member and/or legal representative. Participation of ancillary service providers does not require the provider's physical presence at the IDT meeting. Their participation can be accomplished through the submission of assessments/progress reports, through conference call, or through meeting with another team member prior to the meeting to discuss issues/concerns/recommendations. This is also true for nurses in cases where urgent health needs of another individual prohibited their attending in person.

List all IDT meetings held in the past year, including Annual ISP meetings and all interim IDT meetings held to review and/or revise the ISP. If other relevant meetings have been held such as special meetings based on changes in personal circumstances (e.g., health, IR's, out of home placement, death in the family) you should note them here as well.

TEAM MEETINGS TABLE

Date of Meeting	Type of Meeting or Incident	Follow up Required or Agreed Upon	Evidence & Justifications that Follow Up was done or not? Cite source(s)

8. CASE MANAGEMENT MONITORING

Notes on Monitoring and Coordination of Services by Case Manager. Record information on case manager contact with the person; the frequency and outcome of case manager visits and telephone calls to the person's home and day program/work site; case manager contacts with ancillary providers; information about the outcomes and/or recommendations of physician/dental visits; case manager efforts to locate and secure needed services.

Note: Case Managers are to see class members at least 2 times per month. Note contact with other team members. Look for patterns… when the Case Manager visits is the person always in bed? Is there progress on Outcomes/Action Plans? Does the Case Manager always visit at the same time and same place (their visits are to be at different times and in multiple places)? IDT meetings do count as a face-to-face meeting for that month. IDT meetings can only be replaced as a "face-to-face visit" one time per quarter.

If you find problems, e.g., inadequate number of contacts, inadequate follow up, inadequate attention to issues when visiting, etc.; please note those details. **ALSO:** Note home visits and site visits as well as contacts with providers, the individual, the guardian, and others such as the individual's healthcare providers, follow-ups for appointments and exams, etc. within the past year. Note: If you see exemplary intervention please note in Individual Summary and Good News Section of the Findings and Recommendations.

CASE MANAGEMENT MONITORING TABLE

Contact Date & Time of Day	**Type** (e-mail, site visit, etc.)	**Relevant Content/Issue**	**Comments/Things to follow up on & Justifications**	**Source Documents** (Evidence verifying your findings)

9. CARMP, HEALTH CARE PLANS AND MEDICAL EMERGENCY RESPONSE PLANS

Guidance:

#1. Review the person's HCPs and MERPs found in the file and list in Column "A" below;
#2. Review the person's e-Chat summary and indicate in Column "B" if the HCPs and MERPs listed in column "A" are R = Required or C = Consider;
#3. If there is an HCP or MERP in the e-Chat summary that is "R"/Required but not provided be sure you list that one in Column A and the "R" in Column B.
#4. In Column C, Indicate with a "yes" if this person has this document or a "no" if that document was not provided. (If not provided but required, be sure you ask for it on your Document Request Form).
#5. Read each Plan in detail so you know what the contents require.
#6. In Column D, put a "yes" indicating that you have read the related document and understand the contents requirements.
#7. In Column E, record any comments/justifications you may have regarding the document, especially if follow up is required.

Under "Comments & Justifications" indicate whether or not the instructions are clear, individualized and whether or not they contradict any other assessments or plan, such as the CARMP. Plans should be reviewed quarterly and each time there is a change in status.

Note: Review this person's CARMP and list it in Column A along with the date. Add any issues noted in the "E. Comments & Justifications" column.

CARMP, HCP AND MERP TABLE

A. These Documents are Required/Provided.	B. Indicate if it is R= Required C=Considered	C. Is the document Available? (Yes/No)	D. Have you (Reviewer) comprehensively reviewed this document? (Yes/No)	E. Comments & Justifications

10. NURSING OVERSIGHT

Question #12 provides you with the acuity level of this person as identified in the eChat. The Aspiration Risk Screening Tool (ARST) provides you with the level of risk this person is with respect to aspiration. The minimum frequency of nursing oversight is based on acuity level and level of aspiration risk as required by DDSD as follows:

This person's acuity level is: Choose *Note: This should pre-populate from #12; if it does not, try a print preview.*				
Aspiration Risk *(as noted on the ARST)* Choose		eCHAT Acuity		
		Low	Moderate	High
	Low	Semi-annual	Quarterly	Monthly
	Moderate	Quarterly	Quarterly	Monthly
	High	Monthly	Monthly	Monthly

The number of nurse visits may be affected by hospitalizations and Out of Home Placements. If the person you are reviewing has experienced an Out of Home Placement, you will have received this information but also ask to be sure. If a person is in an Out of Home Placement for over a month, a nursing visit is not required.

Guidance: *read each nursing note/assessment/quarterly/report. Enter the date, a brief description and any comments you wish to make.*

Annual and Semi-Annual Nursing reports should include:

- Changes since last report;
- Discussion of current status/health issues;
- Progress/efficiency of current Care Plan and Goals;
- Plan: What next, e.g., goals or changes that may be needed;
- Signature and title of person completing the report.

NURSING ASSESSMENTS/REPORT/VISIT TABLE				
Date of Visit *(the date the nurse was there in person)*	**Date of Report/ Assessment**	**Type of Visit/ Report** *(e.g., Day Semi-Annual Assessment, Res Visit, Post-Hosp Follow up, etc.)*	**Relevant Details of Note** *(From the Report/Consult)*	**Comments/Things to follow up on & Justifications**

11. INDIVIDUAL SERVICE PLAN (ISP)

Notes on the last two ISPs

Visions: List the vision in each area and for each ISP. Comment to whether or not each vision represents a long-term (3-5 year) aspiration in line with the person's interests and desires.

Outcomes: List the outcomes in each area. Comment on how they relate to the vision, their clarity and their measurability.

Action Steps: List the actions steps in each area. Note the frequency with which they are to be implemented. Are the Action Steps measurable and sequenced in a logical progression which will result in meeting the outcome? Action steps should be focused on what the individual will do.

Evidence of Implementation: Review data sheets. Record 3 months' worth of data, for example:

June: implemented 1x week 1;
July: implemented 3x week 1; 0x week 2; 3x week 3, and 4x week four.
August: implemented 4x week 1; 1x week 2; 1x week 3 and 4x week four.

Does the data provide information on what the person you are reviewing is doing, can you tell from the data if they are making progress towards the skill intended? If the data only shows attendance at events (how frequently the person went to music concerts) that is not skill based and not informative in terms of what skills the person is learning.

Teaching and Support Strategies: Read the T&SS. Comment on whether or not the directions are clear enough for anyone to implement the program. Do they specify when, how often and under what circumstances they should be implemented?

Therapy Integration: Determine if the ISP incorporates information from ancillary providers (from plans, assessments, recommendations, etc.) dealing with how to reinforce skill building/maintenance, personal traits and abilities appropriately? Teaching and Support Strategies, as needed, should contain information from the ancillary providers that supports attainment of the Action Steps. A mere reference to ancillary providers or specific plans/documents is not considered to have sufficient detail to be understood and consistently implemented, unless Written Direct Support Instructions are attached to the Teaching and Support Strategies from the therapist(s).

In any area:

- Note what the barriers are to my success and how they are addressed in either action steps, T&SS and/or support plans.
- Add rows as needed to accommodate more than one outcome, action step or T&SS.
- Compare the two ISPs. It is not acceptable to work on the same outcomes and action steps for several years in a row without clear justification as to why. If there is such justification, be sure you list that in the comments section.
- If Outcomes have been changed during the year, add another line and identify the new outcome.

Comments/Justification: You can make your observations here.

ISP TABLE	Previous ISP	Current ISP	Comments/Justification
A. Live:			

ISP TABLE		Previous ISP	Current ISP	Comments/Justification
1	**Visions:**			
2	**Outcomes:**			
3	**Action steps:**			
4.	**Evidence of Implementation:**			
5.	**Teaching & Support Strategies:**			
6.	**Integration therapies:** Are recommendations and/or objectives/ strategies of ancillary providers integrated into the T&SS?			
7.	a. Was the ISP Developed by an appropriately constituted team? b. If a member was missing, identify who, by title (e.g., SLP, Day DSP) c. For any team members not physically present at the IDT meeting, is there evidence of their participation in the development of the ISP?			
B.	**Work/Education/Volunteer**			
1	**Visions:**			
2	**Outcomes:**			

ISP TABLE		Previous ISP	Current ISP	Comments/Justification
3	**Action steps:**			
4.	**Evidence of Implementation:**			
5.	**Teaching & Support Strategies:**			
6.	**Integration therapies:** Are recommendations and/or objectives/ strategies of ancillary providers integrated into the T&SS?			
C.	**Develop Relationships/Have Fun**			
1	**Visions:**			
2	**Outcomes:**			
3	**Action steps:**			
4.	**Evidence of Implementation:**			
5.	**Teaching & Support Strategies:**			
6.	**Integration therapies:** Are recommendations and/or objectives/ strategies of ancillary providers integrated into the T&SS?			
D.	**Health and/or Other**			
1.	**Visions:**			
2.	**Outcomes:**			
3.	**Action steps:**			

ISP TABLE		Previous ISP	Current ISP	Comments/Justification
4.	**Evidence of Implementation:**			
5.	**Teaching & Support Strategies:**			
6.	**Integration therapies:** Are recommendations and/or objectives/ strategies of ancillary providers integrated into the T&SS?			

12. INCIDENT REPORTS (IR) / GENERAL EVENT REPORTS (GER)

For each General Event Report (GER), DOH Incident Report, and Internal Incident report, note the event date, the type, and a brief description of what happened and indicate any details regarding ANE. In the comments/notes and justification section, note any actions to be implemented to prevent reoccurrence. Add anything that you need to question or watch for to the appropriate interview questions or observation list. *Note: Internal Incident Reports may need to be added during the visit to the home or other program areas. Also, entering these in chronological order helps you 'see' what happened before and after. It also helps you begin to see frequency and trends.*

Date of Event	Type *(IR or GER)*	Brief Event Information	ANE Suspected/ Reported? (Y/N)	If ANE Suspected, Information regarding follow up:	Reviewer Comments/Notes & Justifications
e.g. 1/5/17	*e.g. GER*	*e.g. Staff noted she had foul smelling urine, taken to ER, UTI diagnosed*			

13. TRACKING DOCUMENTATION

This area is for documenting tracking issues you may have found, including gaps in information provided, items that have happened consistently but not picked up so far, etc. Types of tracking that would be relevant here is Seizures, Weight, Vital Signs, Menses, Fluid/Food Intake, and/or Bowel/Elimination Tracking. Note: It will be helpful to enter these by type and then by date; add rows as needed.

Type/Event	Date of Event	Duration/Amount	Relevant Information	Reviewer Comments/Notes & Justifications
i.e., seizure	*4/18/17*	*2 Minutes*		
i.e., BM	*5/23/17*	*Loose*		

14. ADDITIONAL INFORMATION

Notes on Other Information Found in the Record: Use this space to record information that is relevant to the review of this person's services but does not fit into any of the categories above. Be specific in terms of document you are referencing, date, author and issue.
Examples of information that may be included on here: Freedom of Choice (FOC), Human Rights Committee Meeting Minutes (HRC), Request for Regional Office Interventions (RORIs), Previous CPR Findings that continue to be issues, Team Decision Consultation Form/Decision Justification Forms (DCF/DJF); Budget information, Individual Transition Plans, and **ANYTHING YOU DID NOT FIND A LOCATION FOR ABOVE** but you feel should be included.

Date	Source (Document, Author)	Relevant Information	Reviewer Comments/Notes & Justifications
