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| **Individual Quality Outcome Measures Review** |
| Individual’s Name: | CID#:  |
| Physical Address:  | (pulls from member page physical address not agency address)  |
| Location of visit: Choose an item. **Own home Residential (Host Home, CLA) Day Support Community:**  |
| Date of visit: |  | Start Time:  |  | End Time:  |  |
| Note Code:  | Choose an item. |
| Contact Type: | Choose an item. | Contact Purpose: | Choose an item. | Billable Event: | Choose an item. |
| ADA Population | Choose an item. | Funding Source:  | Choose an item. | Exceptional Rate: | Choose an item. |
| Service Monitoring: | Choose an item. |
| HRST Score: | (pulls from members HRST score)  | Date of Last HRST: |  |
| **Individual Support Plan Focus Areas** |  |
| Directions: For each section check if the services are being provided in an adequate manner or if there are concerns. In the *Comment/Actions Needed* box list identified *Concerns, Barriers, and Successes* for each section. Additionally, describe any steps being taken to address any concerns/issues observed.  |
| **Focus Area** | **Select:** | **Comments/Actions Needed:** |
| **Environment** |  | **Concerns, Barriers, Successes** |
| 1 | Is the home/site accessible to the individual?  | Select |   |
| 2 | Does the individual have access to privacy, including but not limited to; personal care, visitors, discussions, mail, and/or other communications?  | Select  |  |
| 3 | The home setting allows the individual the option to have a private bedroom.  | Select |  |
| 4 | Are all assistive technologies being utilized as planned and in good working order?  | Select |  |
| 5 | Does the individual have adequate clothing, food, and supplies available to accommodate the individual’s needs and/or preferences/choices?  | Select  |  |
| 6 | Is the Residential/Day setting clean, safe and appropriate for the individual’s needs and preferences?  | Select  |  |
| **Appearance/Health** |
| 7 | Does the individual appear healthy and safe? Describe appearance and any changes since the last visit.  |  Select |  |
| 8 | Have there been any changes observed or reported in health since the last visit? If yes, describe the change(s) and indicate if the HRST is aligned with the current health and safety needs of the individual.  | Select |   |
| 9 | Are the ISP, healthcare plans, nursing plans, medical crisis plans current and available to staff? Are they being implemented? Are nursing hours being provided as indicated on the ISP?  | Select |  |
| 10 |  Are all medical/therapeutic appointments, follow-up appointments/recommendations/orders, and required assessments/evaluations, being attended, followed, and/or, completed, as ordered?  | Select |  |
| 11 | Has the individual had any hospital admissions and/or Emergency Room visits, since the last visit? Note: Describe follow-up process regarding the discharge planning. | Select |  |
| **Supports and Services** |
| 12 | Do the individual’s paid staff and/or natural supports treat them with respect and dignity?  | Select |  |
| 13 | Are supports and services being delivered to the individual as identified in the current ISP? Are staff ratios in place, as indicated on the ISP?  | Select |  |
| 14 | Is the individual being supported to make progress on achieving their goals (ISP goals and informally expressed goals)? Indicate the status of the individual’s progress on established goals. | Select |  |
| **Behavioral and Emotional**  |
| 15 | Are there any emerging or continuing behavioral, emotional responses for the individual, since the last visit?  | Select |  |
| 16 | Does the individual currently have an implemented Behavioral Support Plan? Crisis Plan? Safety Plan? (Evidence of implementation includes staff being knowledgeable about plan and ability to describe how they are implementing the plan.)  | Select |  |
| 17 | Has the individual accessed the DD crisis system, psychiatric hospital, crisis stabilization unit, ER, or had contact with law enforcement for behavioral issues, since the last visit? (Note: If yes, describe reason, frequency, duration of any admissions, and if discharge recommendations are being followed).  | Select |  |
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| **Home/Community Opportunities** |
| 18 | Does the individual have people in their lives other than paid staff and does the individual have community connections? Note: Describe current natural supports and how/where the individual is connected to that person or group. Describe steps being taken to further develop natural supports.  | Select |  |
| 19 | Is the individual receiving services in a setting where they have the opportunity to interact with people who do not have disabilities (other than paid staff)? Is the individual being offered/provided documented opportunities to participate in activities of choice with non-paid community members? | Select |  |
| 20 | Does the individual have the opportunity to participate in activities he/she enjoys in their home and community? Describe steps being taken to increase opportunities to meet this objective and allow choices to be offered while in services. | Select |  |
| 21 | Is the individual actively supported to seek and/or maintain employment in competitive and integrated settings and/or offered customized opportunities, if desired? Is yes, note how they are supported to do so. If no, how is the issue being addressed? | Select |  |
| 22 | Does the individual have the necessary access to transportation for employment and community activities of their choice? | Select |  |
| **Financial** |
| 23 | Are there barriers in place that limit the individual’s access to spend his/her money, as desired?  | Select  |  |
| **Satisfaction** |
| 24 | How did the individual communicate their overall satisfaction with their life activities during the visit (include providers, services, family, etc.)? Does the individual express/indicate satisfaction with current supports and services? (Note: Describe any dissatisfaction with current supports and services and what steps are being taken to address these identified areas).  | Select |  |
| 25 | Are there any additional service needs not being met at this time? Describe. | Select |  |
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| Observations/Comments: |
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| SC Signature Date |
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