

Name: _____

Phone #: (____) _____ Resident #: _____

Address: _____

City: _____ State: ____ Zip: _____

General

1. Name/County:

2. Type of Service:

3. Service & Support Administrator:

4. Date of Review:

Comments:

ISP Compliance for ALL Individuals 5123:2-1-11 (J)

ISP Meeting Participants

1. Individual participated.

Choose One: Yes - Y, No - N

Comments:

2. Person(s) selected by the individual participated.

Choose One: Yes - Y, No - N

Comments:

3. Provider participated at the request of person.

Choose One: Yes - Y, No - N

Comments:

ISP Addresses/Includes the following

4. Individual's strengths, interests and talents

Choose One: Yes - Y, No - N

Comments:

5. Integrates all sources of supports, including alternative services, available to meet the needs and desired outcomes of the individual

Choose One: Yes - Y, No - N

Comments:

6. Engages the individual in meaningful, productive activities

Choose One: Yes - Y, No - N

Comments:

7. Develops community connections

Choose One: Yes - Y, No - N

Comments:

8. Based on Choice/Preference

Choose One: Yes - Y, No - N

Comments:

9. Funding source for all services

Choose One: Yes - Y, No - N

Comments:

10. Results of QA review and monitoring addressed

Choose One: Yes - Y, No - N

Comments:

11. Seven (7) Quality Indicators

Choose One: Yes - Y, No - N

Comments:

12. All providers

Choose One: Yes - Y, No - N

Comments:

13. Frequency and Duration of services

Choose One: Yes - Y, No - N

Comments:

14. Identify Provider type

Choose One: Yes - Y, No - N

Comments:

15. The Completion date

Choose One: Yes - Y, No - N

Comments:

16. Daily representative

Choose One: Yes - Y, No - N

Comments:

17. Payee

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

18. Correct SSA

Choose One: Yes - Y, No - N

Comments:

19. SSA Signature/Approval/Date

Choose One: Yes - Y, No - N

Comments:

20. Required Signatures

Choose One: Yes - Y, No - N

Comments:

21. Guardian

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

22. Guardian Consented to Services

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

23. Does the ISP match the Assessment

Choose One: Yes - Y, No - N

Comments:

24. Was the ISP sent to Provider/Others seven (7) days prior to Effective Date

Choose One: Yes - Y, No - N

Comments:

ISP Compliance for WAIVER individuals 5123:2-1-11 (J)

ISP Addresses/Includes the following

1. Ensures the health, safety and welfare of the individual

Choose One: Yes - Y, No - N

Comments:

2. Accurate reflection of the individual's needs

Choose One: Yes - Y, No - N

Comments:

3. Maximizes natural supports and generic services

Choose One: Yes - Y, No - N

Comments:

4. Includes at least one skill development

Choose One: Yes - Y, No - N

Comments:

5. Patient Liability identified and being paid

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

6. Correct Span Dates

Choose One: Yes - Y, No - N

Comments:

7. Individual Name & Medicaid Number

Choose One: Yes - Y, No - N

Comments:

ISP Meeting

8. Convene an ISP meeting within ten working days of a request from an individual for a review of the ISP.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

BSP Compliance for all Per the Behavior Support Rule 5123:2-1-02 (J) (2) (a-q)

(2) In the individual's behavior support plan is there evidence of the following:

1. (a) Medical factors were considered in the development of the plan

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

2. (b) A behavior assessment was completed prior to implementation of plan and that the plan followed the findings.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

3. (c) Behavior support methods were designed to help the individual learn new positive behaviors while reducing undesirable ones.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

4. (d) Time-out and restraint were used only when all other conditions were met.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

5. (e) Policies and procedures were available to staff, the individual, parents/guardians.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

6. (f) Behavior supports were employed with sufficient safeguards and supports to ensure the safety of the individual.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

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7. (g) Aversive behavior was not used for retaliation, staff convenience or a substitute for active treatment.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

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8. (h) Positive and less aversive strategies were demonstrated to be ineffective prior to the use of more intrusive procedures.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

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9. (i) Standing or as needed programs were not used.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

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10. (j) Approval was obtained from the behavior support committee for plans that incorporate aversive methods and reviewed ongoing plans with aversive methods.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

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11. (k) Human rights committee reviewed and prior approved/rejected plans using aversive methods and those with potential risks to individual rights and protections.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

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Clearwater Council of Governments

12. (l) Documentation that the behavior support and/or human rights committees were formed by the county board, the provider or were joint.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

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13. (m) Behavior support included:

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14. A case history

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

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15. Behavior assessment, baseline data

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

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16. Behaviors to be increased or decreased

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

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17. Procedures used

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

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18. Persons responsible for implementation

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

19. Review guidelines

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

20. Signature/date blocks including space for dissenting opinions.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

21. (n) Persons who developed the plan were experienced and all persons who are responsible for implementing plans are specified and required training is documented.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

22. (o) Consent was obtained from the individual or guardian prior to implementation of plan, informed consent was updated annually and was obtained for revisions of the behavior plan.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

23. The plan was explained in a manner that was understood by the individual or guardian.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

24. (p) The behavior plan was regularly reviewed at least in conjunction with individual plan updates; review aversive plans at least every 30 days.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

25. (q) Behavior plan included: physical or sexual abuse;

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

26. Behavior plan included: Medically/psychologically contradicted procedures

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

27. Behavior plan included: Psychological/verbal abuse

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

28. Behavior plan included: Placement in a room with no light

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

29. Behavior plan included: Subjecting individual to painful sound/denial of food

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

30. Behavior plan included: Squirting the individual with a substance for a behavior

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

- 31. Behavior plan included: Time-out exceeding one hour for any incident and/or exceeding two hours in a twenty-four hour period.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

Empty text box for comments.

- 32. (q) (x)(xi) Systematic/planned intervention using manual, chemical, or mechanical restraints; or medication for behavioral control, unless prescribed by and under the supervision of licensed physician who is involved in the interdisciplinary process.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

Empty text box for comments.

(3) The use of any restraint listed above or time out were used.

- 33. (3) (f) If yes, was the Department notified by facsimile or other electronic means in a format prescribed by the Department (ODMR/DD Behavior Support Plan Using Restraint or Time-Out Notification Form)?

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

Empty text box for comments.

- 34. If yes, was it sent within 5 working days after local approval of plan?

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

Empty text box for comments.

Service Areas to Improve

For the Service and Support Administrator

- 1. Recommendations for quality improvements:

Empty text box for recommendations.

- 2. Quality Improvement Plan (QIP) Indicated for the SSA:

Choose One: Yes - Y, No - N

Comments:

3. Quality Improvement Plan due to Clearwater COG by:

Comments:

Signatures

1. Quality Assurance Report prepared by:

2. Date:

3. cc: