Assessments and Individual Service Plans for Residential Services

Rehabilitation for Wisconsin in Action and Residential Services Association Conference

May 3, 2017

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360° of Learning

Wisconsin Department of Health Services

Comprehensive Assessments for Residential Services

Agenda

Assessments

1. Introductions
2. Review DHS 83 and DHS 88 Regulations Related to Assessments and Evaluations
3. Types of Assessments and their Purpose
4. Sources of Assessment Information
5. Best Practices for Assessments
6. Review of Comprehensive Assessment Tool

Assessment

Review of DHS 83 (CBRF) and DHS 88 (AFH) Regulations Related to Assessments and Evaluations

(Handout)

Assessment

The Pre-Admission Assessment

- Ensure quality, continuity, and person-centered care for the individual
- Determine whether or not the provider can safely and effectively meet the individual's needs at the particular home
- Determine whether or not the individual is compatible with the other individuals in the home
- Provide detailed information and history to the caregivers who will be working directly with the individual
- Provide the foundation for a comprehensive ISP

Assessment

Change in Condition Assessment and ISP

- Identify and analyze changing needs and develop strategies to address them
- Ensure that treatment and placement is consistent with current needs
- Help a provider and the team determine whether or not they can continue to support the person in their current living situation or if a change in schedule, care level, or residence should be negotiated. Remember – the license type and program statement must be compatible with the person's needs!
- Provide documentation of changes in condition/needs and care provided

Who is responsible for identifying a change in condition?

- Everyone who supports the individual!

Assessment

Annual Assessment and ISP Review

- Ensure that assessment information and ISP are up-to-date
- Identify any subtle changes in condition
- Formally review and adjust goals and outcomes

Assessment

Sources of Assessment Information

- Client/family/guardian
- Care manager
- Day or work service provider (if applicable)
- Speech/OT/PT
- Current residential provider
- Caregivers
- Doctors/pharmacy
- Friends
- Previous documentation

Assessment

Methods of Gathering Assessment Information

Review of Records

- Current and previous assessments
- Current and previous residential service ISPs, Behavioral Support Plans, and Protocols
- Health records including current MAR
- Care-management and social service reports
- Hospital and nursing home reports and discharge summaries
- Therapy and vocational services reports
- Discharge summaries

Interviews and Face-to-Face Meetings

- Client/Family/Guardian interviews
- Interview of current caregiver or providers, especially direct care staff
- Meeting with MCO care manager and treatment team
- Observation

Assessment

Assessment Best Practices

- A face-to-face assessment is highly recommended.
- Prepare by reviewing documentation and filling in as much of the assessment as possible.
- Select a time and place most convenient and comfortable for the individuals in the meeting.
- Conversational (not rapid fire questions). Explain the reason for asking certain questions.
- Consider having two people from your agency in the meeting – one to ask questions and one to take notes.
- Read people's responses and body language – adjust approach accordingly.
- An assessment may not be completed in one meeting depending upon the complexity of a person's needs.
- "Nothing About Me, Without Me."

Assessment

Client Information

Funding and Insurance Information

COMPREHENSIVE ASSESSMENT FOR RESIDENTIAL SERVICES

CLIENT INFORMATION		
Name:	Date of Birth:	
Current Address:		
City:	State:	Zip:
Phone Number:	Residence Type:	
Contact Person and Relationship:		
Male/Female:	Marital Status:	SS#:
DIAGNOSIS: Axis I: Axis II: Axis III: Axis IV: Axis V: **ALLERGIES:** (List all food, drug, and other allergies and any known reactions)		

FUNDING AND INSURANCE INFORMATION		
Funding Source for Residential Care and Supervision: ☐ Family Care ☐ Waiver ☐ IRIS ☐ Insurance ☐ Private Pay ☐ Other, describe: Comments:		
Funding Source for Room and Board: ☐ Social Security ☐ Private Pay ☐ Other, describe:		
☐ Medical Assistance	ID #:	
☐ Medicare	ID #:	
☐ Part A ☐ Part B ☐ Part D	ID #:	
☐ Prescription Drug Insurance	ID #:	
☐ Private Insurance	Carrier:	Policy #:
Comments:		

Assessment

Contact Information

CONTACT INFORMATION

GUARDIAN		
Name:	Relationship:	
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Comments:		

POWER OF ATTORNEY □ HEALTHCARE □ FINANCES		
Name:	Relationship:	
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Comments:		

CARE MANAGER		
Name:	Agency:	
Address:		
City:	State:	Zip:
Phone:	Cell Phone:	
Comments:		

REPRESENTATIVE PAYEE		
Name:	Relationship:	
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Comments:		

FAMILY/FRIEND CONTACT		
Name:	Relationship:	
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Comments:		

Assessment

Assessment Interviews

ASSESSMENT INTERVIEWS		
Name	Title/Relationship to Individual	Date of Interview

Documents Reviewed

DOCUMENTS REVIEWED		
Type of Document	Source	Date Written

Placement History

PLACEMENT HISTORY		
Facility / Home	Dates	Reason for Discharge

Assessment

Healthcare Providers

HEALTHCARE PROVIDERS

(List all applicable providers such as Primary Care, Dentist, Ophthalmologist/Optometrist, Audiologist, Neurologist, Psychiatrist, Podiatrist, Dietician, Endocrinologist, Speech, OT, PT, DME, Pharmacy, etc.)

Specialty: Primary Care		
Name:	Clinic:	
Address:		
City:	State:	Zip:
Phone:	Last Appointment:	Next Appointment:
Comments:		

Specialty: Dentist		
Name:	Clinic:	
Address:		
City:	State:	Zip:
Phone:	Last Appointment:	Next Appointment:
Comments:		

Specialty: Ophthalmologist/Optometrist		
Name:	Clinic:	
Address:		
City:	State:	Zip:
Phone:	Last Appointment:	Next Appointment:
Comments:		

Specialty: Pharmacy		
Name:	Clinic:	
Address:		
City:	State:	Zip:
Phone:	Last Appointment:	Next Appointment:
Comments:		

Specialty:		
Name:		
Address:		
City:	State:	Zip:
Phone:		
Comments:		

Assessment

General Health Status

Chronic and Recurring Conditions

Short-term illnesses over the past 90 days

Other Medical Concerns or Conditions

HEALTH STATUS AND HISTORY

GENERAL HEALTH STATUS		
☐ Good (Stable)	☐ Fair	☐ Poor
Comments:		

CHRONIC OR RECURRING CONDITIONS
(E.g. diabetes, seizure disorder, arthritis, CPOD, congestive heart failure, etc.)

Condition	Status	Treatment	Supervising Physician	Date of last appointment
Comments:				

SHORT-TERM ILLNESSES OVER THE PAST 90 DAYS
(E.g. influenza, bronchitis, skin rash that resolved, pneumonia, UTI, etc.)

Condition	Status	Treatment	Supervising Physician	Date of last appointment
Comments:				

OTHER MEDICAL CONCERNS OR CONDITIONS
(e.g. Prone to UTIs, any symptoms that are currently unresolved, history of colon polyps, etc.)

Condition	Status	Treatment	Supervising Physician	Date of last appointment

Is the Individual cooperative with medical exams and treatments? ☐ Yes ☐ No
If no, what interventions are used?

Who is responsible for medical appointments and transportation? (E.g. family wants to attend psych appointments, Media-van provides transportation, individual is independent, provider transports and attends all, etc.)

Comments:

Assessment

Protocol Alert

PROTOCOL ALERT A protocol is a document that details the condition and provides step by step instructions for staff responsible for providing the care. The conditions below require a treatment protocol. If a protocol is currently in place, attempt to obtain a copy.		
□ Diabetes	□ Seizure Disorder	□ Bowel Program/Incontinence
□ Choking Risk/Feeding Assistance	□ Transfers	□ Repositioning
□ G-tube feedings	□ PRN medication for behaviors	□ Use of AFOs/Braces
□ Restrictive Measures	□ Nebulizer	□ Oxygen
□ Special Transportation Needs	□ Falls History/Risk	□ Autonomic-dysreflexia
□ Range of Motion Exercises	□ Approved Restraints	□ Pain
□ Pressure Sore	□ Hospice care	□ Other:
Comments:		

Assessment

Immune/Infectious Disease History

IMMUNE SYSTEM/INFECTIOUS DISEASE HISTORY			
□ Auto-Immune Disease	□ MRSA	□ HIV Positive	□ AIDS (diagnosed)
□ History of Cancer	□ Positive PPD	□ Shingles	□ Other, describe:
□ Hepatitis If so, type: □ Carrier □ Naturally immune □ Untested □ Tested-no immunity □ Has received vaccinations Dates of vaccinations:			
Comments:			

Skilled Nursing Needs

SKILLED NURSING NEEDS		
Is the individual in need of nursing care? □ Yes □ No If yes, continue below:		
Is the individual currently receiving or in need of hospice care? □ Yes □ No If yes, continue below:		
Reason for nursing care:		
Number of hours per week:	□ Short-term	□ Long-term
Agency/Provider responsible for nursing care:		
Comments:		

Assessment

Vision

VISION	
Current Status: (e.g. near-sighted, blindness, glaucoma, cataracts, etc.)	
Adaptive Equipment? □ Yes □ No	If yes, □ Glasses □ Contacts □ Other:
Level of Assistance/Supervision needed: (e.g. needs help cleaning glasses, frequently breaks or misplaces glasses, remind to wear, etc.)	
Comments:	

Hearing

HEARING
Current Status: (e.g. complete hearing loss, difficulty hearing certain tones, etc.)
Adaptive Equipment? □ Yes □ No If yes, describe:
Compensatory strategies: (e.g. hears best on certain side, speak slowly, make sure the person is looking directly at person speaking, etc.)
Level of Assistance/Supervision needed: (e.g. needs help changing hearing aid batteries, etc.)
Comments:

Pain

PAIN
How does the individual communicate pain? (e.g verbally, gets quiet, rubs head, etc.)
Is the individual currently experiencing pain? □ Yes □ No
If yes, where is the pain, what is the frequency and severity?
If yes, how is the pain being treated?
Is the pain considered chronic or temporary?
Comments:

Assessment

Medications

MEDICATIONS Note: A current copy of the Medication Administration Record (MAR) can be attached in lieu of listing medications					
Medication Name	Dosage	Times	Route	Purpose	Prescribing Physician

Medication Administration

MEDICATION ADMINISTRATION
☐ No routine medications ☐ Self-administered by individual and individual maintains control of medication ☐ Self-administered with supervision – does not control medication ☐ Medication administered by facility staff ☐ Medication administered by facility staff with instruction to promote future self-administration ☐ PRN psychotropic medication Name of medication: Reason: ☐ Special medication administration protocol
Does the individual have a history of refusing medication? ☐ Yes ☐ No If yes, describe behavior and interventions:
Method in which individual takes oral medications (e.g. with water, with pudding or applesauce, through g-tube, etc.):
Is there a protocol in place for use of PRN medications? ☐ Yes ☐ No (If yes, attempt to obtain copy) If yes, describe:
Comments:

Assessment

Dietary

DIETARY		
Current Dietary Status (e.g. Consistency, Calorie Restriction, Low sodium, Low cholesterol, All nutrition through g-tube, etc.):		
□ Diet recommended but not ordered Comments:	□ Diet ordered by Physician or Dietician	
Individual is compliant with diet: □ Yes □ No		
Does the individual have a history of choking? □ Yes □ No If yes, continue below: When and how often did the choking occur? Under what circumstances? Are there certain foods to avoid? Has there been a swallow study? □ Yes □ No If yes, Date of most recent swallow study:		
Level of assistance and/or supervision required at meal time:		
Adaptive Equipment: (e.g. lipped plate, weighted spoon, cup with lid and straw, etc.)		
Restrictive Measures: (e.g. locked food cabinets, refrigerator, etc.) □ Yes □ No If yes, describe:		
Food Allergies and Reactions:		
Food Likes and Dislikes:		
Current Weight:	Ideal Weight Range:	Height:
Are there concerns about weight? □ Yes □ No If yes, what is the concern?		
Is a dietician involved? □ Yes □ No If yes, who and how often?		
Is there a dietary/mealtime protocol in place? □ Yes □ No (If yes, attempt to obtain copy) If yes, describe:		
Comments:		

Assessment

Adaptive Equipment and Environmental Modifications

ADAPTIVE EQUIPMENT AND ENVIRONMENTAL MODIFICATIONS

This section identifies all needed equipment and modifications for the planning purposes of the provider.
Any needed equipment that will not be coming with the individual when they move will need to be obtained prior to admission.
(Check all that apply)

Needs	Owns	Item	Needs	Owns	Item
□	□	Cane	□	□	Walker Type:
□	□	Manual Wheelchair	□	□	Electric Wheelchair
□	□	Specialized Wheelchair Seating System	□	□	Pivot Disc
□	□	Manual Lift Sling Size: Sling Type:	□	□	Mechanical Lift Sling Size: Sling Type:
□	□	Sliding Board	□	□	Standing Table
□	□	Gait Belt	□	□	Floor-to-ceiling pole
□	□	Trapeze over bed	□	□	Shower chair
□	□	Shower Trolley	□	□	Raised Toilet Seat
□	□	Commode	□	□	□ Urinal and/or □ Bedpan
□	□	Hospital Bed	□	□	High-Low Bed
□	□	Special Mattress (e.g. concave, wound care, staph-check, etc.)	□	□	Mat on Floor by Bed
□	□	Bed Rails (AKA Bed Butler or Bed Valet) Type:	□	□	Helmet Type:
□	□	Lift chair	□	□	AFO
□	□	Arm/Hand Brace	□	□	Leg Brace
□	□	Utensils Describe:	□	□	Cup Describe:
□	□	Bowl/Plate Describe:	□	□	Accessible Home
□	N/A	Roll-in shower	□	N/A	Accessible Bathtub
□	N/A	Egress Doors	□	N/A	Wander Guard
□	N/A	□ Door and/or □ Window Alarms	□	N/A	Fenced Yard
□	N/A	Lexan Windows	□	□	Accessible Vehicle/Transportation
□	□	Other, describe:	□	□	Other, describe:
□	□	Other, describe:	□	□	Other, describe:
Comments:					

Assessment

Adaptive Equipment or Treatments with Restraint Alerts

ADAPTIVE EQUIPMENT OR TREATMENTS WITH RESTRAINT ALERTS If possible, obtain copies of any current doctor's orders, restraint waivers, supporting documentation, and POC/protocols. All restrictive measures must be approved by the Department of Health Services.					
Type of Device (Check all that apply)	**Positioning** (Check if device is used for positioning purposes)	**Safety** (Check if device is used for safety purposes)	**Doctor's Ordered** (Check if a Doctor's order is in place)	**Restraint Waiver** (Check if an approved restraint waiver is currently in place)	**Protocol** (Check if a current POC/protocol is in place)
□ ½ Bed Rail	□	□	□	□	□
□ ½ Padded Bed Rail	□	□	□	□	□
□ Full Bed Rail	□	□	□	□	□
□ Full Padded Bed Rail	□	□	□	□	□
□ Wheelchair Seatbelt (worn at all times)	□	□	□	□	□
□ Wheelchair Seatbelt (worn only for transport)	□	□	□	□	□
□ Chest Harness	□	□	□	□	□
□ Lap Tray	□	□	□	□	□
□ Pummels	□	□	□	□	□
□ Straps of any type (chest harness, foot straps, straps on utensils, positioning devices, shower chair, commode, etc.) Describe:	□	□	□	□	□
□ Helmet	□	□	□	□	□
□ PRN Psychotropic Medications for Behaviors	□	□	□	□	□
□ Special needs during health exams/procedures (e.g. sedation, restraint, medication, etc.)	□	□	□	□	□
Other, describe:	□	□	□	□	□
Comments:					

Assessment

Ambulation and Falls Risk

AMBULATION AND FALLS RISK
Describe the individual's ability to ambulate: (e.g. walks independently with good balance, shuffling gait, uses walker at all times, non-ambulatory, etc.)
List any adaptive equipment for ambulation: (e.g. walker, cane, gait belt, manual wheelchair for long distances, etc.)
Does the individual need assistance with transfers? □ Yes □ No If yes, describe: How many people are needed to complete safe transfer?
Is the individual able to bear weight? □ Yes □ No If yes, for how long:
List any adaptive equipment for transfers: (e.g. pivot disc, slider board, mechanical lift, slings, etc.)
Does the individual have a history of falls? □ Yes □ No If yes, continue below: Frequency of falls: Circumstances surrounding the falls: What is being done to prevent falls:
Is a falls prevention protocol in place? □ Yes □ No (If yes, attempt to obtain a copy) If yes, describe:
Comments:

Assessment

Bathing and Showering

Grooming

Dressing

Oral Care

PERSONAL CARE

BATHING/SHOWERING (washing thoroughly including hair, set-up, drying off, etc.)		
Preference	☐ Bath ☐ Shower ☐ Other, describe:	Frequency:
Current status/Level of assistance required:		
Is the individual able to safely regulate water temperatures?	☐ Yes ☐ No	
Adaptive Equipment: (e.g. shower chair, hand held sprayer, roll-in shower, etc.)		
Comments:		

GROOMING (hair styling, shaving, nail care, applying make-up, etc.)	
Current status/Level of assistance required:	
Comments:	

DRESSING (putting on and removing clothing, choosing appropriate garments, etc.)	
Current status/Level of assistance required:	
Does the individual choose clothing appropriate to the weather?	
Comments:	

ORAL CARE (brushing and flossing teeth, swabbing, dental exams/procedures, etc.)	
Current status/Level of assistance required for brushing/flossing:	
Level of cooperation with dental appointments:	
Frequency of dental exams:	
Any special needs during dental exams? (e.g. medication, general sedation, restraint, extra staff support, etc.)	
Comments:	

Assessment

Personal Hygiene

PERSONAL HYGIENE (washing hands, wearing clean clothing, menstrual care, etc.)	
Current status/Level of assistance required:	
Level of cooperation with hygiene tasks:	
Comments:	

Toileting

TOILETING (bowel and bladder control, ability to complete hygiene tasks, products used, etc.)		
Current status/Level of assistance required:		
Adaptive equipment: (e.g. commode, urinal, catheter, etc.)		
Incontinence:	Bladder: □ Yes □No Frequency:	Bowel: □ Yes □ No Frequency:
Is there a toileting/changing schedule in place?	□ Yes □ No Describe:	
Incontinence supplies: (e.g. depends, chux, wipes, catheter, urinal) List sizes, brands, and vendor if known.		
History of constipation:	□ Yes □ No If yes, describe frequency and severity: If yes, how is it treated? (e.g. stool softener, monitoring, protocol, etc.)	
Is there a bowel program/protocol in place?	□ Yes □ No (If yes, attempt to obtain a copy) If yes, describe:	
Comments:		

Skin Care

SKIN CARE (condition, integrity, rashes, pressure ulcers, etc.)	
Does the individual have any skin issues?	□ Yes □ No If yes, describe including frequency and severity:
Describe any prevention methods and treatment:	
Level of assistance required:	
Adaptive equipment and supplies:	
Comments:	

Assessment

Independent Living Skills

INDEPENDENT LIVING SKILLS		
	Current Status/Ability	Describe Assistance Required
Bed Making		
Meal Planning		
Grocery Shopping		
Food Preparation		
Cleaning		
Use of Cleaning Supplies		
Laundry		
Telephone Usage		
Money Management		
Banking		
General Shopping		
Community Independence		
Street Safety		
Stranger Awareness		
Use of Household Equipment		
Transportation		
Are there any special considerations for transporting? (e.g. seat placement in vehicle, removes seatbelt while vehicle is moving, aggression)	☐ Yes ☐ No If yes, describe:	
Other, describe:		
How does the individual best learn new tasks and skills: (e.g. verbal direction, modeling, repetition, pictures, etc.)		
Comments:		

Assessment

Communication Skills

COMMUNICATION SKILLS
Language:
How does the individual communicate? □ Verbally □ Signs/Gestures □ Writing □ Other, describe:
Is there a need for the services of an interpreter? □ Yes □ No If yes, describe:
What is the individual's level of verbal comprehension?
Is the individual able to read and/or write?
What is the individual's level of comprehension of writing?
Does the individual use any adaptive communication devices? (e.g. communication book, mim-speak, iPad, pictures, story board) □ Yes □ No If yes, describe: Does the individual own the device? □ Yes □ No
Does the individual receive Speech Therapy? □ Yes □ No If yes, list provider and frequency of visits:
Does the individual have any memory impairment? □ Yes □ No If yes, describe:
Describe interventions to assist with memory:
Comments:

Assessment

Academic and Vocational

ACADEMIC AND VOCATIONAL			
	History	Current Status	Provider
Education			
Vocational Program			
Day Services			
Community Employment			
Volunteer Work			
Other:			
What are the plans for services when the individual moves? (days of week, hours, provider, location)			
How will the individual get there? (e.g. residential provider, public transportation, day service provider, etc.)			
Comments:			

Emergency and Fire Evacuation Skills

EMERGENCY AND FIRE EVACUATION SKILLS	
	Comments
Does the individual initiate evacuation?	
Does the individual resist evacuation?	
Does the individual respond to verbal directions/prompts during emergencies or evacuations?	
Does the individual awaken when the fire alarm sounds?	
Does the individual stay in the designated safe area?	
Can the individual locate help during an emergency?	
Type of assistance required during an emergency/evacuation:	
List any adaptive equipment required (e.g. bed shaker, flashing lights, etc.)	
Comments:	

Assessment

Psychological/Behavioral Functioning

PSYCHOLOGICAL/BEHAVIORAL FUNCTIONING					
	Exhibits Behavior (Yes or No)	If yes, Frequency (Hourly, Daily, Weekly, Monthly, Rarely, History of)	Severity (Low, Moderate, Severe, Unknown)	Description of Behavior and Intervention Strategies	Behavioral Support Plan (BSP) Indicated (Yes or No)
Verbal Aggression					
Physical Aggression					
Property Destruction					
Wandering					
Elopement					
Fire Setting					
Taking property of others					
Self-injurious Behavior (SIB)					
Suicidal Tendencies/Attempts					
Depression/Isolation					
Anxiety					
Delusional thinking					
Paranoia					
Ritualistic Behavior					
Dementia					
Memory Impairment					
Inappropriate sexual behavior					
Inappropriate behavior in community					
At risk of victimization					
Criminal Behavior					
Intrusive Behavior					
PICA (ingesting inedible objects)					
Irregular sleep patterns					
Other:					
Comments:					

Assessment

Mental and Emotional Health

MENTAL AND EMOTIONAL HEALTH	
What appears to be the individual's self-concept?	
How would the individual's typical mood be described?	
Does the person have a concern and understanding for others?	
Describe the individual's level of maturity:	
Does the individual actively participate in treatment and activities?	
Describe the individual's ability to cope with strong emotions:	
Does the individual have any symptoms of mental illness that have not been formally diagnosed?	
Comments:	

Assessment

Spirituality and Cultural Background

SPIRITUALITY AND CULTURAL BACKGROUND	
Religious Preference:	
How does the individual practice their religion? (e.g. mass daily, no meat on Friday, Kosher diet, etc.)	
Does the individual practice any cultural customs? (e.g. dietary, ceremonial, avoids certain activities, clothing, etc.)	□ Yes □ No If yes, describe:
Level of assistance required for religious/cultural activities: (e.g. requires transportation to services, supervision at activities, friends/family involved, etc.)	
Comments:	

Leisure Skills and Activities

LEISURE SKILLS AND ACTIVITIES	
What leisure activities does the individual enjoy at home? (e.g. music, TV, knitting, baking, cards, exercise, etc.)	
What leisure activities does the individual enjoy in the community? (e.g. sporting events, concerts, YMCA, art class, etc.)	
Level of assistance required to participate: (e.g. planning, initiating, transportation, support, etc.)	
Does the individual participate in any social groups or clubs? (e.g. Bible study, card club, Special Olympics, etc.)	□ Yes □ No If yes, list including frequency and location:
Does the individual prefer individual, small group, or large group activities?	
Comments:	

Assessment

Social Skills

SOCIAL SKILLS	
With whom are the individual's closest relationships?	
Describe any family supports the individual has and how they interact: (e.g. phone, mail, visits, family parties, etc.)	
Describe the individual's ability to engage in appropriate social interactions:	
Describe the individual's ability to make friends and maintain friendships:	
Comments:	

Self - Direction

SELF-DIRECTION	
Describe the individual's ability to communicate their needs and wants:	
Describe the individual's decision making skills and abilities:	
List some examples of decisions the individual has made:	
Describe the individual's level of self-direction and independence:	
With whom, if anyone, does the individual consult with when making big decisions?	
Comments:	

Assessment

Client, Family, and Guardian Interviews

CLIENT, FAMILY, AND GUARDIAN INTERVIEW	
How do you feel about moving to a new home?	
What are you most looking forward to when you move?	
What concerns, if any, do you have?	
What is most important to you?	
What goals and ambitions do you have?	
Is there anything that you would like us to know that would be helpful in providing successful support?	
Comments:	

For Provider:	
Was interview conducted in-person, over the phone, or other?	
If interview did not occur, explain why:	
Comments:	
Assessment Completed by:	
In-person Assessment Date/s:	Tour/Visit Date:
Transition Plan:	

Signatures

SIGNATURES	
Client: (if able to sign)	Date:
Name: Relationship to Client:	Date:
Name: Relationship to Client:	Date:
Name: Relationship to Client:	Date:

Assessment Updates

All updates to the assessment status will be reflected in the Individual Service Plan (ISP)

Individual Service Plans (ISP) for Residential Services

Agenda

Individual Service Plans (ISP)

1. Review of DHS 83 and 88 Regulations
2. What makes a good ISP?
3. ISP Best Practices
4. Operationalizing the ISP
    - Goal Setting
    - The use of Protocols
    - ISP and Goal Writing Activity
    - Documenting Updates and Reviews
5. Key Points to Remember and Wrap-up

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Individual Service Plan

Review of DHS 83 (CBRF) and DHS 88 (AFH) Regulations Related to Individual Service Plans

(Handout)

Individual Service Plan

A good ISP is…

- Person-centered
- Reflective of the Assessment
- Focused on the individual's needs and personal goals
- Involves the input of the care team and individuals of the resident's choosing
- Current and up-to-date at all times
- A dynamic document
- Accessible to all caregivers, at all times
- Specific and thorough
- Updated as required by regulation and anytime the resident experiences a significant change in condition
- Positive and outcome oriented

Individual Service Plan

Individual Service Plan Best Practices

- The ISP should be developed in a person-centered manner with the individual at the center of all discussions. Remember – "Nothing About Me, Without Me"
- Participants should be given as much notice as possible for routine ISP reviews and meetings. Consider planning ISP reviews at the start of each year.
- Meetings should be held at a time and place that is most comfortable for the resident and they should be given ample time to express their needs and goals.
- Many individuals have preferred caregiver/s that they just seem to click with. Whenever possible, involve them in the meetings. They will often know the resident the best and will make the process more comfortable.
- Empower direct support professionals to be a part of the ISP process.

Individual Service Plan

Identifying Formal Goals within an ISP

When developing formal goals…

- Work with the individual to choose a few formal goals.
- Goals should be something the individual is interested in accomplishing.
- Document and measure progress towards goals in daily logs.
- Adjust goals as needed or when they are accomplished.

Individual Service Plan

Goals

Specific – Identifies specifically what the person wants to accomplish

Measurable – Identifies how the results be quantified and measured

Actionable – Identifies the steps necessary to accomplish the goal (Objectives)

Realistic – Reasonable chance of accomplishing

Time-bound – Identifies the time period in which to accomplish the goal

Objectives

Objectives are the steps that will be taken in an effort to meet the goal

Individual Service Plan

A Protocol…

- Is used for complex conditions that require detailed care instructions.
- Describes a condition or treatment need in detail.
- Lists step-by-step instructions for the caregiver and is an especially valuable reference for new caregivers.
- Needs to be readily accessible to caregivers.
- Describes signs or symptoms that require emergency care and outlines that procedure.
- Identifies the documentation process.
- Is developed in consultation with the appropriate professionals such as physician, nurse, dietician, PT, OT, etc.
- Is signed by the individual, legal representative, and consulting professional**.**

Individual Service Plan

ISP and Formal Goal Writing Activity

Individual Service Plan

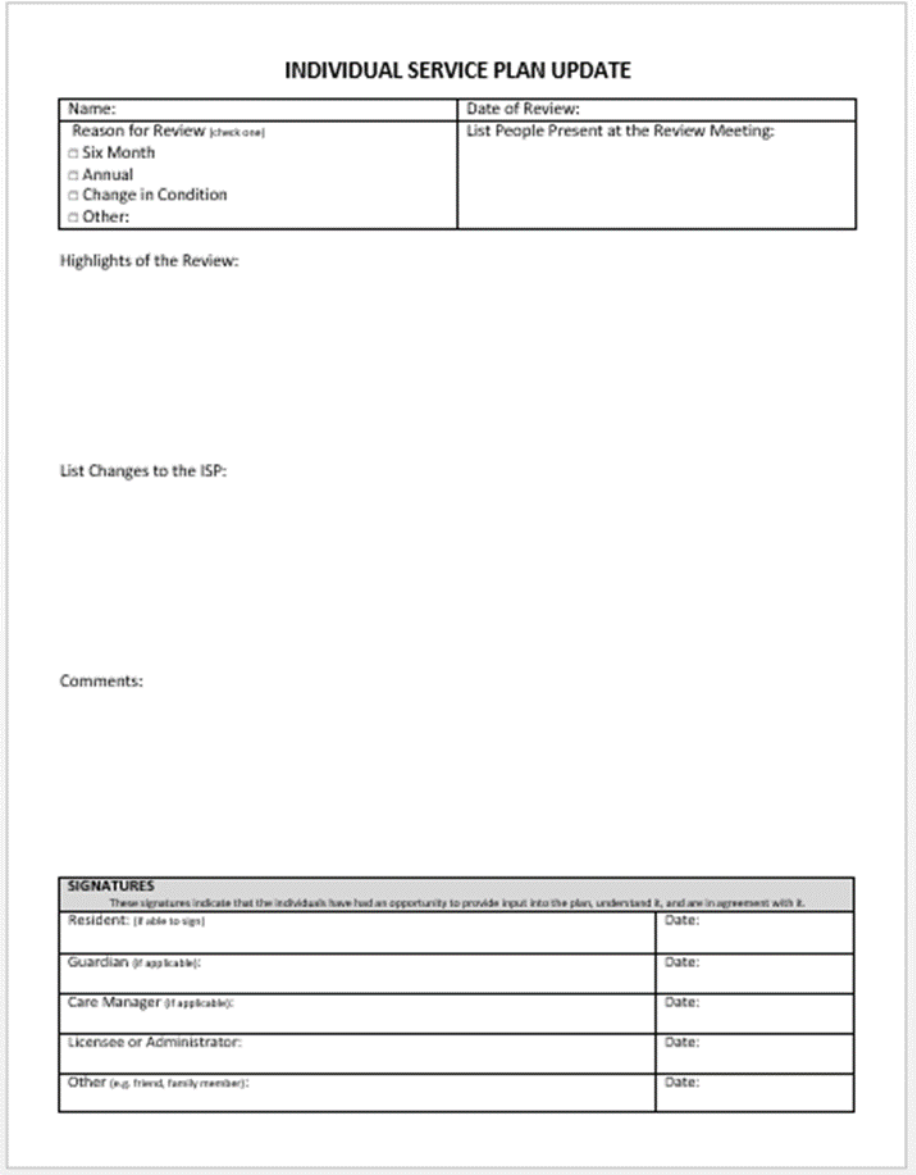
ISP Update Documentation
Sample Form

Utilized to:

- Document ISP Meetings
- Collect Signatures

For individuals not present:

- Call and inform of meeting outcome
- Send completed update form and request signature
- Document calls and mailings



INDIVIDUAL SERVICE PLAN UPDATE

Name:	Date of Review:
Reason for Review (check one) ☐ Six Month ☐ Annual ☐ Change in Condition ☐ Other:	List People Present at the Review Meeting:

Highlights of the Review:

List Changes to the ISP:

Comments:

SIGNATURES These signatures indicate that the individuals have had an opportunity to provide input into the plan, understand it, and are in agreement with it.	
Resident: (if able to sign)	Date:
Guardian (if applicable):	Date:
Care Manager (if applicable):	Date:
Licensee or Administrator:	Date:
Other (e.g. friend, family member):	Date:

Individual Service Plan

Key Points to Remember

- Assessments and ISPs must be Person-Centered.
- Individuals have the right to be involved in the assessment and planning process regardless of their disability or cognitive functioning.
- “Nothing About Me, Without Me.”
- Make the process as convenient and comfortable as possible for all participants.
- Know the regulations for you licensing type!
- Don’t be afraid to say “no” if you are not confident that you have the skills, experience, and caregivers to safely and effectively meet the individuals needs. Resident needs and abilities must be consistent with the licensing type and program statement.
- Clear and thorough documentation is essential.
- A comprehensive assessment and ISP are the foundation for quality care.

Individual Service Plan

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