Individual Quality Review

Section 2. Nurse and Therapist Interviews

Class Member	On-Site Date	Region	Reviewer	Case Judge

1. Nursing Interview
2. Physical Therapy Interview
3. Occupational Therapy Interview
4. Speech Language Pathologist Interview
5. Behavior Support Consultant Interview

1. NURSING INTERVIEW	
Guidance: *Read the file thoroughly including each nursing note/quarterly to ensure that you know what evidence exists with respect to nursing oversight. That includes an understanding of whether the nurse is conducting visits as required (e.g., based on ER Visits, Hospitalizations, changes in personal circumstances, incident reports…). If you have questions, add those to the list below so you do not have to go back and get the information later. You won't have time!*	
Nurse's Name:	
Agency:	
Phone Number:	
Email address:	
Interview Date & Time:	
Interview Method:	
1.	How long have you been (Name's) Nurse?
1A.	
2.	How often do you see (Name) face-to-face?
2A.	
3.	Where do those visits usually take place?
3A.	
4.	What do you typically do during those visits?
4A.	
5.	Please describe any health-related needs (Name) may have. Please include current medical diagnoses. *Note: The information you receive here should be verified by the record, ask the case manager about any discrepancies.*
5A.	
6.	Are there any concerns regarding the individual's health? Is he/she having issues with incontinence, falls, constipation, aspiration, weight issues, etc.? Please explain
6A.	
7.	What specialists does the individual see? How often does he/she see the specialists? Are there any issues? What does he/she see the specialists for? *Note: not every chronic condition needs a specialist, as long as the condition is being addressed and monitored regularly by the PCP.*

1. NURSING INTERVIEW	
7A.	
8.	Are there assessments that have not been completed this year? If yes, which ones? *(Note: if the recommended assessment is late, ask why.)*
8A.	
9.	Does (name) have a CARMP, Health Care Plan(s) or Medical Emergency Response Plans? If so, what are they? What are staff to do? How often do you review the plans? *Note: If you have specific questions regarding a specific plan(s), be sure to add your questions below… you can ask them now or later, just be sure to record the answers with the question(s) you ask.*
9A.	
10.	How often are health indicators (such as seizure tracking records, weight records, bowel movements, labs, PRN medication use, etc.) monitored?
10A.	
11.	How often is medication assessed for effectiveness and to monitor for side effects? How do you make those determinations? (side effects and effectiveness?) What side effects are staff expected to monitor and/or report?
11A.	
12.	If (name) experiences pain, how does he/she communicate that? What is done? Is the management of pain shared with treating health care professionals?
12A.	
13.	Has (name) received all age and gender appropriate health screenings and immunizations? If not, please explain why.
13A.	
14.	What do you do to ensure nursing oversight? How do you provide oversight to ensure medical appointments are made/attended and medications changes occur timely?
14A.	
15.	Overall, has (name) experienced improved health, stable health or regressing health over the past year? Please provide examples or explanation for answer.
15A.	
16.	Does (Name) have any advanced medical directives, or any end-of-life directions? If so, what are the instructions? Do you know how these were chosen? **If not**, do you know why none have been prepared?
16A.	
17.	If you were to suspect abuse, neglect or exploitation, or note a suspicious injury, how and to what agency would you report it?
17A.	
	Add your additional questions here… add as many questions/rows as are needed.
	Add your additional questions here… add as many questions/rows as are needed.

2. PHYSICAL THERAPY INTERVIEW	
☐	**N/A – This individual does not have this service.**
Therapist Name:	
Agency:	
Phone Number:	
Email address:	

2. PHYSICAL THERAPY INTERVIEW	
Interview Date & Time:	
Interview Method:	
1.	How long have you worked with (Name)?
1A.	
2.	How often do you see (Name) face-to-face?
2A.	
3.	Where do those visits usually take place?
3A.	
4.	What are you working on with (Name)?
4A.	
5.	What is (Name's) level of risk for aspiration?
5A.	
6.	Does (Name) have a CARMP? Are there issues that require PT participation on the CARMP? If yes, are staff in both day and residential trained on the current CARMP?
6A.	
7.	Are staff implementing the CARMP consistently across all environments? If no, please explain.
7A.	
8.	What physical therapy related plans/activities are direct support staff to be implementing? How often? *(Note: this is asking what is expected.)*
8A.	
9.	Are WDSI's written for these plans/activities? If yes, please describe.
9A.	
10.	Are staff implementing therapy plans consistently and as trained? *(Note: This is asking what is actually happening.)*
10A.	
11.	What progress has (name) made on therapy goals/objectives in the past year?
11A.	
12.	How is this progress measured/documented?
12A.	
13.	If there has been a lack of progress or regression, what has been done to address this issue?
13A.	
14.	What challenges to his/her achievement are identified and how are those being addressed?
14A.	
15.	Has (Name) made progress in other areas of his/her life in the past year?
15A.	
16.	What devices or equipment is (name) supposed to be using?
16A.	
17.	Are the devices or equipment in working order and used across all environments? If not, why not?
17A.	
18.	Does (Name) need additional devices or equipment? If yes, what is needed and when was that identified as a need? What is being done to obtain it?

2. PHYSICAL THERAPY INTERVIEW	
18A.	
19.	What do you see (Name) accomplishing in the next few years with respect to the therapy you provide?
19A.	
20.	If you were to suspect abuse, neglect or exploitation, or note a suspicious injury, how and to what agency would you report it?
20A.	
	Add your additional questions here… add as many questions/rows as are needed.
	Add your additional questions here… add as many questions/rows as are needed.

3. OCCUPATIONAL THERAPY INTERVIEW	
☐	**N/A – This individual does not have this service.**
Therapist Name:	
Agency:	
Phone Number:	
Email address:	
Interview Date & Time:	
Interview Method:	
1.	How long have you worked with (Name)?
1A.	
2.	How often do you see (Name) face-to-face?
2A.	
3.	Where do those visits usually take place?
3A.	
4.	What are you working on with (Name)?
4A.	
5.	What is (Name's) level of risk for aspiration?
5A.	
6.	Does (Name) have a CARMP? Are there issues that require OT participation on the CARMP? If yes, are staff in both day and residential trained on the current CARMP?
6A.	
7.	Are staff implementing the CARMP consistently across all environments? If no, please explain.
7A.	
8.	What occupational therapy related plans/activities are direct support staff to be implementing? How often? *(Note: this is asking what is expected.)*
8A.	
9.	Are WDSI's written for these plans/activities? If yes, please describe.
9A.	
10.	Are staff implementing therapy plans consistently and as trained? *(Note: This is asking what is actually happening.)*

3. OCCUPATIONAL THERAPY INTERVIEW	
10A.	
11.	What progress has (name) made on therapy goals/objectives in the past year?
11A.	
12.	How is this progress measured/documented?
12A.	
13.	If there has been a lack of progress or regression, what has been done to address this issue?
13A.	
14.	What challenges to his/her achievement are identified and how are those being addressed?
14A.	
15.	Has (Name) made progress in other areas of his/her life in the past year?
15A.	
16.	What devices or equipment is (name) supposed to be using?
16A.	
17.	Are the devices or equipment in working order and used across all environments? If not, why not?
17A.	
18.	Does (Name) need additional devices or equipment? If yes, what is needed and when was that identified as a need? What is being done to obtain it?
18A.	
19.	What do you see (Name) accomplishing in the next few years with respect to the therapy you provide?
19A.	
20.	If you were to suspect abuse, neglect or exploitation, or note a suspicious injury, how and to what agency would you report it?
20A.	
	Add your additional questions here… add as many questions/rows as are needed.
	Add your additional questions here… add as many questions/rows as are needed.
	Add your additional questions here… add as many questions/rows as are needed.

4. SPEECH LANGUAGE PATHOLOGY INTERVIEW	
☐	**N/A – This individual does not have this service.**
Therapist Name:	
Agency:	
Phone Number:	
Email address:	
Interview Date & Time:	
Interview Method:	
1.	How long have you worked with (Name)?
1A.	

4. SPEECH LANGUAGE PATHOLOGY INTERVIEW	
2.	How often do you see (Name) face-to-face?
2A.	
3.	Where do those visits usually take place?
3A.	
4.	What are you working on with (Name)?
4A.	
5.	What is (Name's) level of risk for aspiration?
5A.	
6.	Does (Name) have a CARMP? Are there issues that require SLP participation on the CARMP? If yes, are staff in both day and residential trained on the current CARMP?
6A.	
7.	***If the person has a CARMP and a Nutritionist,*** Does the CARMP include recommendations made by the Nutritionist?
7A.	
8.	Are staff implementing the CARMP consistently across all environments? If no, please explain.
8A.	
9.	What speech-language therapy related plans/activities are direct support staff to be implementing? How often? *(Note: this is asking what is expected.)*
9A.	
10.	Are WDSI's written for these plans/activities? If yes, please describe.
10A.	
11.	Are staff implementing therapy plans consistently and as trained? *(Note: This is asking what is actually happening.)*
11A.	
12.	What progress has (name) made on therapy goals/objectives in the past year?
12A.	
13.	How is this progress measured/documented?
13A.	
14.	If there has been a lack of progress or regression, what has been done to address this issue?
14A.	
15.	What challenges to his/her achievement are identified and how are those being addressed?
15A.	
16.	Has (Name) made progress in other areas of his/her life in the past year?
16A.	
17.	What devices or equipment is (name) supposed to be using?
17A.	
18.	Are the devices or equipment in working order and used across all environments? If not, why not?
18A.	
19.	Does (Name) need additional devices or equipment? If yes, what is needed and when was that identified as a need? What is being done to obtain it?
19A.	
20.	What do you see (Name) accomplishing in the next few years with respect to the therapy you provide?

4. SPEECH LANGUAGE PATHOLOGY INTERVIEW	
20A.	
21.	If you were to suspect abuse, neglect or exploitation, or note a suspicious injury, how and to what agency would you report it?
21A.	
	Add your additional questions here… add as many questions/rows as are needed.
	Add your additional questions here… add as many questions/rows as are needed.

5. BEHAVIOR SUPPORT CONSULTANT INTERVIEW	
☐	**N/A – This individual does not have this service.**
BSC's Name:	
Agency:	
Phone Number:	
Email address:	
Interview Date & Time:	
Interview Method:	
1.	How long have you worked with (Name)?
1A.	
2.	How often do you see (Name) face-to-face?
2A.	
3.	Where do those visits usually take place?
3A.	
4.	What is (Name's) level of risk for aspiration?
4A.	
5.	Does (Name) have a CARMP? Are there risky eating behaviors or other issues that require BSC participation on the CARMP? If yes, are staff in both day and residential trained on the current CARMP?
5A.	
6.	Are staff implementing the CARMP consistently across all environments? If no, please explain.
6A.	
7.	What behaviors does (Name) have that may prevent him/her from being integrated into the community, doing things, gaining employment or having relationships?
7A.	
8.	What are you working on with (Name)?
8A.	
9.	What do you collect data on? How do you use that data?
9A.	
10.	How does staff relay behavioral information to you? Are they consistent in providing this information?
10A.	
11.	Do you feel that you receive accurate information?

5. BEHAVIOR SUPPORT CONSULTANT INTERVIEW	
11A.	
12.	Does (Name) have a Behavior Crisis Intervention Plan (BCIP)?
12A.	
13.	Is the Positive Behavior Support Plan (PBSP) for (Name) being consistently implemented as trained?
13A.	
14.	What progress has (name) made on behavioral goals/objectives in the past year?
14A.	
15.	If there has been a lack of progress, or regression, what has been done to address this issue?
15A.	
16.	How is this progress measured/documented?
16A.	
17.	If (Name) takes psychotropic medication regularly or as a PRN, how is behavioral information related to the prescribing physician?
17A.	
18.	Is (Name) restricted in any way? If so, why were those restrictions put in place, for how long and how are they monitored?
18A.	
19.	Is there a plan to support (Name) to regain his/her rights?
19A.	
20.	Is (Name) free from restrictions which are applied to another person living in the home (or served by the agency)?
20A.	
21.	Has (Name) made progress in other areas of his/her life in the past year?
21A.	
22.	What do you see (Name) accomplishing in the next few years with respect to the behavioral support you provide?
22A.	
23.	If you were to suspect abuse, neglect or exploitation, or note a suspicious injury, how and to what agency would you report it?
23A.	
	Add your additional questions here… add as many questions/rows as are needed.
	Add your additional questions here… add as many questions/rows as are needed.