HIGHLIGHT AND PLACE NAME HERE

Date of PSP: ______________________________

Date of Dissemination: ____________________

Instructions for the Health Care Checklist and Risk Worksheet

This Health Care Checklist and Risk Worksheet has been developed in collaboration with Dr. Jean Justad, DDP Medical Director.

- ✓ This form is completed as part of the information gathering process prior to the annual planning meeting.
- ✓ The residential provider is responsible for gathering as much information as possible.
- ✓ This form is then completed collaboratively by the team with case manager facilitation.
- ✓ If there is no residential provider, the case manager is responsible for completing the form.
- ✓ Any health or safety issues identified in this form must be addressed in the PSP.

Use the follow-up sections from identified/documented issues to guide the team as it moves forward in meeting the needs of the person being supported.

- ✓ Appropriate medical evaluation has occurred addressing these concerns? If it has, great. If it hasn't then the team should be prompted to follow-up.
- ✓ Protocol has been developed? If it has, great. If it hasn't then the team should be prompted to follow-up.
- ✓ If yes, at the time of the meeting, staff have been trained in protocol? If the protocol has already been developed this questions confirms that staff have been trained to properly implement the protocol.
- ✓ Support needs have been identified? Does the person, or do the staff need any additional supports to address the identified need such as additional training?
- ✓ Notes related to: include any additional information that should not be lost and has not yet been covered within the section.

Montana Department of Public Health & Human Services Developmental Disabilities Program
111 North Sanders
Helena, MT 59604-4210
Phone: 406.444.2995 • Fax: 406 444 0230

Personal Support Plan

Name:	Effective Date of Plan:

Health Care Checklist and Risk Worksheet

The purpose of this worksheet is to assess health and safety risks. This worksheet must be completed at entrance into Services and annually thereafter as part of the PSP planning process.

Team members contributing: ______________________________

Health Care Provider: ______________________________

1. Seizures/ Epilepsy	Y	N	N/A	Change
a. Does this person have a diagnosis of seizures or epilepsy?				
b. Have seizure medications and/or dosages been changed in the past six months?				
c. Has a seizure occurred or the average number of seizures per month increased in the last year?				
d. Has this person been hospitalized because of seizures within the past year?				

FOLLOW-UP:

Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				
Notes related to seizures:				

2. Neurological/Musculoskeletal	Y	N	N/A	Change
a. Does this person have a diagnosis of osteoporosis?				
b. Does this person report headaches or indicate through behavior that he/she is having pain located in the head more than one time per week?				
c. Does this person show signs of dizziness such as an unsteady gait or report that the room is spinning more than two times a month?				
d. Does this person have a tremor?				
e. Has this person lost consciousness at any time during this past year?				
f. Does this person have joint or muscle pain, swelling or stiffness?				

FOLLOW-UP:

Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				
Notes related to neurological/musculoskeletal:				

3.	Diabetes	Y	N	N/A	Change
a.	Does this person have a diagnosis of diabetes? http://www.dphhs.mt.gov/dsd/ddp/documents/Type2Diabetes.pdf				
	(a-i) Was a diagnosis of diabetes made within the past year?				
b.	Does this person have routine blood sugar testing in his/her home?				
c.	Has this person been hospitalized for diabetes or a related condition within the past year?				

FOLLOW-UP:

	Y	N	N/A	Change
Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				
Notes related to diabetes:				

4.	Nourishment	Y	N	N/A	Change
a.	Does this person have a feeding tube i.e., PEG (gastric tube) or J-tube?				
b.	Does this person require assistance in order to eat or drink fluids?				
c.	Does this person refuse food or fluids more than one time per week? (indicate”no” if refusal is due to dislike of a particular food or drink.)				
d.	Does this person have a special diet?				
e.	Has this person required IV fluids due to dehydration in the past year?				
f.	Has this person gained or lost more than ten pounds in the past year?				
g.	Does this person require an altered consistency of food?				

FOLLOW-UP:

	Y	N	N/A	Change
Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				
Notes related to nourishment:				

Personal Support Plan

Name:	Effective Date of Plan:

5. Aspiration

		Y	N	N/A	Change
a.	Does this person have a diagnosis of dysphagia?				
b.	Does this person have a diagnosis of Gastroesophageal Reflux Disorder (GERD)?				
c.	Has this person been identified to be at risk for aspiration by a medical professional?				
d.	Does this person have a feeding tube?				
e.	Does someone else put food or fluids into this person's mouth?				
f.	Does this person eat or drink without chewing, without swallowing between bites, etc.?				
g.	Does this person have pneumonia that occurs more than one time per year?				
h.	Does this person cough or choke while or after eating or drinking?				
i.	Does this person report pain in the upper stomach or chest, especially after meals, or show signs of heartburn such as rubbing the chest, burping, or try to vomit more than one time per week?				
j.	Does this person vomit, especially after meals?				
k.	Does this person have a cough that is present daily?				
l.	Does this person have chest congestion that is present at least one time per week?				

FOLLOW-UP:

Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				

Notes related to aspiration:

6. Cardiac/Respiratory

		Y	N	N/A	Change
a.	Does this person have a diagnosis of a cardiac condition? http://www.dphhs.mt.gov/dsd/ddp/documents/Warfarin.pdf				
b.	Does this person have a diagnosis of a respiratory condition? http://www.dphhs.mt.gov/dsd/ddp/documents/AsthmaTriggers.pdf				
c.	Does this person cough or wheeze five or more days per week?				

		Y	N	N/A	Change
d.	Does this person have respiratory infections that occur more than three times per year?				
e.	Does this person have shortness of breath while at rest?				
f.	Does this person have shortness of breath during exertion?				
g.	Does this person report pain in the chest area or indicate discomfort in the chest area during exertion?				
h.	Does this person get blue discoloration of lips or fingertips/nails?				
i.	Does this person have daily swelling of the feet or ankles?				
j.	Does this person show any signs of sleep apnea? (snoring, pauses in breathing during sleep, falling asleep during the day while engaged in activities , restless sleep, etc)				
k.	Does this person require supplemental oxygen or use CPAP or BiPAP? http://www.dphhs.mt.gov/dsd/ddp/documents/OxygenEquipmentCleaning.pdf				

FOLLOW-UP:

	Y	N	N/A	Change
Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				

Notes related to cardiac/respiratory issues:

7. Elimination

		Y	N	N/A	Change
a.	Does this person take medications that list constipation as a side effect?				
b.	Does this person have very hard or small stools?				
c.	Does this person report or indicate abdominal pain with bowel movements?				
d.	Has this person received prn medications for constipation more than two times a month within the past year? *(Do not include fiber)*				
e.	Has the person been hospitalized for bowel problems (constipation or obstruction) in the past year?				
f.	Does this person vomit two or more times per week?				
g.	Does this person have very loose stools or diarrhea?				
h.	Does this person have urinary tract infections more than once every two months? http://www.dphhs.mt.gov/dsd/ddp/documents/UrinaryTractInfections.pdf				
i.	Does this person show any signs of difficulty urinating such as taking a long time to start to urinate or having to urinate again within minutes of emptying the bladder or have to urinate frequently (more than every 4 hours)?				
j.	Does this person report or indicate that it hurts or burns during urination?				
k.	Does this person get up more than two times at night to urinate?				
l.	Does this person have an ostomy or catheter?				

	Y	N	N/A	Change
m. Does this person have a colostomy or ileostomy?				

FOLLOW-UP:

Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				
Notes related to elimination:				

8. Skin/Nails/Mucus Membranes

	Y	N	N/A	Change
a. Does this person have rashes or a skin condition that never fully heals or recurs every one to two weeks? http://www.dphhs.mt.gov/dsd/ddp/documents/AthletesFoot.pdf				
b. Is this person incontinent of stool or urine?				
c. Does this person have any pressure sores?				
d. Does this person have a mole that is being monitored by a medical professional?				
e. Does this person have a nail disorder?				
f. Does this person have mouth sores or swollen gums that occur weekly?				

FOLLOW-UP:

Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				
Notes related to skin/nails/mucus membranes:				

9. Movement/Mobility:

	Y	N	N/A	Change
a. Does this person fall more than one time per month, or sustained fractures due to a fall?				
b. Does this person have gait changes or balance problems?				
c. Does this person require special shoes?				
d. Does this person require orthotic, braces, or prosthetics?				
e. Does the person need assistance (device or person) for mobility?				

FOLLOW-UP:

Appropriate medical evaluation has occurred addressing these concerns?				

Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				
Notes related to movement/mobility:				

10. Behavioral/Mental Health Issues	Y	N	N/A	Change
a. Does this person have a mental health diagnosis?				
b. Does this person have a diagnosis of dementia or Alzheimer's?				
c. Does this person ingest non-edible objects(pica)?				
d. Does this person exhibit physical aggression?				
e. Does this person damage or destroy property?				
f. Does this person display self-injurious behavior?				
g. Does this person make suicidal attempts, gestures, or threats?				
h. Does this person leave or attempt to leave supervised settings and is unsafe to do so?				
i. Does this person use weapons, objects, or flammable material in an unsafe manner?				
j. Does this person use illegal drugs, abuse drugs, or abuse alcohol?				
k. Does this person exhibit unsafe social behavior?				
l. Does this person have problematic interpersonal relationships?				
m. Does this person display sexually problematic behavior?				
n. Does this person demonstrate behavior that is harmful to animals?				
o. Does this person have a behavior issue not addressed in the section?				

FOLLOW-UP:

Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				
Notes related to behavioral health:				

11. Medications	Y	N	N/A	Change
a. Has this person been prescribed medication from a health care provider?				
b. Has this person received a prescription for required medication supervision? (ARM				

	Y	N	N/A	Change
37.34.114)				
c. Is this person compliant with taking medications as prescribed?				
d. Does this person need supervision with self-administration of medications?				
e. Has this person reached maximum potential with self-administration of medications?				
f. Does this person have a training program for self-administration of medications?				
g. Has this person been prescribed a PRN Medication?				

FOLLOW-UP:

Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				
Notes related to medications:				

12. Environment

	Y	N	N/A	Change
a. Does this person's living environment meet their health and safety needs?				
b. Does this person's work environment meet their health and safety needs?				
c. Are there specific communication needs and are those needs being met?				
d. Are this person's community mobility/transportation needs being met?				

FOLLOW-UP:

Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				
Notes related to environment:				

13. Safety

	Y	N	N/A	Change
a. Is this person able to remain at home or in the community without support for any length of time?				
(a - i). For how long?				
b. Does this person's bedroom have at least two exits, one of which is a door or stairway providing a means of unobstructed egress out of the building?				
c. Does this person demonstrate the ability, at least annually, to appropriately exit the				

	premises during a fire and other emergency drills both with and without supervision?				
d.	Does this person need assistance to evacuate when a fire or smoke alarm sounds?				
e.	Does this person need a specialized emergency response system?				
f.	Does this person need assistance to remain safe around household chemicals?				
g.	Does this person have any other safety issues not addressed in the previous questions?				
h.	Does this person require supervision while bathing? (DDP Bathing Policy)				
	(h-i). Seizure				
	(h-ii). Mobility				
	(h-iii). Medications				
	(h-iv). Inability to regulate water temperature				
	(h-v). Cognitive or physical changes				
i.	Are there caregiver concerns that need to be addressed?				

FOLLOW-UP:

Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				
Notes related to safety:				

14. Miscellaneous

		Y	N	N/A	Change
a.	Has this person had a physical or other health exam as appropriate, by current standards, in the last year?				
	(a-i). Bone Density screening				
	(a-ii). Mammogram				
	(a-iii). Pap Smear				
	(a-iv). Prostate exam				
	(a-v). Colon Cancer screening				
	(a-vi). Immunizations				
b.	Has this person been diagnosed with a new medical condition during the past year?				
c.	Has this person had frequent hospitalizations, emergency department or Urgent Care visits over the past year?				
d.	Does this person get regular dental, vision, and hearing exams?				
e.	Does this person have an Advance Directive?				

		Y	N	N/A	Change
	(e-i). If yes, was it reviewed?				
f.	Does this person have a POLST in place? http://www.dphhs.mt.gov/dsd/ddp/ddppoliciesandprocedures/memopolst021710.pdf				
	(f-i). If yes, was it reviewed?				
g.	Does this person have a guardian with supporting documentation?				
h.	Does this person have a Power of Attorney with supporting documentation?				
i.	Does this person have a Rights Restriction?				
j.	Does this person have a Documentation of Choice?				
k.	Does this person have an emergency picture identification card?				
l.	Does this person have other concerns not listed?				

FOLLOW-UP:

	Y	N	N/A	Change
Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				
Notes for miscellaneous:				

15. Adult Protection Services (APS) Notification

		Y	N	N/A	Change
a.	Can this person keep themselves safe in the community and avoid dangerous situations, being exploited, and taken advantage of?				
b.	Has this person been explained the APS notification process?				
c.	Does this person understand the APS notification process and have the ability to contact APS should the need arise? Team consensus needed.				
d.	Does this person need further training in APS notification?				
e.	Has this person reached his/her maximum potential in this area? If it is the consensus of the team no training is proposed.				

FOLLOW-UP:

	Y	N	N/A	Change
Appropriate medical evaluation has occurred addressing these concerns?				
Protocol has been developed?				
If yes, at the time of the meeting, staff have been trained in protocol?				
Support needs have been identified?				
Notes related to APS notification:				

Personal Support Plan

Name:	Effective Date of Plan: