OUTREACH SERVICES
HEALTH ASSURANCE REVIEW GUIDE

NAME: AGENCY: ADDRESS:

DATE: COMPLETED BY:

GENERAL HEALTH

#	ITEM	YES	NO	NA	COMMENTS
1	Has the individual been hospitalized or required ER treatment during the past 12 months? **If no, go to #4.**	☐	☐		
2	Is the reason for each hospitalization or emergency room visit documented on a log or record?	☐	☐	☐	
3	Has a follow up care plan been implemented?	☐	☐	☐	

DIAGNOSTIC TESTS

#	ITEM	YES	NO	NA	COMMENTS
4	Have diagnostic procedures been completed during the past 12 months? (i.e.: blood work, x-rays, CAT scans, mammogram, sleep study, etc). **If no, go to # 7.**	☐	☐		
5	Are diagnostic procedures documented on a log or record?	☐	☐	☐	
6	Have the results of diagnostic procedures been communicated with members of the team and applicable changes made to the diagnosis listing?	☐	☐	☐	

LABS

#	ITEM	YES	NO	NA	COMMENTS
7	Are protocols in place for collecting labs related to the individuals' diagnosis and medications?	☐	☐		
8	Are lab values being monitored by a designated IST member?	☐	☐	☐	
9	Have there been abnormal lab values during the past 12 months?	☐	☐		
10	Are there strategies addressing the cause of the abnormal lab values?	☐	☐	☐	

OUTREACH SERVICES
HEALTH ASSURANCE REVIEW GUIDE

OUTPATIENT PROCEDURES

#	ITEM	YES	NO	NA	COMMENTS
11	Has the individual had consultation or treatment by a **health care specialist** during the past 12 months? **If no, go to #15.**	☐	☐		
12	Are the consultations/treatments documented on a log or record that includes the provider's name, reason, and outcome?	☐	☐	☐	
13	Has the IST met to discuss and implement the recommendations made by the medical specialist?	☐	☐		
14	Has the IST received training for medical procedures recommended and established a system to track and monitor the effectiveness of the intervention?	☐	☐	☐	

MEDICATION MANAGEMENT

#	ITEM	YES	NO	NA	COMMENTS
15	Is individual receiving prescription or OTC medications? **If no, go to # 19.**	☐	☐		
16	Is a method of monitoring side effects for each medication in place?	☐	☐	☐	
17	Is there a corresponding diagnosis for each medication prescribed by the physician?	☐	☐	☐	
18	Is there an effective medication administration system?	☐	☐		

OUTREACH SERVICES
HEALTH ASSURANCE REVIEW GUIDE

HEALTH ISSUES

#	ITEM	YES	NO	NA	COMMENTS
19	Does the individual have chronic health conditions? **If no, go to # 21.**	☐	☐		
20	If there are chronic health issues, the health assurance nurse will complete the Risk Issue/Evaluation Worksheet for each issue identified.	☐	☐	☐	
21	Has the individual had acute health conditions during the past 12 months? **If no, go to # 25.**	☐	☐		
22	Are the acute health conditions documented on a log or record?	☐	☐	☐	
23	Are symptoms of the acute health conditions tracked until the issue resolves?	☐	☐	☐	
24	Is there documentation of the date when each acute health condition resolved?	☐	☐	☐	

MEDICAL RESTRAINTS/INCREASED STAFFING RATIOS

#	ITEM	YES	NO	NA	COMMENTS
25	Were there medical conditions that required a 1:1 or 2:1 staffing ratio or use of medical restraints during the past 12 months? **If no go to # 27.**	☐	☐		
26	Is a protocol in place that describes when increased staffing ratio is needed due to a medical condition?	☐	☐	☐	

NEUROLOGICAL

#	ITEM	YES	NO	NA	COMMENTS
27	Does the individual have a seizure diagnosis? **If no, go to # 32.**	☐	☐		
28	Is a protocol for seizure care or seizure management plan in place?	☐	☐		
29	Is there a method for tracking seizures?	☐	☐		
30	Does the individual receive more than one medication for the purpose of treating seizures?	☐	☐		
31	Is there a protocol in place to collect labs to monitor anticonvulsant medication levels and monitor for blood dyscrasia that may result from the anticonvulsant medication?	☐	☐		

OUTREACH SERVICES
HEALTH ASSURANCE REVIEW GUIDE

PSYCHIATRIC

#	ITEM	YES	NO	NA	COMMENTS
32	Does the individual have a psychiatric diagnosis? **If no, go to #38.**	☐	☐		
33	Has individual been hospitalized for psychiatric treatment during the past 12 months?	☐	☐		
34	Are psychiatric symptoms being tracked?	☐	☐	☐	
35	Does the individual receive psychotropic medications?	☐	☐		
36	Is the AIMS scale used to screen for TD side effects of antipsychotic medications?	☐	☐	☐	
37	Is there a psychotropic medication reduction plan?	☐	☐	☐	

OPTOMETRIC

#	ITEM	YES	NO	NA	COMMENTS
38	Does the individual have a vision deficit? **If no, go to # 42.**	☐	☐		
39	Has the individual been assessed by an optometrist or ophthalmologist during the past 12 months?	☐	☐	☐	
40	Are interventions in place for vision deficits?	☐	☐	☐	
41	Has a mobility assessment been completed?	☐	☐	☐	

AUDIOLOGY

#	ITEM	YES	NO	NA	COMMENTS
42	Does the individual have a hearing deficit? **If no, go to # 45.**	☐	☐		
43	Has the individual been assessed by an audiologist during the past 12 months?	☐	☐	☐	
44	Are interventions in place for hearing deficits?	☐	☐	☐	

DENTAL

#	ITEM	YES	NO	NA	COMMENTS
45	Has individual been to the dentist in the past 12 months? **If yes, go to # 47.**	☐	☐		
46	Has a dental appointment been scheduled?	☐	☐	☐	
47	Has the treatment recommended by the dentist been completed?	☐	☐		

OUTREACH SERVICES
HEALTH ASSURANCE REVIEW GUIDE

HYDRATION

#	ITEM	YES	NO	NA	COMMENTS
48	Has individual been diagnosed with dehydration during the past 12 months?	☐	☐		
49	Is a protocol in place to ensure adequate hydration?	☐	☐	☐	

PHYSICAL AND NUTRITIONAL MANAGEMENT

#	ITEM	YES	NO	NA	COMMENTS
50	Does the individual eat by mouth?	☐	☐		
51	Has the individual had any choking incidents during the past 12 months	☐	☐		
52	Has the person been assessed for choking and pneumonia risks in the past 12 months?	☐	☐	☐	
53	Has the individual experienced dysphagia triggers including: coughing with signs of struggle, sudden change in breathing, wet vocal quality, wet respirations, excessive drooling, sudden change of color around the lips and face, watery eyes, or gagging during the past 12 months? **If no, go to # 56.**	☐	☐		
54	Has the individual been referred for an assessment of dysphagia symptoms (swallow study)?	☐	☐		
55	Are there protocols and strategies in place to address identified risks?	☐	☐		
56	Does the individual receive enteral nutrition (tube feeding)? **If no, go to # 59.**	☐	☐		
57	Has staff, including residential and day services, received competency based training for enteral feedings by a licensed nurse?	☐	☐		
58	Does the individual have a current Nutritional Management Plan?	☐	☐		

OUTREACH SERVICES
HEALTH ASSURANCE REVIEW GUIDE

DIETARY/IDEAL BODY WEIGHT

#	ITEM	YES	NO	NA	COMMENTS
59	Is Individual weighed at least monthly?	☐	☐		
60	Is there a weight tracking sheet?	☐	☐		
61	Has the physician written a diet order?				
62	Has individual gained or lost more than 5 lbs in one month during the past 12 months and/or has a BMI outside normal range? **If no, go to # 67.**	☐	☐		
63	Is there a professionally developed nutritional plan that records food intake, weekly weights?	☐	☐	☐	
64	Does a Registered Dietitian assess the individual annually and review the nutritional plan quarterly (ICF/MR requirement only)?	☐	☐	☐	
65	Is a protocol in place that addresses methods to ensure ideal body weight or BMI through diet, exercise, fluids, calories, and dietary supplements?	☐	☐	☐	
66	Has the physician made recommendations for exercise to prevent health issues associated with weight (cardiovascular disease, hypertension, diabetes, etc.)	☐	☐		

ASPIRATION/ RESPIRATORY

#	ITEM	YES	NO	NA	COMMENTS
67	Has the individual been diagnosed with pneumonia during the past 12 months?	☐	☐		
68	Has the individual been diagnosed with aspiration pneumonia in the past 12 months?	☐	☐		
69	Has the individual been diagnosed with acute asthma in the past 12 months?	☐	☐		
70	Does the individual receive supplemental oxygen and are protocols in place for monitoring oxygen levels?	☐	☐		

OUTREACH SERVICES
HEALTH ASSURANCE REVIEW GUIDE

CARDIAC

#	ITEM	YES	NO	NA	COMMENTS
71	Does the individual have cardiovascular disease? **If no, go to # 75.**	☐	☐		
72	Are vital signs monitored with parameters established for reporting abnormal vital signs?	☐	☐	☐	
73	Are vital signs tracked on a flow sheet?	☐	☐		
74	Has the individual had diagnostic screenings such as ECG or echocardiogram in the past 12 months?	☐	☐		
75	Does the individual have edema?	☐	☐		

ENDOCRINE

#	ITEM	YES	NO	NA	COMMENTS
76	Has the individual been diagnosed with hypothyroidism or hyperthyroidism? **If no, go to # 78.**	☐	☐		
77	Are thyroid level monitored at least annually?	☐	☐		
78	Has the individual been diagnosed with diabetes? **If no, go to # 86.**	☐	☐	☐	
79	Are systems in place to monitor blood glucose?	☐	☐		
80	Is there a tracking sheet to record blood sugars?	☐	☐		
81	Have the DSPs been trained to recognize symptoms of elevated or low blood sugars?	☐	☐		
82	Does the individual receive insulin?	☐	☐		
83	Has a licensed nurse provided the DSPs with competency based training to administer insulin?	☐	☐	☐	
84	Have the DSPs received competency based training for dietary management?	☐	☐		
85	Does the individual receive annual eye exams?	☐	☐		

OUTREACH SERVICES
HEALTH ASSURANCE REVIEW GUIDE

GASTROINTESTINAL

#	ITEM	YES	NO	NA	COMMENTS
86	If the individual have symptoms of GERD (belching, heartburn, rumination), are they being treated? Are there protocols in place?	☐	☐		
87	Are the GERD symptoms and use of prn treatments being tracked?	☐	☐	☐	
88	Has the individual experienced irregular bowel movements, been diagnosed with a condition that may effect elimination such as megacolon or Hirshprungs, or received medications and other elimination aids including dietary means, enemas or suppositories in the past 12 months? **If no, go to # 91.**	☐	☐		
89	Is a bowel protocol in place?	☐	☐	☐	
90	Are bowel movements and use of bowel aids being tracked?	☐	☐	☐	

GENITO-URINARY

#	ITEM	YES	NO	NA	COMMENTS
91	Has the individual been diagnosed with a medical condition that affects urinary output? **If no, go to # 95.**	☐	☐		
92	Is a system in place to monitor intake and output?	☐	☐	☐	
93	Does the individual have an external catheter, Foley catheter or suprapubic catheter?	☐	☐		
94	Has a licensed nurse provided competency based training to DSPs for catheter care?	☐	☐	☐	

OUTREACH SERVICES
HEALTH ASSURANCE REVIEW GUIDE

INTEGUMENTARY

#	ITEM	YES	NO	NA	COMMENTS
95	Has the individual had red pressure areas lasting longer than 1 hour within the last year or had any open skin pressure areas within the last 3 years? **If no, go to # 98.**	☐	☐		
96	Has there been an assessment of skin integrity (such as Braden's) completed and updated quarterly?	☐	☐	☐	
97	Is there a comprehensive plan in place to address pressure, moisture, nutrition, friction, repositioning and mobility/positioning devices with evidence of review and revision at least quarterly (at least weekly if an open or worsening pressure area)?	☐	☐	☐	

MUSCULO-SKELETAL

#	ITEM	YES	NO	NA	COMMENTS
98	Has the individual had any fractures in the last 3 years?	☐	☐		
99	Does the individual have conditions or medications that increase the risk of osteopenia or osteoporosis?	☐	☐		
100	Has there been a dexascan (bone density) or assessment by a physician to diagnose or rule out osteoporosis or osteopenia?	☐	☐	☐	
101	Is there a plan in place that addresses medication and other management strategies related to the prevention of bone loss or further fractures?	☐	☐	☐	

OUTREACH SERVICES
HEALTH ASSURANCE REVIEW GUIDE

SAFETY

#	ITEM	YES	NO	NA	COMMENTS
102	Does the individual ambulate independently (i.e.: needs no staff assistance or devices during walking)? **If no, go to #105.**	☐	☐		
103	Has there been a comprehensive physical therapy evaluation completed?	☐	☐	☐	
104	Is there documentation of a comprehensive plan developed by a physical therapist that describes the use of devices/ staff assistance during ambulation?	☐	☐	☐	

MOBILITY

#	ITEM	YES	NO	NA	COMMENTS
105	Does the individual spend more than 12 hours per day lying down in bed or other devices, including lying down in a recliner?	☐	☐		
106	Is the individual dependent on others for repositioning? **If no, go to # 110.**	☐	☐		
107	Is there a comprehensive positioning evaluation from an occupational therapist or physical therapist with recommendations within the last year?	☐	☐	☐	
108	Are there specific instructions for positioning related to eating and after meals, taking medications, completing oral care, bathing/showering, personal care/ADLs and sleeping/lying down?	☐	☐	☐	
109	Is there a positioning schedule data sheet including times and positions to be implemented throughout 24 hours that has been updated or reviewed within the last quarter AND does the schedule ensure that one position is not maintained for more than 2 hours?	☐	☐	☐	
110	Does the individual spend more than 2 hours per 24-hour day in a wheelchair? **If no, go to # 114.**	☐	☐		
111	Has the individual had a wheelchair seating and mobility evaluation completed or reviewed and updated within the last year by an occupational therapist or physical therapist?	☐	☐	☐	
112	Is the individual independent in all transfers from	☐	☐		

	one surface to another, such as from bed to chair?				
113	Are there specific transfer assistance instructions developed by a physical therapist that has been updated or reviewed within the last quarter?	☐	☐	☐	

ADAPTIVE EQUIPMENT

#	ITEM	YES	NO	NA	COMMENTS
114	Does the individual use aids for ambulating, mobility, positioning, splinting, safety bracing or any other adaptive equipment? **If no go to # 118.**	☐	☐		
115	Is there evidence that the individual's equipment and devices are regularly cleaned, checked for safety, fit and function correctly, and are all in good repair?	☐	☐	☐	
116	Is there evidence that broken equipment is repaired or replaced timely?	☐	☐	☐	
117	Is there evidence that the individual's equipment is being used consistently and correctly according to the plans?	☐	☐	☐	

RISK AREAS

#	ITEM	YES	NO	NA	COMMENTS
118	Is there a risk/health plan for each health/safety risk identified? Complete Health Plan Evaluation Worksheet for each issue.	☐	☐		

OUTREACH SERVICES
HEALTH ASSURANCE REVIEW GUIDE

SAFETY

#	ITEM	YES	NO	NA	COMMENTS
119	Is individual aware of all environmental dangers and how to protect self from dangers? Examples: pedestrian-traffic safety, hot water, hot surfaces, sharp objects. **If no, go to # 122.**	☐	☐		
120	Have assessments been completed to determine areas of deficit?	☐	☐	☐	
121	Is a protocol/risk plan in place to address the identified environmental dangers?	☐	☐	☐	
122	Has individual had injuries that met external reporting requirements in past 12 months? **If no, go to # 124.**	☐	☐		
123	Were injuries reported and addressed in a timely manner according to external reporting requirements?	☐	☐	☐	
124	Has the individual had more than one reportable injury during the past 12 months? **If no, go to # 126.**	☐	☐		
125	Were injuries addressed by the IST in a timely manner based on the severity of the injury or potential risks associated with the incident?	☐	☐	☐	
126	Has the person fallen during the past 12 months? **If no, go to #130.**	☐	☐		
127	Are falls being tracked?	☐	☐	☐	
128	Has a fall assessment been completed?	☐	☐	☐	
129	Have interventions been identified and implemented to prevent future falls?	☐	☐	☐	

ABUSE/NEGLECT

#	ITEM	YES	NO	NA	COMMENTS
130	Has the individual been a victim of substantiated abuse or neglect in past 12 months? **If no, go to # 132.**	☐	☐		
131	Was the incident investigated and action taken to ensure the safety of the individual?	☐	☐	☐	
132	Have errors occurred in administration of the individual's medication during the past 12 months? **If no, go to # 134.**	☐	☐	☐	

133	Were corrective measures implemented to ensure safety of the individual?	☐	☐	☐	

MEDICAL RECORDS

#	ITEM	YES	NO	NA	COMMENTS
134	Is there a complete listing of each diagnosis as determined by a physician or psychologist for the person in their official record? (Diagnoses can only be made or removed by a physician or psychologist) **If no, go to # 136.**	☐	☐		
135	Has a team member been assigned to update the diagnosis list?	☐	☐	☐	
136	Is there a corresponding Risk Plan for each listed diagnosis?	☐	☐	☐	
137	Has the team discussed and documented why a risk plan (s) is not needed?	☐	☐	☐	

#	ITEM	YES	NO	NA	COMMENTS
138	Is there justification documented by the IST for recommendations that have not been implemented? (NA if no consultant recommendations in past 12 months)?	☐	☐	☐	

Additional Comments:

Plan: