Policy and Procedures for the Individual Plan of Protective Oversight (iPOP-General, iPOP-Residential, iPOP-Day Hab)

iPOP-General

For those who have Residential placement within SB, the Residential QIDP will be responsible for completing the IPOP- General and iPOP-Residential **within 25 days of the ISP review**. In the case of people who only receive Day Hab, the Day Hab QIDP will be responsible for the completion of the iPOP-General as well as the IPOP-Day Hab **within 25 days of the ISP review**. In the case of an individual who attends more than ONE Day Program, the QIDP of the program in which the individual spends most of their time will be responsible for completing the general IPOP. In the case of people who only receive Supportive Employment Services, the Supportive Employment Specialist will complete the i-POP-General. Individuals receiving only Family Support Services (Community Hab /Respite) will refer to the Hab Plan policy for the iPOP procedure. Unless otherwise noted, the sections (1-10) provided in the template should be completed according to the prompts provided within the Therap system. As such, the sections itemized below will only be explicated when Agency-specific, and/or department-specific practices need to be explained. As this document provides guidance for all divisions within the Agency, users should complete the information using the prompts provided within the Therap template and the instructions below, unless provided with department-specific guidance. In this case, follow the department-specific guidance.

To create the iPOP-General, first left click the Individual tab on the left side of the screen, then scroll down to the entries for iPOP General Information, then click”New”. The screen will refresh and you will choose the program with which the individual is affiliated. Once you have located the program, click the individual’s name. The iPOP General Information form will appear. Proceed to supply information in the sections below:

1. PROFILE INFORMATION
   1. These fields will be pre-populated with information from the Individual Data Sheet and cannot be edited from this screen.
2. COMMUNICATION ABILITIES
   1. For the item “How does the individual communicate wants and needs?”, check all boxes appearing to the right that apply.
   2. Comments section will be completed to provide clarification
3. HEALTH CARE NEEDS- In the case of the Residential program, this information will be extracted from the “Health Care Needs” section of the Plan of Protective Oversight. In the case of the Day Hab program, this information will be extracted from the “Health Care Needs” section of the “Day Habilitation Safeguards”. The Supportive Employment Program will extract this information from the IEP and/or ISP.
   1. Comments sections will be completed to provide clarification as needed.
   2. Any box that is checked for a condition MUST be accompanied by a comment briefly explaining the protocol addressing it. If there is an outlined plan, this information is to be included as an attachment (see bottom of second screen).
   3. Repositioning and Transfer Guidelines are to be recorded in the list of special health care needs within the “Other” textbox.
   4. The item “Staffing requirements for medical/dental appointments/hospitalization” will be completed by the Residential QIDP using individual-specific guidelines as determined by the team.
4. MEDICATIONS-
   1. For the item “Indicate level of self-medication and type of assistance required”, this information will be extracted from the medication skills assessment provided by Nursing.
   2. For the item, “Indicate precautions for food/liquids (alcohol) due to certain medications”, this information will be extracted from the nutrition/dietary/nursing assessment.
   3. For the item, “Indicate any special instructions for medication administration (crushed, with food, applesauce)” this information needs to be extracted from the physician orders and nursing/dietary recommendations.
5. NUTRITION
   1. For the item, “Any special modified diet?” check yes or no and provide information in the comments box extracted from the physician’s orders
   2. Comments sections will be completed to provide clarification.
   3. The items “If yes, what”, “Type of monitoring and/or assistance needed”, and “Reason for monitoring and/or assistance”, this information for Residential and Day Hab programs will be extracted from the Dining Fact Sheet.
   4. **DO NOT USE** the item “Individual's ability to plan, choose and prepare small snacks, lunches, meals, etc. that are nutritionally balanced”.
6. DENTAL CARE- This information will be extracted from the “Health Care Needs” and “Activities of Daily Living” sections of the General-iPOP and/or Individual-Specific Plan of Protective Oversight.
   1. Comments sections will be completed to provide clarification.
7. BEHAVIORAL NEEDS- In general, this information will be extracted from the Behavior Plan. In the case of the Residential program, this information will be extracted from the “Mental Health” section of the Plan of Protective Oversight. In the case of the Day Hab program, this information will be extracted from the “Health Care Needs” and “Mental Health” section(s) of the “Day Habilitation Safeguards”.
   1. Comments sections will be completed to provide clarification.
   2. The items “Behavior Management Program/Staff Guidelines” and “Other concerns/behaviors not addressed in a BMP or staff guidelines” will be completed on an as-needed basis. The MIPS plan will be placed in the text box provided for the “Other concerns/behaviors not addressed in a BMP or staff guidelines”.
8. OTHER SIGNIFICANT INFORMATION
   1. Comments sections will be completed to provide clarification.
   2. In the case of the Residential program, voting capability and location are to be included in the comments section.
9. INDIVIDUAL RIGHTS- This information will be extracted from the “Mental Health” section of the Plan of Protective Oversight.
   1. **DO NOT USE** the items “Is person aware of personal rights and can protect self?” (and its accompanying comments box), or “Capable adult status for program planning?”
   2. For the items “Ability to consent for medical procedures (may include need to bedetermined on an individual and by case procedure)” (see Sec. 11a(i) in the IDS Policy), “Does the individual have a legal guardian?”(see Sec. 11a(i) in the IDS Policy), and “Does the individual have health care proxy?” (see Sec. 8b in the IDS Policy) will be completed using information saved in the Individual Contacts Section of the Individual Data Sheet.
10. ATTACHMENTS
11. REVIEWER COMMENTS
    1. Check the “I have reviewed this form” box.
    2. The “ISP Meeting Date” will be placed in the top of the comment box.

iPOP- Residential

Unless otherwise noted in the text that follows, sections (1-8) provided in the template should be completed according to the prompts provided within the Therap system. As such, the sections itemized below will only be explicated when Agency and/or department-specific practices need to be explained.

1. EMERGENCY EVACUATION AT HOME-This information will be extracted from the “Fire Safety” section of the Plan of Protective Oversight.
   1. Comments sections will be completed to provide clarification.
2. PERSONAL HYGIENE- This information will be extracted from the “Health Care Needs” and “Activities of Daily Living” sections of the General-iPOP and/or Individual-Specific Plan of Protective Oversight.
   1. Comments sections will be completed to provide clarification.
   2. The comments section will include bathing assessment results.
3. MONEY MANAGEMENT- This information will be extracted from the “Activities of Daily Living” section of the Plan of Protective Oversight.
   1. Select from the check boxes those describing the individual’s ability to use money (check as many as apply).
   2. Comments sections will be completed to include money management assessment and provide clarification.
4. DAILY LIVING SKILLS- This information will be extracted from the “Activities of Daily Living” section of the Plan of Protective Oversight.
   1. Select Yes or No for each question and provide comments as necessary.
5. SUPERVISION IN THE COMMUNITY- This information will be extracted from the “Community Activities” section of the Plan of Protective Oversight.
   1. Select from among the available check boxes describing the individual’s need to supervision in the community.
      1. “Route Traveler” refers to those who take public transportation.
   2. Comments sections will be completed to provide clarification.
   3. Comments will also include likes and/or dislikes for activities in the community.
6. SUPERVISION IN THE HOME- This information will be extracted from the “Mental Health”, “Activities of Daily Living”, and “Health Care Needs” sections of the Plan of Protective Oversight.
   1. For the item “Lives independently…” this refers to individuals who are not supervised in their home setting, e.g., supportive apartment dwellers. Check this box only for these individuals.
   2. For those living in supervised settings, the item “Able to stay home alone” will be completed using information derived from the Activities of Daily Living, and the Mental Health sections of the Plan of Protective Oversight. If “Yes” is checked, specify the time in the space provided.
   3. For the section “Specialized Instructions”, if “special checks” is selected from the available options, then “specify frequency” will be completed using information derived from the Health Care Needs section of the Plan of Protective Oversight.**The check box “Other” will signify overnight checks according the Overnight Check Assessment and MUST be completed for everyone in a supervised setting.**
      1. **The frequency and type of check will be recorded in the comments box.**
   4. The item “Sexual consent status” will be completed using information derived from the Mental Health section of the Plan of Protective Oversight.
   5. The item “Bed Checks” **WILL NOT BE USED**.
7. OTHER SIGNIFICANT INFORMATION
   1. Comments section will be completed to provide clarification.
   2. Hospital coverage and pharmacy review, and other data located in the Heath Care Needs section of the Plan of Protected Oversight not inserted into other regions of Therap, will be included in the comments section.
8. ATTACHMENTS
   1. The first page of the house-specific Plan of Protective Oversight will be uploaded as an attachment.
   2. Attach Standard Fall Precautions if the individual has Standard Precautions. If the individual is high risk attach both the standard and high risk assessment.
9. REVIEWER COMMENTS
   1. Check the “I have reviewed this form” box.
   2. The “ISP Meeting Date” will be placed in the top of the comment box.

iPOP- Day Hab

Unless otherwise noted in the text that follows, sections (1-6) provided in the template should be completed according to the prompts provided within the Therap system. As such, the sections itemized below will only be explicated when Agency and/or department-specific practices need to be explained.

1. SUPERVISION AT DAY PROGRAM
   1. For the item, “Indicate approved route(s) of travel” select from among the check boxes, but **DO NOT USE** “Route traveler within the building.” Provide comments as needed in the box provided.
   2. The items “Specialized Instructions” and “Supervision and assistance required for use of restrooms (note reason for supervision)” will be completed using information from the “Health Care Needs” section of the “Day Habilitation Safeguards” used by the Day Hab Program.
      1. For the item “Specify Frequency”, indicate in the box provided the frequency with which Visual Checks, or other Specialized Checks are to be done.
2. SUPERVISION ON DAY PROGRAM COMMUNITY OUTINGS- This information will be extracted from the “Community Activities” section of the “Day Habilitation Safeguards” used by the Day Hab Program.
   1. For the item, “Indicate approved route(s) of travel” select from among the check boxes, but **DO NOT USE** “Route traveler within the building.” Provide comments as needed in the box provided.
   2. The item “Supervision and assistance required for use of restrooms (note reason for supervision)” will be extracted from the “Community Activities” section of the “Day Habilitation Safeguards” used by the Day Hab Program.
      1. For the item “Specify Frequency”, indicate in the box provided the frequency with which Visual Checks, or other Specialized Checks are to be done.
3. ADAPTIVE EQUIPMENT AT DAY PROGRAM
   1. Comments sections will be completed to provide clarification.
4. EMERGENCY EVACUATION FROM BUILDING
   1. Comments sections will be completed to provide clarification.
   2. The items “Specialized assistance needed” and “Behavioral Concerns” will be completed using the “Fire Safety” section of the “Day Habilitation Safeguards” used by the Day Hab Program.
5. OTHER SAFEGUARDS AND/OR IMPORTANT INFORMATION
   1. The item “Other Information (i.e.: diet issues, special monitoring, etc.) will include daily exercise and money.
   2. Day Services will identify the health tracking needs (Intake/Elimination, Menses, Seizures, Vital Signs, Blood Glucose, and Weight) in this text box.
6. ATTACHMENTS
   1. Attach Standard Fall Precautions if the individual has Standard Precautions. If the individual is high risk attach both the standard and high risk assessment.
7. REVIEWER COMMENTS
   1. Check the “I have reviewed this form” box.
   2. The “ISP Meeting Date” will be placed in the top of the comment box.