CCRSS PROVIDER NAME	CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)

Washington State Department of Social & Health Services
Transforming lives

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Certification Evaluation Client Observation

CLIENT NAME	CLIENT SAMPLE ID NUMBER	LOCATION
Brief Review of PCSP / ISP, IISP, PBSP, IFP (list any area of concern)		

The observations below serve to assist in the determination if the service provider is meeting the client's needs as identified in the Person-Centered Service Plan (also known as the Individual Support Plan (ISP) and the Individual Instruction and Support Plan (IISP).

Use the guidelines listed in left box of each category and document observations in the right box. If no observation occurred, document Not Applicable (N/A) for that section.

A. Staff / Client Interactions	**Include Date(s), Time(s), and Location(s) of Observation(s).**
What staff instruction and supports were observed (provider staff name / identifier)?	
B. Staff Response to Challenging Behaviors	**Include Date(s), Time(s), and Location(s) of Observation(s).**
What challenging behaviors did the client exhibit, if any? What were the antecedents? How did the staff respond to the behaviors? Did staff remain calm, reassure the client and use the directives in the Positive Behavior Support Plan (PBSP) to assist the client?	
C. Meals	**Include Date(s), Time(s), and Location(s) of Observation(s).**
What meal(s) were observed? Any dietary restrictions? Were the restrictions accommodated? Did the meal appear balanced and nutritious? How much did the client assist with meal preparation? How much set-up did the client require?	
Does Group Training Home Meals include breakfast, lunch, dinner, and 24-hour access to snacks / beverages?	

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D. Medication Assistance	**Include Date(s), Time(s), and Location(s) of Observation(s).**
What kind of assistance did the client require for medications? Who prepared the medications? Preparation includes removing the pills from the bottle / blister pack or bubble. How did the client take their pills? Was the medication mixed in food?	
E. Nurse Delegation (for clients with administration of medications)	**Include Date(s), Time(s), and Location(s) of Observation(s).**
Was there a need for nurse delegation for any medications? What type of medication? • Oral • Topical • Eye medications • Ear medications • Suppositories • Enemas Did the staff explain to the client prior to administration? Is there documentation of the Nurse Delegator's review at least every 90 days?	
F. Physical / Mechanical Restrains, Medical Devices, Alarms and Monitoring Devices, and Restrictive Procedures	**Include Date(s), Time(s), and Location(s) of Observation(s).**
Note the presence of: • Medical Devices • Alarms / Monitoring Devices • Restrictive Procedures How are they used? Do they affect housemates and does the provider have the housemates' consent to use alarms / monitoring devices? Are there safety concerns? Review the client's record for required orders / approvals / consents.	

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RESIDENTIAL CARE SERVICES

Community Residential Services and Supports Certification Evaluation Client Observation Notes

NOTE: This form should be used to document any additional information or data that does not fit in the designated space.