Policy / Procedure Details	Title:	**Individual Planning – Adult Services**		
	Type:	**Services**		
	Related Personal Outcome Measure:	**I choose Personal Goals**		
	Code:	**1.1**		
Original Version Details	Date Released:	**31/10/2001**		
Revised Version/s Details	Date/s Released:	**21 / 11 / 2003**	**21 / 06 / 2012**	**31 / 10 / 2013**
Current Version Details	Written By:	**Evaluation & Training Department**		
	Reviewed By:	**Leadership Team**		
	Approved By:	**Executive Director**		
	Date Released:	**30 / 09 / 2016**		
	Monitoring Process:	**Procedural Review Process**		
	Date Due for Review:	**30 / 09 / 2019**		

FLOWCHART

The Line Manager of the Person's Main Service assigns a Named Staff (Residential/Day) to Support the Individual to develop an Individual Plan. Line Managers in other complimentary services, i.e. Day/Respite should also identify Link Staff. Both managers should have an agreement in place as to how Named and Link Staff will coordinate their work on implementation of IPs.

The Person and Named Staff complete the **Planning Booklet.** This process should involve linking with other services involved, reviewing all key IP documents and identifying priorities for the coming year

A Formal Planning meeting is held with the Person, their family/advocates and all key staff involved. At this meeting, the Named Staff prepares a **Named Staff Report** of all the relevant work carried out on priorities over the last year and indicates the likely priorities for the coming year. The outcome of this meeting is recorded in **Formal Planning Meeting Minutes,** which are circulated and agreed with all attendees. An **Annual Action Plan** is set out at this time, to specify actions to be taken, people responsible and timescales involved.

The Named Staff ensures all relevant staff are informed of the priorities in the coming year. Work carried out by all staff in support of priorities should be referenced clearly in **Daily Logs**.

Throughout the planning year, every four months, the Named Staff ensures that a **Progress Update** is prepared to account for work carried out on each priority and indicate the next steps in each case. This document allows for alterations to the plan to be identified and logged. There should be three progress updates completed over the year. A critical component in these reports is to ensure that staff in other services are linked into this process, either by meeting with the Named Staff on a quarterly basis or through some other agreed communication pathway. Line managers across services are responsible for ensuring these communication pathways are in place.

The process is restarted at the end of the 12 month period, by the Person and the Named Staff reviewing and updating the **Planning Booklet** for the year ahead.

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Policy and Procedure Feedback Form

A Policy and Procedure Feedback Form is available on the Western Care Association Intranet (under Procedures) which will provide an opportunity to comment on any policy/procedure.
Your comments will be forwarded to the person who has the lead for the ongoing development of the policy/procedure.
All comments will be collated by the person responsible and will inform the three-yearly review cycle for updating procedures.

1. Policy

Western Care Association Mission Statement: Western Care Association exists to empower people with a wide range of learning and associated disabilities in Mayo to live full and satisfied lives as equal citizens.

Individual Planning and Mission Statement: In order to achieve our mission of equal citizenship for people who use services we need to have a process of empowering people to identify their priorities and match those priorities with our service efforts and resources. Our approach to Individual Planning is based on Person Centred values and actions.

Individual Planning is the process by which the person is supported to identify their hopes and dreams, their preferences for belonging and participating in community, what they want to achieve in their everyday lives, how they want to spend their time and with whom, what do they want to spend their time doing, what are their requirements around health, rights, safety and security.

The Individual Planning Process seeks to identify **what really matters** to the person and to respond to this. As the person's identity develops over time and their preferences change or become clearer the plan evolves to support the growth of the person. Learning and listening are at the heart of the individual Planning process. Developing a vision gives direction to the person and to their support network.

The **person's support network** needs to act together to be helpful and work effectively to support the person. How to best organise the person's support network becomes a vital part of person centred planning. Circles of Support are one well established method of mobilising the resources in the person's support network. A Circle of Support is a process that brings together the people who the person feels can help best.

Some Key Issues in Individual Planning: This Individual Planning system is a set of tools to help us provide supports that address the person's priorities. It is a way that we can be organised to take action. It also involves a level of formal process. People who are supported may not want to be involved in the paperwork and formal planning involved with this particular system or set of tools. This is their choice.

Honouring Preferences: Each person is a unique individual with their own life experience, their own potential, their capacities, perspective, preferences, likes and dislikes. Being person centred means we try to honour the individual nature of the person. We listen and learn about what really matters to them. We try to personalise our supports to each individual. Individual Plans can help us to be organised to take the required actions. This type of Individual Planning system provides a set of tools to help us to support people. If it is to be truly individual it has to be capable of becoming personalised to the individual. Staff should use it as the organisation approach but if the person supported wants a different approach staff should accommodate this while remaining true to the principles of the Associations Individual Planning system.

Strong Support Networks: People who have strong support networks have a much better chance of having a fulfilled life. Having someone in your corner can make all the difference in a person's life. Typically support networks are strongest among family members. This remains the case throughout the life cycle. It is important to bear in mind that adults, with and without disabilities, typically continue to be important members of their families and look to their family ties for support and a sense of belonging. Families have a natural authority as advocates for their loved ones which needs to be understood and respected. Staff may come and go but family ties often last a lifetime and cross several generations. Over the lifecycle, the type of issues that might arise for adults in family relationships will change. A young adult with parents who are also reasonably young is likely to encounter different issues than an older adult who might have elderly parents. A different set of issues may arise if the adult has no family through ageing and loss.

Each situation has to be considered in context of the individual and their family circumstances. The strength of Support Networks however is further increased by the inclusion of others who hold their best interests at heart. They can be friends, neighbours or advocates with whom the person has a positive relationship. One of the areas of work we need to focus on is the strengthening of people's support networks.

Connecting to Communities and Developing Positive Social Roles: Being Person Centred challenges us to think beyond the routines and resources of the service. Sometimes the formal support system 'takes charge' without meaning to. This can result in the person remaining disconnected from others in their neighbourhoods and communities. Community members think we are the experts. They might also think we are the person's friend and that they don't need anyone else. We need to be aware of how we "model or translate" people to others. The community looks to us for example and leadership. We need to connect people with their communities in ways they find meaningful. We need to look to the contributions people can make to their communities and to discover what positive social roles they can play. Positive social roles bring people into contact with others on more equal terms than the role of service user. This can change the way people are seen and the way they see themselves in very significant ways. It can literally change people's lives.

Holding High Expectations: People respond to what we believe about them. Having high expectations helps others to see the potential in themselves. It also helps the wider community to see possibilities they may not have expected to find. We have many, many examples of people who have surprised others because of the belief someone had in them and who helped them find the courage to pursue their goals.

Individual Planning for People who do not communicate with Words: This may pose a particular challenge for some people. However, it is never the case that Individual Planning is considered suitable for some and not for others because of their ability to communicate or to function in different situations. There are many people who do not use words to communicate who will be quite clear on what they want and can be very clear in telling others exactly what they mean. For some it is more difficult. They may struggle with being clear in themselves to begin with. Some people with complex ways of processing information may have many challenges in making sense out of things in general. People who struggle to be clear in themselves will have difficulty in being clear to others. We have learned a great deal about how to listen more deeply and more carefully to the person with complex processing issues in recent years. We understand better the role stress may play in affecting their ability to process information at different times. We have developed more supports and strategies to help us listen to the person. We know that over time people who have strong empathetic relationships with the person can help provide insights and direction that can inform others.

Families and those who know the person best are the deepest and richest source of information. People who through their behaviour have 'asked questions' of their support arrangements have been listened to and supported differently and with considerable success.

There will be situations in which people seem puzzled, distressed and confused for considerable periods. We respond to them in the best and most positive way we can until we reach a point where the person's life is back on track. We know there is no formula for this. Intensive Individualised Planning however is the basic process by which we approach these situations.

Choice and Confusion: We have also learned that the issue of presenting choice to people who are stressed may not be helpful. It may add confusion to their already confused state. There is a judgement in knowing what is helpful and what is not. This needs to be based in our knowledge of the person and the evidence of experience. If the person has a diagnosis of autism for example we know that they may not be in control of their choices. They may get stuck and not be able to move on without help. Choice should never be dressed up as something it is not. People who are in deep distress are not in a position to self-manage and to make choices. The choice of doing nothing as a so called lifestyle has to be challenged vigorously. It is not a direction in life. It is too often a life without hope, dreams or direction leading to poor and sometimes disastrous results for the person.

On the other hand, control over people is never our objective. People who are out of control need to be given control back. Lack of control may be the source of distress for the person. They may need to feel more in control but are not able to self-regulate at particular times. One thing that may add to the stress in their lives is that they experience the service increasing the number of rules and restrictions in response to their behaviour. Our task is to give people control in their lives. This does not mean either overwhelming them with choice or making all the decisions for them. It means finding out how to give control to this person in ways that help them feel in control. In some cases this will require us to support the person who is stuck and overwhelmed with anxiety by providing structure and direction in their day so they can eventually be helped to cope with choice.

People with autism present particular dilemmas around the area of choice as even people who are not going through a difficult time can become stressed by the difficulty they experience in making choices. Our approach has to be informed by the knowledge of the individual and how their autism impacts on them. An individual plan must also take into account what we know about the person's preferences when we know the act of choosing is a stressful experience for the person.

The Challenge of Vision: A test of effectiveness of the Individual Planning process is being able to answer, at any point in time, what the person's vision for the future is and how current activity is leading them there. All of us have struggled at one time or another with planning a future and imagining what direction our lives may take. People who have had limited life experiences (despite their age) and may have experienced low expectations of themselves often struggle to develop a direction in life beyond what the service arrangement offers. They may lack confidence or the ability to tell people what is important for them. They may be fearful of hope due to disappointment in the past. They may not have any idea what is possible for them. The role of the support network is to help the person explore a bit further, to develop their confidence and help them to foster their own identity. This takes careful listening and creative support. The process of planning and taking actions based on the person's preferences and priorities over time can lead the Circle or support network towards a clearer sense of what is possible.

Sharing Power: The idea of the service being the source of all solutions in a person's life is neither accurate nor desirable. It is not an empowering proposition. The extent to which people are connected to people beyond the formal service system can tell a lot about their quality of life on many levels from safety to social life. One of the things we have learned over the years is that in order to increase the strength of the person's support network we need to consciously and deliberately develop partnerships with the person and their family and advocates. This means that we have to work very hard at sharing power with others outside of the formal paid support system.

It is so important to go beyond an 'annual case review' approach to Individual Planning where the service engages with a member of the family in a general kind of discussion in which they may be passive participants. In these situations, even though it is not the intention, the power is generally seen to lie with the staff and the organisation. The staff are often seen as being in charge of the process by families who may not really feel engaged. To many families it may feel like a routine ritual but not very empowering. Of course there are many examples where this is not the case and we can learn from these. By sharing power and creating partnerships with the person and their family and advocates we increase the energy in the person's support network and increase the prospects for that person's quality of life.

An Important Reminder: The Named Staff has to play a lead role in listening, negotiating, problem solving, advocating for and co-ordinating the supports for the person. They need to have a strong belief in the person as a person and to be in their corner as an advocate and a voice for them. However, because of the way many services are organised there will be more than one person to support at any given time. It is essential that the Named Staff feels they are part of a team who will carry on the work they require when they are not present due to leave / rosters, etc. By the same token, each and every Named Staff must play the part of a team member who is there to support each individual and not exclusively to focus on the person for whom they are Named Staff. There is a danger that in their efforts to deliver for the person, the Named Staff may lose sight of their primary role, which is to be a member of a staff team who support all the people in their service. If each team member plays their part then the concerns about consistency, follow through etc. should be more comprehensively addressed. It is vital to avoid fragmenting the team into a series of individual Named Staff who focus too exclusively on particular people which will actually be self-defeating.

2. Roles and Responsibilities

The IP process is a central part of the everyday support provided to individuals using services. It begins with the line manager of the person's main service assigning a staff member to be that person's Named Staff. In practice, this usually means that when a person lives in a residential service, one staff in that service is their Named Staff. When a person attends a Western Care Day Service but lives in their own home, then a staff member in the Day Service assumes Named Staff responsibilities. These arrangements can vary according to the individual's situation. However, the responsibility for assigning the Named Staff lies with the line manager of the person's main service. An assigned staff in the corresponding service usually takes on a Link Staff role. Usually staff working in a respite setting will be assigned a Link Staff role, although occasionally the person may only be attending that respite service, in which case, respite staff may take on a Named Staff role. The key functions of these roles are set out below

It is the responsibility of the Named Staff to:

- Complete the Individual Planning Booklet with the Individual
- When completing the Planning Booklet to ensure that all relevant IP documentation is reviewed and updated as required.
- Prepare a report on the previous year's planning for discussion at a formal planning meeting with the person, family members and key staff
- Support the Individual to set out these goals at a formal planning meeting and to engage in problem solving in relation to how best to respond to these priories. Written minutes are to be kept to record the meeting and its outcome
- Complete the Annual Action Plan
- Complete Progress Updates at four monthly intervals during the planning cycle
- Keep their line manager informed of progress.
- Liaise with other services involved, particularly with assigned Link Staff.
- Link with other staff in the service to ensure that daily record keeping specifies the nature of supports given or progress made in relation to identified priorities.

It is the responsibility of the Link Staff to:

- Be involved in completion of the Planning Booklet
- Ensure that all IP documents in the Link Folder are up to date.
- Attend the formal planning meetings.
- Agree an ongoing communication system with the Named Staff to ensure key information is shared.
- Where required, address a particular goal. Where goals are being progressed by link staff, they need to maintain their own Progress Update, setting out progress made each four months. This information needs to be shared quarterly with the Named Staff to ensure that an overall view of progress is being maintained throughout the year.
- Link with other staff in the service to ensure that daily record keeping references supports given or progress made in relation to identified priorities.

It is the responsibility of the Line Manager to:

- Manage and co-ordinate the overall operation of all IP's in their service
- Assign Named Staff/Link Staff in consultation with the person, the staff member and any relevant others.
- Have an agreement with the other line managers in their area so that regular communication and co-ordination across Named Staff/Link Staff is facilitated. This is essential in order to implement the agreed plan and track its progress.
- Ensure that regular IP audits are carried out to track progress and monitor compliance with the IP policy.
- Use the Support and Supervision process to provide feedback to the Named/Link staff's on their performance in their assigned role.

It is the responsibility of the Regional Services Manager to:

- Manage and co-ordinate the overall operation of the IP system in their area.
- Support line managers in their area to have effective IP's in place where individuals require them. Where an individual does not wish to have an IP, then the RSM should agree an alternative framework with the line manager in accordance with the wishes of the person and/or their advocates.
- Review IP audits in order to monitor compliance with the IP policy.
- Use the Support and Supervision process to provide feedback to the Line Manager on their performance in the management of IPs.

3. Identifying Priorities

The Structure of the IP is also follows:

1. **Foundations** which are concerned with Basic Assurances and Safeguards such as Health, Rights, Privacy etc.
2. **Development** which is concerned with daily routines, learning, meaningful day etc.
3. **People and Places in My Life** which are about the bigger dreams and choices such as choosing where and with whom I want to live, what I do in my community etc.

The first step in planning is to support the completion of the Individual Planning Booklet. This is the foundation of all planning efforts. The Named Staff will be leading the completion of this document. However, they must link with other relevant staff, i.e. day/respite staff, BSS, SLT to seek their input into relevant sections. They must also ensure that the supporting forms for each section are checked for accuracy, remain relevant and are within date.

- ***Introduction.*** These are key pages that provide a short introduction to the person, their interests and characteristics. Key contact information should also be recorded in this section.

- ***Foundation Area – Health.*** The planning booklet contains a copy of the Health Action Plan. Part of reviewing the individual's health issues, is to check all relevant health forms on file to ensure that they are still relevant and within date. All forms should be signed and dated fully. Some people need specific plans for certain medical conditions, i.e. epilepsy, diabetes. These plans are developed in consultation with the medical teams involved and should be reviewed formally at least annually and more frequently if required. ***(See Also Enabling People to Enjoy Best Health Policy).***

If the person has had a significant number of health issues/appointments over the coming year, a summary report of these appointments should be developed so that any outstanding health issues can be identified. At this point, any outstanding health issue must be addressed. These should be set out in the final part of this section and followed up on.

- ***Foundation Area – Communication.*** This part of the booklet contains the Communication Profile. It also contains sections that can be individualized to include specific guidance as to how to communicate with the person. If there are SLT guidelines on how best to communicate with this person, these should be checked at this point to ensure that these are still relevant and being used by all staff. Should BSS have an active role, it is also appropriate to include their guidelines in this section. Any BSS report/guidelines on file should be reviewed for relevance annually and incorporated into priorities as required. At this point, any outstanding communication issue must be addressed. These should be set out in the final part of this section and followed up on.

- ***Foundation Areas – Free From Abuse and Safety.*** The next two sections of the report cover areas of safeguarding. The Named staff must consider any unaddressed safety or protection concern in these areas. It is vitally important that the PRMP is checked for relevance and is updated as required. Incident forms should also be checked to ensure that there is no outstanding area of concern not being addressed. At this point, any outstanding protection and safety issues must be addressed. These should be set out in the final part of this section and followed up on.

- ***Foundation Areas – Privacy.*** The Named Staff now considers any relevant privacy issues. The Intimate Care Plan should be checked for relevance. It should be updated as required. At this point, any outstanding privacy issues must be addressed. These should be set out in the final part of this section and followed up on.

- ***Foundation Area – Rights.*** The final foundation area to be reviewed is the area of rights. The Named Staff reviews this section and notes issues of concern. Particular attention should be paid to the Rights Checklist to make sure that it is up to date. Where RRC recommendations are in place, these should be followed up on. Any outstanding rights issue must be added to the final part of this section and followed up on.

- ***Development Areas – My Daily Routine, Learning New Skills and Work/ Meaningful Day.*** These three complementary areas concern the day to day activities that people take part in. These should be based on their interests and preferences. These should lead to development opportunities and increased independence. People should have as full and active a day as possible in keeping with their interests and preferences. The Named Staff should review each section with the individual. It is important that the schedule is completed fully representing all the activities of the week. The Named Staff will have to link with other services involved to ensure that this is as comprehensive as possible. Where a priority emerges under any of these headings, it should be noted in the final part of each section.

- ***People and Places in My Life: Choose Live, Family/Friends and Community.*** The Named Staff completes each of these sections in turn, noting the person's preferences in each case. Where priorities emerge in the Choose Life, Family/Friends sections these should be noted at the end of these sections. However, the Community Section is the community mapping tool from the Natural Supports Policy. There are two sections to complete. The individual map should be completed as comprehensively as possible for the individual person. The final part of this section lists specific actions to be taken to enhance community participation. There is detailed guidance in this section on how best to approach this. Any specific work set out in the final section should be carried forward as a priority area to be developed.

- ***Summary:*** The final part of the Planning Booklet is a summary section. It sets out:
    - What the person achieved this past year.
    - What the person would like to do next year.
    - Lists the priorities that have emerged under the preceding sections of the booklet. All issues identified in the foundation area should be followed up on. The goal should be to balance this with selecting at least one priority in the area of Development and another in the area of People/Places in My Life. However, the Named Staff will need to select priorities based on their importance to the person and the urgency of the particular situation.

Once completed, the document should be typed up and saved in the person's F Drive folder, in the Person Centred Plan subfolder. The person who completed the document and the date of completion should be noted on the cover of the booklet. The line manager will support the Named Staff to file the document in this way. The Named Staff should make arrangements for the link staff to get a copy of this document.

4. The Formal Planning Meeting

Once Individual Planning Booklet is completed, the Named Staff will prepare for the formal planning meeting.

A key part of the preparations is the ***Named Staff Report***. This is where the staff summarise their work on the IP in the preceding year so that there is evidence to track the implementation and effectiveness of the plan. The Progress Updates will be very useful in compiling this report.

The Named staff report should:

- Restate last year's priorities
- Describe what was achieved in the past year
- Outline what changes had to be made to the plan and why
- Indicate what difficulties arose during the previous year that impacted on the priorities
- Set out what the person has indicated in the Individual Planning Booklet as priorities for the year ahead.

The meeting should be arranged at a time and place to suit the person and their family so as to facilitate their full participation.

If the person or family members decide not to attend a planning meeting, then arrangements will need to be made to discuss the outcome of the meeting with them and seek their agreement on the way forward. This process will need to be documented in a file note.

Where the Named staff has invited key services/therapist involved and they are unable to attend, it is also vital that arrangements are made for them to submit reports or updates on progress.

A chair and note taker should be appointed.

The agenda for the meeting will need to cover the following:

- The Named Staff Report
- The Key Issues emerging from the Individual Planning Booklet
- Feedback from other services/therapists on their involvement. Where reports have been submitted by people unable to attend the meeting, these are referenced where applicable.
- Agreeing the **Annual Action Plan** which sets out priorities and associated actions for the coming year.

The Named Staff ensures that the minutes of this meeting are typed up and circulated to all involved for agreement. The meeting minutes should be saved in the person's F Drive folder, in the Person Centred Plan subfolder. A copy should be placed on the IP folder.

At the same time, the Named Staff types out the Annual Action Plan with the goals as agreed at the planning meeting with people responsible and time frames assigned to actions where possible. This document should be typed up and saved in the person's F Drive folder, in the Person Centred Plan subfolder.

A copy of both the planning meeting minutes and the Annual Action plan should also sent to the person's family and the relevant link services.

5. Addressing Priorities

Once the Annual Action plan is agreed, the Named Staff can begin work on addressing identified priorities. It is very important to ensure that notes of work carried out on priorities are made in the **Daily Logs** as evidence of action. These logs should be used to record progress on priorities, skill development, community involvement and other areas of importance to the person. All staff need to be familiar with individual's priorities and reference these in the logs. Logs should not be used to repeat information already noted in food diaries, incident forms or complaint forms as this is an unnecessary duplication. Instead where this information has been completed the log can direct the reader to the relevant record. The information in the daily logs will provide a record for Named Staff when they are completing the Progress Updates. This information will assist named Staff to recall actions taken and provide the evidence of work done to progress the persons priorities.

Line managers in each service need to ensure that daily logs are fit for purpose in recording important information and collating progress on specific priorities. A number of options are available to be used as logs whether in diary or loose leaf format. The line manager should agree which format suits their individual service context best and ensure that it is consistently followed by all staff. It is good practice for manager to regularly review these logs and sign off that this has occurred.

At the end of the four month period, the Named Staff completes the Progress Update form for each priority, with one page given over to a report on each priority, noting the action taken by whom and when.

The final section of this document provides for the Named Staff to note if new priorities emerged during that four month period or if the plan had to be changed in some way.

Once completed, this document should be typed up and saved the document should be typed up and saved in the person's F Drive folder, in the Person Centred Plan subfolder. A copy should be placed on the IP folder. Link Staff should also complete a Progress Update on their work and save this on their Link Folder.

This process will need to be repeat twice over the next two four month periods until the year is completed and it is time to review the Individual Planning Booklet.

It is essential that a communication pathway is in place between services to ensure the plan is being implemented as agreed. This will need to be agreed in advance by the relevant line managers. Line managers should select the most appropriate method of communication that suits the individual situation. Depending on the situation, they may choose that:

- Line Managers will meet at agreed intervals throughout the year to monitor the implementation of the plan recording the outcome of these meetings in file notes that can be shared across services.

- Named and Link staff to meet quarterly and develop a joint Progress Update to be filed on both the IP and Link Folder

- Named and Link staff to complete their own Progress Update and circulate these to each other as update on progress made.

6. Layout of the IP Folder

The IP folder contains a large volume of documents and it can be difficult to navigate. With that in mind, the following filing system is presented as an example of how this information can be presented in an organized fashion. This filing system should be set up once the first part of the planning cycle is completed, i.e. the booklet is completed, the formal meeting has been held and the annual action plan is in place. The suggested layout is set out overleaf.

IP Layout	
Inside Cover	□ Daily Logs □ Information checklist – respite only
Part 1 - Overview	□ Introduction - Pages 1 to 4 of the Planning Booklet □ Summary - Pages 30 to 32 of the Planning Booklet □ Named Staff Report □ Formal Planning Meeting Minutes □ Annual Action Plan □ Progress Updates – current year □ Individual Service Agreement(Residential/Respite Only
Part 2 - Health	□ Health – Pages 5-11 of the Planning Booklet □ MP1/MR2 □ Health Conditions Plan, i.e. Epilepsy □ MUST/Weight Charts □ Menu plan or Food Charts □ Dietician report □ FEDS report □ Summary of Appointments Report/Current years MAF's □ Self-Administration Forms □ Medical Appointment Forms □ Medical consent form □ PRN protocol, non-psychotropic □ Any other health condition plan/Any other medical form
Part 3 - Communication	□ Communication – Pages 12-16 of the Planning Booklet □ Any SLT guidance/plan on communication □ Behaviour Support Plan
Part 4 –Protection and Safety	□ Protection – Page 17 of the Planning Booklet □ Safety – Page 18 of the Planning Booklet □ PRMP □ Incident Reports □ Individual Evacuation Plan □ Informing Families about Incidents
Part 5 - Privacy & Rights	□ Privacy – Page 19 of the Planning Booklet □ Intimate Care Plan □ Rights – Page 20 of the Planning Booklet □ Rights Checklist □ PRN – psychotropic □ Concealed Medication □ Financial self-assessment □ Physical Restraint Protocol □ Property Register
Part 6 – Development	□ Daily Routine – page 21 of the Planning Booklet □ Learning New Skills – Page 22 of the Planning Booklet □ Work/Meaningful Day – Page 23 of the Planning Booklet
Part 7 – People and Places in My Life	□ Choose Live – Page 24 of the Planning Booklet □ Family/Friends – Page 25 of the Planning Booklet □ Community Connections – Page 26 of the Planning Booklet