St. Michael's House

Person-Centred Planning Policy & Procedures

Written By:	**….**	Person Centred Planning Steering Group
Reviewed By:	**….**	Executive Management Team
Approved By:	**….**	Executive Management Team
		Signed: ***Anna Shakespeare, C.E.O.***
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		Signed: ***Anna Shakespeare, C.E.O.***
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Monitoring Mechanism:	**….**	Person Centred Planning Steering Group

CONTENTS

Policy Development Working Group:

David Dunne (Chairperson)
Elaine Teague
Eilín de Paor
Grania Clarke
Róisín Deery
Stephen Hennessy
Christine Delany
Mary Sloan
Stephen Cullen
Joan Gillvarry
Lorraine Ledger (until mid-2015)
Grainne Bourke

1.0 Purpose

The purpose of this document is:

- To state the Organisation's policy on Person-Centred Planning with adults.
- To describe the St. Michael's House approach to Person-Centred Planning with adults using our services.
- To outline the procedures involved in Person-Centred Planning with adults.
- To identify the roles and responsibilities of all involved in Person-Centred Planning with adults.

2.0 Scope

2.1 This policy and these procedures apply to all St. Michael's House staff working with adult service users. This includes all adults who are in receipt of day, residential and/or respite services (whether residential respite or alternative home-based respite models) from the Organisation.

2.2 Children 0-18 years who avail of residential or respite services from St. Michael's House are also covered by this policy and procedures. Children and families who do not utilise these services do not directly come under the scope of this policy, but they have other planning processes e.g. Early Services Family and Child Plans, Individualised Family Support Plans and Individual Education Plans.

2.3 Adults who interact with the Organisation for limited, so-termed 'community clinic team' or 'clinic only' inputs, and who are not availing of a day, residential or respite service, do not generally fall under this policy, except in cases where an individual specifically requests engagement in part or all of the Person-Centred Planning Process, as part of their service from St. Michael's House.

3.0 Context

3.1 Overall Context for Person-Centred Planning

Person-Centred Planning has its roots in the normalisation and independent living movements of the 1970's and 1980's. It is grounded in a social model of disability and is a strengths-based approach. Person-Centred Planning was developed because people with disabilities often find it difficult to have the kinds of basic opportunities and life experiences that others take for granted. Person-Centred Planning seeks to describe the person's vision for his/her life as a full member of the community and society and to identify goals and actions to support him/her to move in the direction of that vision (NDA, 2005).

There is an increasing focus on quality assurance and value for money in social and health care settings. Person-Centred Planning directs the energies of those providing support services towards working in partnership with the people receiving supports to achieve real and positive outcomes in the areas of increased wellbeing, quality of life and social capital.

Person-Centred Planning enables those providing services to address the exact needs and preferences of people using the services, through the development of targeted support plans and actions, with a clear rationale. In this way, Person-Centred Planning is the tool whereby services and supports become individualised for each person. Support plans should also be effective and well-founded on evidence-based best practice.

Human beings grow and develop by making decisions, trying out new things, having achievements, making mistakes and learning from experience. Best practice in Person-Centred Planning and support planning involves empowering individuals to take and retain ownership of their lives and lifestyles in as much as possible and to engage in proactive risk-taking. Some people with intellectual disabilities have had limited opportunities and experiences to make decisions and speak up for themselves.

For these individuals it is important for them to have someone who takes the time to understand their views and preferences and who can support them to make these known or who can speak on their behalf. Person- Centred Plans work well when these advocates of the person are included throughout the process. Advocates can come from any part of the person's life (e.g., family members, keyworkers, friends, clinicians, colleagues, volunteers or independent advocates, etc.).

3.2 Legislative and Best Practice Context for Person-Centred Planning

The following key statutory instruments, national standards and policies and best practice guidance documents set out the context for and have heavily influenced the content of the Organisation's Person-Centred Planning Policy and Processes:

- The Health Act 2007: S.I. No. 367 of 2013, which places a requirement on organisations to have a timely comprehensive assessment and Person-Centred Plan in place for each person residing in a designated centre. The plan must be available to the person in an accessible format and reviewed annually or more frequently if changes necessitate.
- Health Information and Quality Authority (HIQA): National Standards for Residential Services for Children and Adults with Disabilities (2013)
- Health Information and Quality Authority (HIQA): Guidance for Designated Centres: Intimate Care (2014)
- Health Information and Quality Authority (HIQA): Guidance for Designated Centres: Restraint Procedures (2014)
- New Directions Review of HSE Day Services and Implementation Plan 2012-2016: Personal Support Services for Adults with Disabilities: Working Group Report (2012)
- Value for Money and Policy Review of Disability Services in Ireland: National Implementation Framework (2012)
- Health Service Executive (HSE): Standards and Recommended Procedures for Healthcare Records Management (2011)

- National Disability Authority (NDA): Principles of Person-Centred Planning (2014)
- National Disability Authority (NDA): Guidelines on Person-Centred Planning in the Provision of Services for People with Disabilities in Ireland (2005)
- Assisted Decision-Making (Capacity) Act (2015) commenced in 2016

3.3 St. Michael's House Policy Context

The Person-Centred Planning Policy and Procedures sits alongside and should be read in conjunction with a number of other St. Michael's House policies and procedures relating to the provision of services and supports to people (the following is not an exhaustive list):

- St. Michael's House - Safeguarding Service Users Policy
- St. Michael's House Positive Behaviour Support Policy
- St. Michael's House Records Policy (creation, maintenance, retention, destruction and access of records)
- St. Michael's House Risk Management Policy and Procedures
- St. Michael's House Policy on the Use of Restrictive Practices
- St. Michael's House Communication Policy
- St. Michael's House Admissions Policy
- St. Michael's House Policy on the Provision of Information to Service Users
- St. Michael's House Policy on Education and Learning

4.0 What is Person-Centred Planning:

Staff in St. Michael's House have a job. Their job is to help you to be the boss of your life. Their job is to support you to live your best life. Living your best life means that:

- You spend time with people you like.
- You do things that make you happy.
- You get a job if you want one.
- You go to college if you want.
- You are a part of your community and are respected.

St. Michael's House knows that every person is different. What you want for your life is different to what your friend want for their life.

Staff in St. Michael's House need to find out what you want to do in your life/ what your best life looks like. They need to find out what supports you to get what you want. They will find out by talking to you and your family and friends. They will help you to make a plan to get your best life. This is called person centred planning.

Person-Centred planning gets everyone to work together as a team. You are the most important person on your team. You are the boss. You decide who you want on your team to support you. Everyone works together to support you to get your best life.

5.0 Principles

Principles 5.1 - 5.6 below are taken from the National Disability Authority's Key Principles of Person-Centred Planning (2014). The additional principles guide the practice of Person-Centred Planning with persons availing of services from St. Michael's House.

5.1 Person-Centred Planning is planning from an **individual's perspective** on his or her life. The individual around whom planning is conducted and his or her wishes are taken as the single most important point of reference for the entire planning venture (after Mansell & Beadle-Brown, 2004).

5.2 Person-Centred Planning entails a creative approach to planning which asks 'what might this mean?' and 'what is possible?**'** rather than assuming common understandings and limiting itself to what is available. Person-Centred Planning aims to 'unpack' and understand what people desire and connect what is discovered with practical ways of making things happen for them (despite apparent difficulties) - e**xploring what is possible for them rather than simply what is available to them** (Frizzell, 2000).

5.3 Person-Centred Planning takes into consideration all the resources available to the person – it **does not limit itself to what is available within specialist services**.

5.4 Person-Centred Planning requires serious and **genuine commitment and cooperation** of all participants in the process. It may take some considerable time and effort to develop plans that are meaningful for the person let alone begin to realise these plans. Both the quality of plans developed and their final effects on the life of the person depend hugely on all participants (family, friends, service providers, advocates etc.) realising this from the outset and being prepared and committed to see the planning process through to fruition.

5.5 Person-Centred Planning is an art – not a science: It is best viewed as an **organic, evolving process** which emphasises: taking time to really get to know people and build relationships and rapport over time; encouraging open and flexible attitudes in all participants in the planning process; listening carefully, acknowledging and exploring various and, in particular, opposing perspectives; and responding creatively, practically and reasonably to what is heard.

5.6 The development of a plan is not the objective of Person-Centred Planning: making **real, positive differences** to someone's life is.

5.7 The person has **personal goals that are <u>important to</u> him/her** and the service has **support goals or plans that are <u>important for</u> the person**. The Person-Centred Plan is a bringing together of both sets of goals.

5.8 The **Person-Centred Plan belongs to the person** and is shared with and guides the service. All staff supporting the person contribute to achieving the person's goals.

5.9 Person-Centred Planning strives to promote and enhance the **person's involvement in his/her community and society**.

5.10 The **consent and involvement of the person** using services in his/her Person-Centred Planning Process is fundamental. The Assessment of Need and Person-Centred Plan are statutory requirements for the Organisation, however the wishes of the person regarding who their information is discussed with and what information is recorded in these documents should be fully respected. The All About Me process should only be undertaken with the full engagement of the person, preferably with the inclusion of others important to the person (his/her natural support network) identified in 'My People' in the All About Me. It should never be undertaken against the wishes of the person.

5.11 The **accessibility of information** for the person and **communicating in ways that are understandable** to him/her are crucial if people are to be involved in their Person-Centred Planning Processes in a real and meaningful way.

5.12 Person-Centred Planning is about **supporting and partnering** the person on his/her life journey. Using the services of an agency such as **St. Michael's House is only one aspect of the person's life and should never dominate the person's life experience**. The person's own goals and natural networks of supports are of primary importance. Service support goals should aim to be compatible with these. Person-Centred Planning is not about the service granting wishes or making dreams come true.

5.13 Person-Centred Plans are reviewed at minimum annually, but they are **not a static once a year paper exercise**. If the information they contain becomes irrelevant or outdated because of changes in the person's goals or needs, then the plan should be reviewed and amended as soon as possible to reflect these changes. The Wellbeing Outcome Review is the process whereby this is done.

5.14 Throughout the Person-Centred Planning Process, it is essential to uphold the principle of **positive risk taking**. Opportunities to take risks are a normal part of life. Experience of taking risks enables a person to participate more fully in life in the community. The rights of service users to make decisions in their own lives and to take risks must be respected.

5.15 **Person-Centred Plans should not be limited** by what the service currently knows how to do. Barriers to the person's achievement of his/her goals should be tackled with optimism, creativity and an open mind.

5.16 **Person-Centred Plans are collaborative:** Staff from all areas of the organisation work together to produce a person centred plan. The service user is the owner and director of the plan.

5.17 Person-Centred Plans are developed in line with the Assisted Decision Making (Capacity) Act 2015. St. Michael's House recognises that the person has the right to make decisions about their life and what is important to them.

St. Michael's House presumes that the person has the capacity and right to make decisions unless they have shown that they don't. People may have capacity to make decisions about some things in their life and lack capacity to make decisions about other things.

St. Michael's House recognises that people sometimes need support to make decisions. St. Michael's House will work with the person to agree what level or type of support is needed and who will provide the support.

Capacity

Capacity for decision-making is defined as the ability to understand, at the time the decision is being made, the nature and consequences of the decisions in the context of the available choices.

A person lacks the capacity to make a decision if they are unable:

- To understand the information relevant to the decision
- To retain that information long enough to make a voluntary choice
- To use or weigh that information as part of the process of making the decision.
- To communicate that decision in whatever way they communicate.

Any decisions that are made will be done in a way that does not restrict the person's own freedom and rights. Any decisions made will be in line with the will and preference of the person. The person's will and preference will always be prioritised over service goals and/or family wishes.

The Assisted Decision Making Act 2015 only applies to adults over 18 years of age. Parents or Guardians remain as decision makers for children unless they are a Ward of Court.

6.0 Definitions

6.1 Person-Centred and Individualised

Being Person-Centred means keeping the person and his/her preferences and goals at the centre of all service delivery, discussions and interventions. All organisational activity is guided by the wishes and needs of those who use the services. Personal Plans must be Person-Centred if they are to be legitimate, meaningful and effective. Being individualised means differentiating the supports and services provided so that each unique person who uses the services gets the specific supports and services that they wish for and/or require.

6.2 My People

In the St. Michael's House Person-Centred Planning Process the way to identify the people who are important to the person is part of the All About Me Process. The person will be supported to think about all the people in their life and explore their relationships with those people. This information will be recorded in the 'My People' section of the All About Me. This information is then used to identify:

1. The People who are important to the person and who he/she wishes to included in the Person-Centred Planning process. This group is typically made up people who know and care about the person and are available to help support the person to identify what they want in life.
2. People who may be able to support the person with achieving their goals. This group may be made up of the same people who are involved in the planning process already or they may be other people identified as the planning process progresses.

"My People" is equivalent to the concept of Circles of Support. Every "My People" group is different, because every person is unique. Some are long-term, with a consistent static membership, while others may be short-term or may have a frequently changing membership. This depends on the person's preferences and on what they want to achieve and who they wish to involve in their planning and goals.

While a person's "My People" group could include members of staff or other paid persons, groups should predominantly consist of unpaid friends and family members.

6.3 Person-Centred Planning

Person-Centred Planning is the process of discovering how a person wishes to live his/her life and what is required to make this possible (NDA, 2005). Person-Centred Planning involves listening, discovering, learning, documenting and planning. It is a Person-Centred, creative and individualised process. No process and no plan are exactly the same. Throughout the Person-Centred Planning Process , the person receiving services, together with his/her 'My People' and key staff members, discover, identify, learn and document what is **important to** the person and what is **important for** the person at this point in his/her life. The person, his/her 'My People' and key staff members then plan together by agreeing actions that will work towards the person's goals and that will enable him/her to receive the supports that he/she requires in life. Person-Centred Planning should help move a person's life in the direction he/she wants, build his/her place in the community and help the community to welcome, appreciate and value him/her (NDA, 2005).

6.4 Person-Centred Plan

The person's Person-Centred Plan is a document. It is the end product of the Person-Centred Planning Process. The Person-Centred Plan belongs to the adult using the services and it guides the work of all staff working closely with him/her. The Person-Centred Plan needs to be meaningful and accessible to the person, therefore it may not be suitable to have a lot of detailed information in it. Staff will still need to keep their own records of the detailed information. The way in which this information is recorded is outlined in the detailed guidance document for the planning process. There is an annual review of the Person-Centred Plan of each adult using St. Michael's House services. The person, member(s) of his/her 'My People' and identified members of his/her multi-disciplinary team are involved in this review. It takes place at am Outcome Review Meeting (see below). If the person's circumstances or needs change during the year, necessitating changes to his/her Person-Centred Plan, then an earlier Outcome Review is scheduled.

6.5 Accessible

Making information accessible means giving people meaningful information in a way that they understand. The regulations state that each Person-Centred Plan should be accessible to the person. The process of making something accessible will be different for every person in St. Michael's House. The person should be involved in the process of making their plan accessible. There are many different ways that information can be shared e.g. easy read format, lámh, video, sound, photographs, symbols, objects, sensory stories etc. For some people with more complex communication needs, information can only be understood in the actual situation. All staff working with each person should ensure that they have a good understanding of the person's preferred ways of giving and receiving information e.g. speech, lámh, pictures, objects, touch, body movements, etc.

6.6 Multi-Disciplinary

Multi-disciplinary is defined as involving the input of two or more staff members, coming from differing parts of the service, grades, disciplines or expertise. The membership of each person's multi-disciplinary team (MDT) is individualised and bespoke. It is determined by the person's wishes and needs. For example, one person may wish or require to only have 2 members of staff in his/her MDT e.g. a keyworker from residential and a keyworker from day; or a keyworker from day and one member of the cluster clinical team. Another person may wish or require a much larger team, with 2 keyworkers plus a number of clinicians from a range of clinical disciplines, from within and/or outside St. Michael's House services (e.g. nursing, psychiatry, medical, dietetics, psychology, social work, physiotherapy, speech and language therapy and/or occupational therapy). Membership of the person's multi-disciplinary team can change. A clinician who is very involved and relevant to the person's Person-Centred Plan one year may not be involved at all one year on.

6.7 Cluster Clinic Team

St. Michael's House has a network of cluster clinic teams; one for each cluster of services that is managed by a Service Manager. The cluster clinic team is a team of clinicians, consisting of representatives from a range of disciplines. The Service Manager and a Lead Clinician for the cluster convene monthly meetings, where any requests/referrals for clinical input for people who receive their supports from the services in that cluster are considered. Responses to requests depend on the person's support needs and may take the form of scheduling an Individual Coordination Meeting (ICM) where the person's clinical and frontline support needs can be discussed and an action plan agreed; or specific input from 1-2 clinicians on the team; or a meeting with the person using services and/or family, etc.

6.8 Support Plans

A support plan is a detailed plan for how care and supports are provided to a person in a particular area of their life. They are written and signed by the Key Worker / PIC and are reviewed quarterly. Support plans are prepared following Assessment of Need to guide staff practice in how to meet the individual service user's needs. Service users generally have a range of support plans, the complexity and number varying, depending on their level of support needs and the nature of the services provided to them.

Support plans should reference any clinical guidelines or good practice strategies that exist for the person. Support plans should not contain transcribed or summarised versions of clinical guidelines. Support plans may also reference any risk assessments in place.

6.9 Clinical Guidelines:

Clinical guidelines are written, dated and signed by one or more clinicians. They guide frontline staff on how to support a specific aspect of the person's health and wellbeing on a day-to-day basis. They are based on an individualised clinical assessment. They are written on a standard template and are signed and dated as read by the P.I.C. and frontline team.

Clinical guidelines are reviewed annually or sooner if things change for the person. In some cases it may be indicated at the end of the guidelines that they should remain in place longer than a year. Clinical guidelines remain current and should not be removed from the person's Green file (active file) unless they have been updated or directed by a clinician that they are no longer used.

6.10 Goals

A goal describes an intended result. Person Centred Planning Goals describe what the person wants to achieve. Goals should be important to the person and their achievement should make a meaningful positive difference in the person's life. Goals should encompass; what the person wants to do and where they want to go with their life. Goals should not be decided on the basis of resources or service provision. A goal without a plan is just a dream. It is important to have a plan to identify how to achieve goals.

Goals are not activities of daily living and are typically not health related.

7.0 Person-Centred Planning Process

The Person-Centred Plan is constructed from information gathered in two different but equally important processes:

a) All About Me (a person centred and accessible process) which results in goals that are **important to** the person

b) Assessment of Need (focused on supports required) which results in support plans that are **important for** the person.

7.1 The Person-Centred Plan

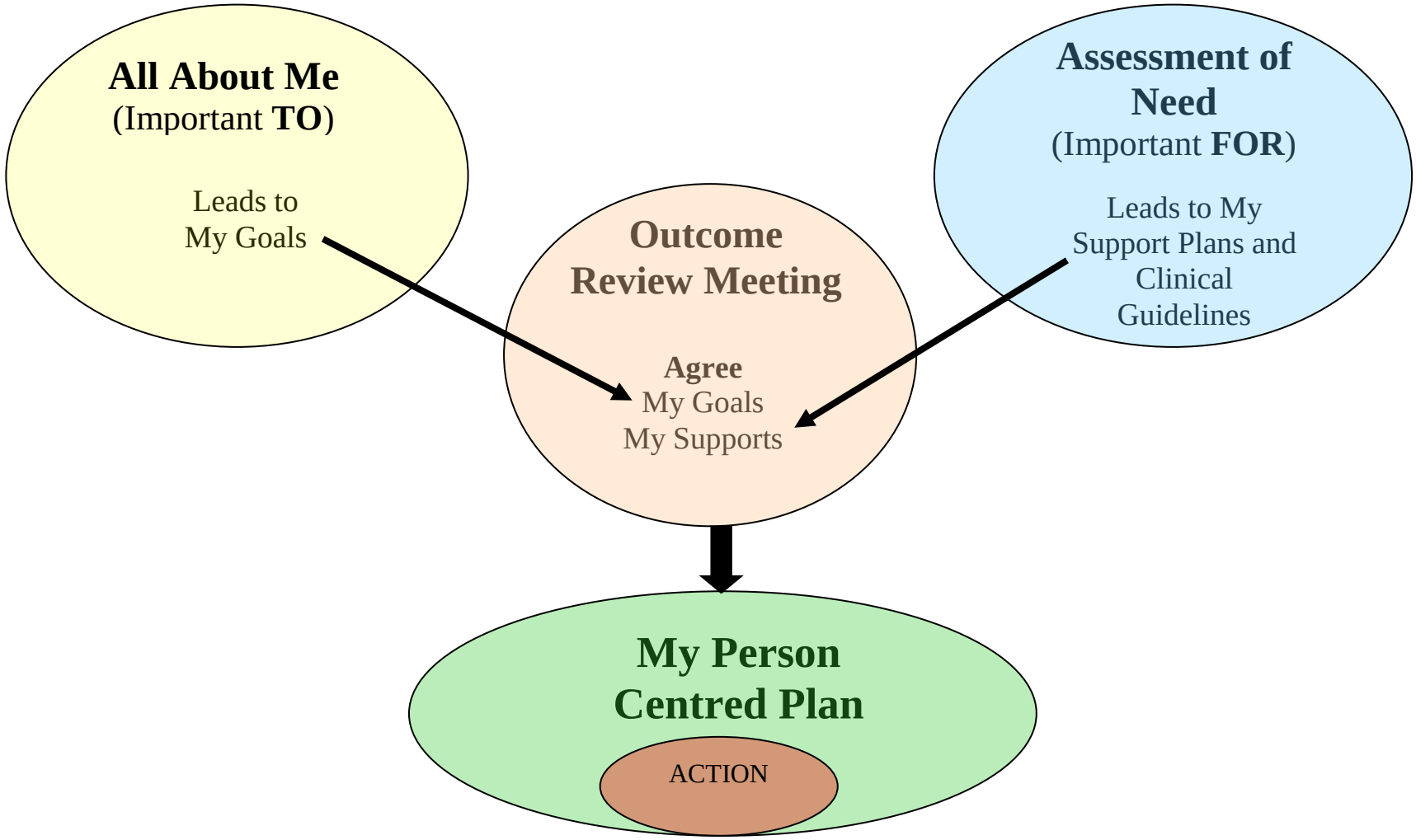
The Person-Centred Plan is accessible. It contains a summary of the key information that has been gathered from the All About Me process and Assessment of Need. The Person-Centred Plan consists of:

- Accessible All About Me
- The person's All About Me goals
- A list/ photographs of the members of his/her 'My People' and multi-disciplinary team
- An accessible account of the Outcome Review meeting in line with the person understanding.
- If appropriate, an accessible summary of the key elements of the person's support plans should also be included in his/her Person-Centred Plan. Note: This should only be included if it is possible to find a way of representing the summary of support plans that is meaningful and understandable accessible to the person.

The person owns his/her own Person-Centred Plan and can store it where ever he/she wishes. Staff may ask for a copy/photograph of the plan. Consent must be sought to take a copy of it and the person's decision in this regard must be respected.

A staff record of key information should be maintained separately, using the staff record sheet.

The Person Centred Planning Process



7.2 The 5 Stages of Person-Centred Planning

There are six stages in the St. Michael's House Cycle for Person-Centred Planning:

STAGE 1 **All About Me and My Goals**

STAGE 2 **Assessment of Need and support plans**

STAGE 3 **Outcome Review Meeting to agree actions to achieve priorities and goals.**

STAGE 4 **Working on the Person-Centred Plan**

STAGE 5 **Review of the Person-Centred Plan**

The Person-Centred Planning Process should follow the above 5 stages in a natural progression i.e. Stage 1, then Stage 2, Stage 3 etc, except in the following exceptional cases, where the order of the process may need to be changed, i.e.,

- A person is newly admitted to a St. Michael's House service (day/residential/respite)
- A person is moving between St. Michael's House services (day/residential)
- A person's needs have significantly changed from the last time his/her Assessment of Need and support plans were written

7.3 Facilitators of the Person-Centred Planning Process

- If possible and appropriate the person should be supported to be the facilitator of the Person-Centred Plan/ elements of the plan. The person may require significant support initially to do this but may develop the skills overtime. This should be supported and encouraged.
- A family member or member of the 'My People' group may be the facilitator of the plan/ part of the planning process. This should be supported if it is appropriate and in line with the person's wishes and preferences. The Keyworker must ensure the statutory requirements to have an Assessment of Need and Support Plans is completed.
- If a person lives in a St. Michael's House residential service, the keyworker from that residential service is the facilitator of the Person-Centred Plan.

He/she is responsible for supporting the person to develop the plan in close consultation with the person's 'My People' day service keyworker and multi-disciplinary team.

- If a person lives at home, the day service keyworker is the facilitator of the Person-Centred Plan. He/she is responsible for supporting the person to develop the plan in close consultation with the person's 'My People' and multi-disciplinary team. If the person is a regular user of respite services, a member of the respite team should also be consulted and involved in the process. A copy of all relevant information should be shared with respite staff with the person's permission.
- If the person lives in a non-St. Michael's House residential service, the PIC from the day service will make arrangements with and for the person to have a Person-Centred Plan. This might include working collaboratively with the residential service or developing a bespoke process for the individual.

7.4 Stage 1: 'All About Me'

The purpose of this process is to get to know the person in a new way. There are 8 themes to guide this work. The process is guided by the person and what is important to him/her. An All About Me is only undertaken with the person's permission, willingness and involvement. It is not compulsory for any service user to have an All About Me process if they do not wish to. In line with the Assisted Decision Making (Capacity) Act 2015, if the person does not have capacity to consent to undertaking an All about Me, his/her best will and preference should be taken into account.

All About Me is accessible to the person and belongs to him/her. It should involve the person's 'My People' and should identify meaningful goals for each person. All About Me is reviewed and updated annually or more often if required. The timeframe for achieving the person's goals is agreed with the person and his/her 'My People'. There is no minimum or maximum number of goals to be identified through the All About Me process.

When the All About Me themes have been reviewed with the person (and his/her 'My People' if available) there should be a record of what has been discussed and discovered. It may not be possible for all of this record to be accessible to

the person, as it may need to include detail that is not fully understandable to him/her. An accessible summary of the findings of the process should, however, be prepared with the person. The format of this could be anything that is meaningful and accessible for the person e.g. a scrapbook, poster, audio CD, DVD, photographs, objects or sensory story. The goals identified after this discussion and discovery process should also be recorded in a format that is accessible for the person.

At this stage the keyworker(s) will have used the All About Me process to develop a person centred description of the person's life. You should now have a good idea of the person's capacities and strengths as well as what is important **TO** the person.

You should now have an awareness of the things that are of real importance to the person whether these are places, events, people, activities or something else. You should then use this information to jointly develop goals that are meaningful and have the potential to have a positive impact on the persons life.

7.5 Stage 2: 'Assessment of Need' & Support Plans

The Assessment of Need identifies support needs and what is important for the person. Corresponding support plans will be developed to outline how to meet the person's needs.

The Person in Charge (PIC) of the service nominates a member of staff to complete the Assessment of Need with each of the people availing of services and to develop the corresponding support plans that will guide the actions and efforts of staff as they support that person. The decision of who to nominate should be based on the PIC's judgement of the complexity of the person's needs and the most appropriate staff member to complete the Assessment of Need and support plans.

The staff member will develop the support plans with advice and guidance from others as appropriate e.g. the person him/herself, family members, staff team colleagues, Person in Charge, clinicians. The preferences and consent of the individual regarding who his/her information will be discussed with must, wherever possible, be established and abided by. Some people supported by St.

Michael's House will be able to contribute information to their own Assessment of Need and support plans. This should be encouraged and facilitated.

When preparing to complete the Assessment of Need with and for an individual, the staff member responsible for the process consults with the person, family members and frontline, management and clinical colleagues in order to establish who the key members of the multi-disciplinary team for this individual are. In the case of each member of staff listed as a key member of the person's MDT, it should be identified whether his/her attendance at the person's Outcome Review Meeting is considered important to or for the person. Once the person completing the Assessment of Need has developed a clear proposal for the membership of the person's MDT, this is sent to the Service Manager and Lead Clinician for the person's cluster clinic team for approval.

Where there are clinical guidelines/plans or assessment reports in place or required to inform and guide the person's day-to-day supports, these should be referenced in the Assessment of Need and in the relevant support plans.

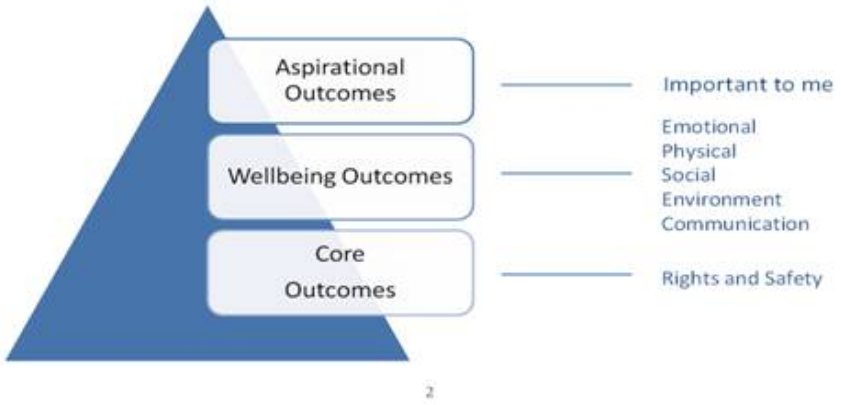
In some sections in the Assessment of Need, there are prompts for risk assessments or other assessments/tools to be completed. Whenever a need for an assessment or risk assessment is identified for a person, the staff member(s) or team completing the assessment should aim to support and empower the person to take positive risks. If there is tension between the person's life opportunities and the risks involved; the will, choices and preferences of the person must always be given primacy in the risk assessment. The approach must be: how can we support the person and help them to manage the risk so that they are comfortable with the level of risk they are taking. If there are urgent concerns about a person's capacity to make decisions, then the provisions of the Assisted Decision Making (Capacity) Act 2015 must be applied.

The Assessment of Need and support plans must be reviewed at least annually and more frequently if required. A person may have a short-term need for an intervention (e.g. an antibiotic, use of a splint because of an injury, medication to manage anxiety). Even a short term need such as these should trigger a review of the relevant sections of the Assessment of Need and the development of

support plans for the duration of the need. Where a person has changing needs that need a very quick response, an ICM should be called to agree any prompt changes necessary to the Assessment of Need and support plans. Any significant and/or lasting changing needs should prompt a full review of the Person-Centred Plan through the convening of a Outcome Review Meeting.

7.6 Stage 3: The Outcome Review Meeting:

Outcomes for people can be seen as falling into 3 categories, core, wellbeing and aspirational outcomes. These can be understood as what is fundamental **FOR** the person's safety and rights, what is important **FOR** the person in terms of their everyday wellbeing (wellbeing outcomes) and what is important **TO** the person.



An Outcome Review Meeting is held with and for each adult using St. Michael's House services on an annual basis, and also with and for those children living in St. Michael's House residential services.

The Outcome Review Meeting takes place after the completion of the person's All About Me and Assessment of Need. An earlier Outcome Review Meeting should be called during the year if there are significant changes for the person or concerns about any aspect of their wellbeing (e.g., change in health status, moving service, new behaviours that challenge or bereavement).

The Outcome Review Meeting has 2 parts:

- All About Me Review (Review of aspirational outcomes)
- Wellbeing Outcome Review (Review of core and wellbeing outcomes)

The two parts of the meeting may be held on the same day at the same time with the same people attending, or if the service user wishes to have each part of the meeting separate this should be supported.

What is the Purpose of the Outcome Review Meeting?

The fundamental purpose of the Outcome Review Meeting is for the person, together with those important in their life (termed as 'My People') and key members of their multidisciplinary team, to come together:

- to discuss and consider the person's overall wellbeing, goals and support needs.
- to review the person's previous year's Person-Centred Plan.
- to finalise the person's new Person-Centred Plan for the coming year.
- to agree specific actions necessary to achieve the person's Person-Centred Plan.

The purpose of Part 1 of the Outcome Review Meeting: All About Me Review

- To review, evaluate and celebrate achievements in the person's last Person-Centred Plan (i.e. review of aspirational outcomes).
- To think positively about how to work towards the person's All About Me Goals for the coming year.
- To agree actions to achieve the person's All About Me Goals, including who the service user wishes to support them with each action and when it will be done.

The purpose of Part 2 of the Outcome Review Meeting: Wellbeing Outcome Review

- To confirm that the Assessment of Need is fully completed and that all necessary Support Plans and clinical guidelines are in place and still relevant and appropriate and that the person is being supported to have the best possible wellbeing (i.e. review of core and wellbeing outcomes).
- To identify and highlight links between the person's aspirational outcomes (All About Me Goals), core outcomes and wellbeing outcomes (Outcome Review Meeting, including review of Assessment of Need, Support Plans & Clinical Guidelines).

- To agree and detail specific actions or additional supports required to support the person's core, wellbeing or aspirational outcomes e.g. changes to support plans, referral to clinical disciplines, etc.
- The staff record form should be used to record the minutes of the Outcome Review meeting.

7.8 Stage 4: Working on the Person-Centred Plan

Each person who has committed to carrying out an action at the Outcome Review Meeting should ensure that they work towards achieving it. All actions (big and small) to achieve the person's goals must be recorded. The keyworker should be kept informed of, and where necessary should actively seek information on, the actions taken and progress made by all involved in the plan, so this can be recorded on the Person Centred Plan Action Tracker.

The Action Tracker is reviewed monthly by the keyworker to ensure work on goals is progressing and to identify any additional actions required to overcome any barriers encountered.

7.9 Stage 5: Review of the Person-Centred Plan

The minimum requirement is that the Person-Centred Planning process is repeated annually with each person. There will be occasions when it is necessary to repeat the full process or elements of the process in a shorter period of time e.g. if the person's needs, health or life situation changes.

In such situations the Person-Centred Planning process will need to be revisited and reviewed, regardless of whether the changes are short-term or long term in nature. This is because the Person-Centred Plan must always reflect the current situation for the person.

The effectiveness of the overall Person-Centred Planning process and its outcomes are evaluated at the person's annual Outcome Review Meeting.

8.0 Relationship between Person-Centred Planning & Other

Meetings/Assessments

8.1 Individual Planning (IP)

The new St. Michael's House Person-Centred Planning process fully replaces the previous Individual Planning (IP) system that was based on 23 Personal Outcome Measures.

8.2 Individual Coordination Meetings (ICMs)

ICMs are brief action-focused meetings. They are the practical way in which frontline staff and cluster clinic team staff come together to coordinate their inputs. ICMs can be called at short notice (2-4 weeks) and are therefore a useful support to the Person-Centred Planning process as a way of responding quickly to the person's changing needs/circumstances. However, an Outcome Review Meeting, with the involvement of the person and members of his/her "My People" is required if and when a person's needs, preferences or life circumstances change to the extent that significant or detailed changes are required to the person's Person-Centred Plan.

8.3 Cosán

Cosán is a tool for developing/exploring aspects of the person's skills and how best to support these. It is specifically designed for use with people who have high and complex support needs. Information from a Cosán can be highly useful for the All About Me or the Assessment of Need and support plans. In some cases, a support plan could identify the completion of a Cosán as a follow-up action. Cosán is currently primarily used with people attending St. Michael's House local centres.

8.4 Clinical Assessments and Guidelines/Plans

Some people who avail of services from St. Michael's House may require clinical assessments and clinical guidelines/plans. Clinical assessments/guidelines/plans are listed in the record of the Outcome Review Meeting. Clinical guidelines/plans should not be translated / transcribed into support plans but should be referenced in and attached to the relevant support plans.

9.0 Management of the Person-Centred Planning System

Each person availing of services from St. Michael's House should have one single Person-Centred Planning Process, which identifies what is important to and important for him/her in all aspects of life and guides the supports provided by all staff, be they from day, residential, respite or clinical services.

Strong management of the Person-Centred Planning Process and creative thinking are essential to ensuring good outcomes for the people who use the service. Mangers, leaders and keyworkers at all levels in the organisation have responsibility to ensure that decisions are person-centred and that actions taken contribute to achieving what is important to or important for the people who use the services of St. Michael's House.

Organisational learning from the Person-Centred Planning processes enables St. Michael's House to stay closely connected to and to be led by the goals and support needs of those using the Organisation's services. This is supported by integrated communication systems and clear governance structures, as well as by an effective ICT system that enables recording, reporting and analysis to be carried out in a time effective and reliable manner.

10.0 Roles and Responsibilities

This section of the policy outlines in detail the roles and responsibilities of all involved in the Person-Centred Planning process i.e. the person, members of his/her "My People" group and the various designations and levels of staff and management throughout the Organisation.

10.1 The Person Using St. Michael's House Services will have individualised support to participate as much as possible in all stages of the Person-Centred Planning process and be responsible for some or all of the following:

- Thinking about the All About Me process and deciding if they wish to participate or not participate in the process. (See All About Me Guidance Document for more information on this).
- Identifying members of his/her 'My People' that will help and support the development of the All About Me and My Goals.
- Contributing (where possible) to the Assessment of Need and Support Plans.
- Agreeing with the keyworker, the details of the Outcome Review Meeting including who to invite, where it will be held, and what will be discussed.
- Attending, participating and contributing as much as possible in the Outcome Review Meeting.
- Owning the Person-Centred Plan.
- Working towards their goals.
- Discussing regularly with their keyworker and/or members of 'My People' the progress made on My Goals.
- Letting someone know if they are unhappy about any part of the Person-Centred Planning process.

10.2 Members of the Person's "My People" group will be supported to be involved in the Person-Centred Planning process, in line with the person's wishes. They will have responsibility for some/all of the following, in line with the person's wishes:

- Working in partnership with the person to develop the All About Me and My goals.
- Contribute to the Assessment of Need and Support Plans.
- Attending and participating in the Outcome Review Meeting. This may

include chairing the Outcome Review meeting if appropriate.

- Agree actions that they will undertake to support the achievement of the person's goals.
- Carry out the actions they have committed to and update the person/ keyworker on actions achieved.

Be an advocate for the person, representing their needs, wishes and preferences when needed.

10.3 Keyworkers have responsibility for:

- Supporting the person to be as involved as possible in all stages of the Person-Centred Planning Process.
- Listening carefully (through verbal and non-verbal cues) to the person's wishes/ views and preferences and respecting these views.
- Being an advocate for the person to ensure their wishes, views and preferences are understood and respected.
- Adapting the All About Me process to best suit the person's needs and preferences.
- Identifying what 'accessible' means to the person and ensuring that All About Me is recorded in an accessible way in line with the person's understanding and awareness.
- Linking with colleagues in other parts of the organisation at all stages of the Person-Centred Planning process.
- Keeping notes of information gathered throughout the All About Me process.
- Completing to a high standard the Assessment of Need and Support Plans.
- Sharing Assessment of Need and Support plans with colleagues from other parts of the organisation.
- Wherever possible, producing an accessible summary of the key elements of support plans and including this summary in the person's Person-Centred Plan, so that he/she is as aware of and informed about the supports being provided as possible.
- Preparing the necessary documentation for the Outcome Review Meeting
- Attending and being a primary contributor at the person's Outcome Review Meeting and supporting the person to participate as much as possible.
- Communicating with the person's 'My People' and multi-disciplinary team;

gathering information from them to inform the Assessment of Need and keeping them informed of the progress on All About Me goals.

- Recording all actions taken to achieve the All About Me goals on the Action Tracker form and updating support plans to reflect any changes or enhancements required. Wherever possible, progress on goals should also be recorded in a way that is meaningful and understandable to the person e.g. a video, photos etc.
- Ensuring all staff working with the person are aware of his/her All About Me goals and Support Plans
- Identifying actions required by self and colleagues to support the person's achievement of All About Me goals.
- Discussing with the PIC any difficulties/challenges identified as part of the Person-Centred Planning Process.
- Identifying their own support needs as they work through the Person-Centred Planning Process e.g. coaching, mentoring, training, skills development, experience in new areas.
- Supporting those using services to advocate for themselves and/or being an advocate for the person or referring the person to an independent advocate, as appropriate.
- Keyworkers and all members of the frontline staff team must sign clinical guidelines/plan that are in place or developed as a result of the Person-Centred Planning Process to indicate that they have read and understood them and that they agree to follow and implement the guidelines with the person.

10.4 Persons in Charge (PIC) have responsibility for:

Implementing the Person-Centred Planning Process in the service(s) they manage.

- Managing Peron-Centred Planning on a day-to-day basis in the service(s) for which they have responsibility.
- Ensuring the quality of person-centred plans in the service(s) they manage.
- Ensuring that each person using the service is allocated a keyworker to support him/her to work through the 6 stages of the Person-Centred Planning process.

- Nominating and supporting the keyworker or another staff member to develop the All About Me and All About Me Goals.
- Nominating and supporting the keyworker or another staff member to complete and document the Assessment of Needs, support plans and any associated risk assessments to a high standard
- Supporting keyworkers to ensure effective communication with colleagues in other parts of the organisation.
- Supporting keyworkers to identify barriers to achieving All About Me goals and to think creatively about how to overcome these barriers.
- Supporting keyworkers to ensure there is good communication between all members of the 'My People' and multi-disciplinary team.
- Identifying with keyworkers and the person, who the multi-disciplinary team for the person should be and bringing this to the Service Manager and Lead Clinician for agreement.
- Charing some/all of the Outcome Review Meeting or nominating someone to chair some/all of the meeting (this might include the person themselves or a member of his/her 'My People'). This allows the keyworker to be a primary contributor to the meeting or to support the service user to be a primary contributor.
- Nominating someone to take minutes of the Outcome Review Meeting.
- Reviewing and auditing the process for the people using the service and the progress achieved on Person-Centred Plans.
- Making referrals to relevant clinical departments or requesting ICMs for needs identified through the completion of the Assessment of Need or in response to the person's changing needs or circumstances.
- Seeking support and guidance from the Service Manager, clinical colleagues, members of the frontline team, peer Persons in Charge or others in the Organisation to identify creative solutions to barriers identified to the person's achievement of All About Me goals.
- Identifying if additional resources are required to support the person's achievement of All About Me goals and to identify creative solutions while continuing to develop and progress All About Me goals.
- Supporting proactive/positive risk management, including risk assessment and the implementation of risk control measures that support and work

towards the person's achievement of All About Me goals.

- Developing Person-Centred Planning in the service(s) and identifying trends/themes and areas of good practice that can be shared.
- Supporting keyworkers to identify what would support them to implement Person-Centred Planning e.g. coaching, mentoring, training, experience etc.
- The Person in Charge (PIC) or designated alternate signs clinical guidelines/ plan to indicate that they have read and understood it and that they agree to support the staff team to follow and implement the guidelines/plan with the person.

10.5 Clinicians have responsibility for the following, when relevant to their discipline, expertise and role:

- Contributing information to the person's Assessment of Need, as appropriate.
- Providing clinical inputs, plans and guidelines in response to a person's identified needs, with their agreement/consent.
- Where there are clinical guidelines/plans in place relevant to the Assessment of Need and Support Plans, these are produced, reviewed as necessary, signed and dated by the responsible clinician(s).
- Participating in risk assessment and the development of support plans, as appropriate.
- Committing, where relevant and feasible and if acceptable to the person, to act as a key member of his/her Multidisciplinary Team, who will attend and contribute to the person's Outcome Review Meetings.

- Attending the Outcome Review Meetings of those persons for whom they are a key member of their Multidisciplinary Team.
- Attending Individual Coordination Meetings where relevant and appropriate.

10.6 Service Managers have responsibility for:

- Supporting each PIC reporting to him/her to implement the Person-Centred Planning Process in the service.
- Supporting each PIC to problem solve and share good practice relating to Person-Centred Planning at cluster meetings.

- Ensuring Person-Centred Planning is regularly discussed at support meetings with each PIC.
- Identifying with each PIC, what his/her support needs are relating to the successful implementation of the Person-Centred Planning Process in the service e.g. coaching, mentoring, peer support, training etc.
- Reviewing, as part of the Annual Review of Service, how the Person-Centred Planning Policy is being implemented in each service in the cluster.
- Identifying what resources are required and what resources are available to support All About Me goals.
- Linking with the Lead Clinician to identify what clinical resources are required to support Person-Centred Plans.
- Identifying trends/themes relating to Person-Centred Planning in the cluster and identifying areas of good practice that can be shared.
- Managing the resources within the cluster to support Person-Centred Planning e.g. establishing peer mentoring within the cluster, opportunities to visit other services etc.
- Seeking support and advice from the Organisation's Person-Centred Planning Steering Group and/or other organisational quality and planning structures as appropriate.

10.7 Heads of Department/Principal Clinicians/Lead Clinicians have responsibility for:

- Ensuring that the work of all clinicians is integrated into the Person-Centred Planning process.

- Establishing systems for reviewing and updating clinical assessments /guidelines/ plans as required.
- Guiding the prioritisation of clinical work and the management of caseload demands in line with best practice.

Supporting clinicians to attend Outcome Review Meetings for the service users they know well and with whom they are currently working closely.

10.8 Directors of Service have responsibility for:

- Ensuring that the processes of Person-Centred Planning are established and

active in all of the Service Area.

- Supporting Service Mangers to think creatively and positively about Person-Centred Planning.
- Auditing the performance of Person-Centred Planning in the services of the Service Area.
- Identifying resource issues relating to Person-Centred Planning and supporting appropriate proposals for additional resources.
- Ensuring Annual Reviews of Services cover Person-Centred Planning.
- Identifying Person-Centred Planning activity levels, outcomes, themes and trends arising in the Service Area and reporting these to the Executive Management Team.
- Seeking support and advice from the Organisation's Person-Centred Planning Steering Group and/or other organisational quality and planning structures as appropriate.

10.9 The Executive Management Team has responsibility for:

- Overseeing Person-Centred Planning across the Organisation's services.
- Considering and analysing reports, received from Areas of Service, on the implementation and outcomes of Person-Centred Planning.
- Taking decisions regarding the commitment of resources to support Person-Centred Planning, as required.
- Directing policy and procedural reviews as necessary.
- Overseeing the Organisation's Person-Centred Planning Steering Group and/or other organisational quality and planning structures as appropriate.