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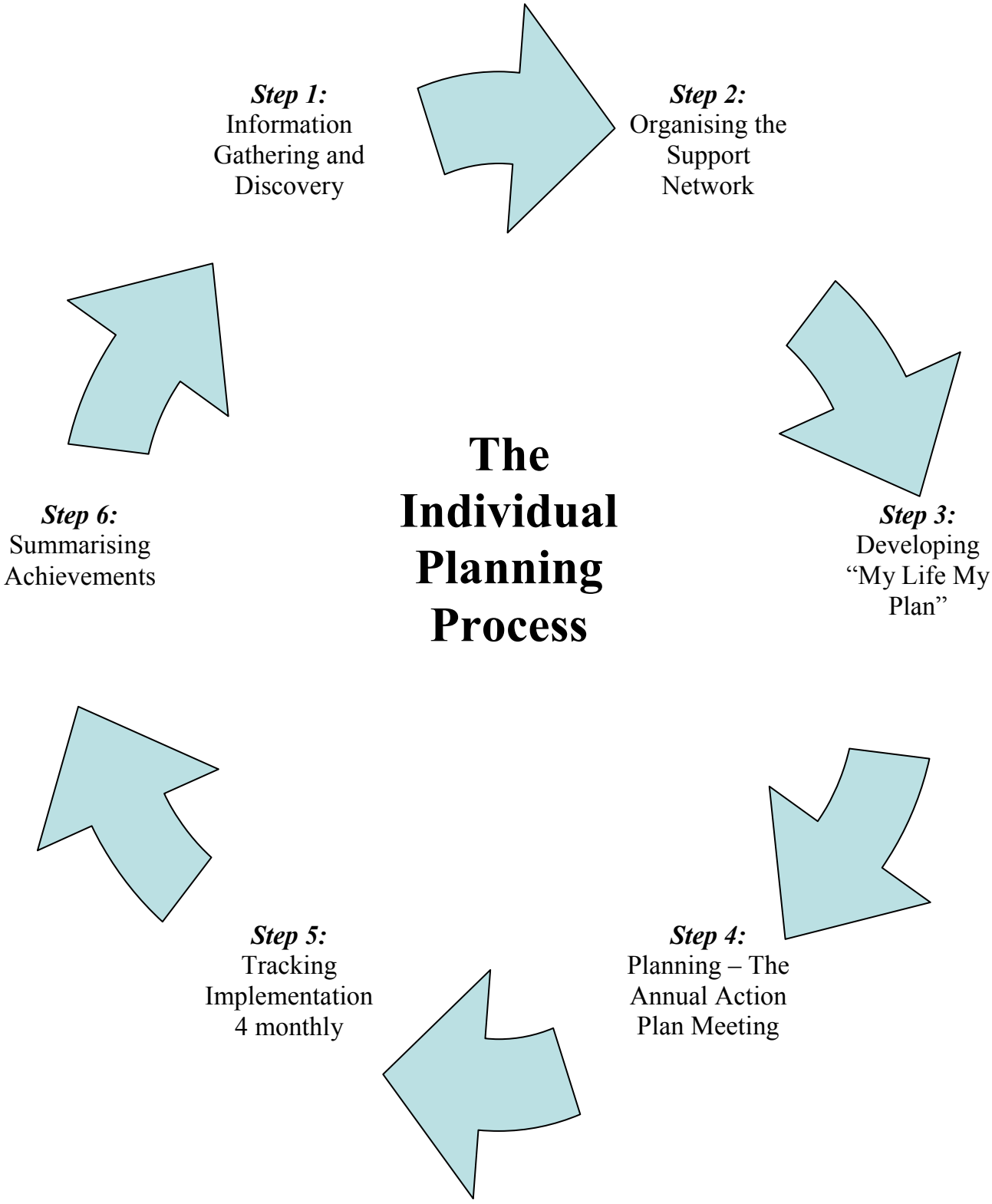
Annual Individual Planning Cycle



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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. Summary of IP Process

The Starting Point
The starting point is always the person. In most situations, the person is already very well known to the staff. Often, the person will be well able to tell their own story and to communicate about important parts of their life. The person's story about the past, what they have experienced in life, their family, their home and many of the other things in their past can be important in helping staff to understand what is important to them.

However, some people will struggle to communicate and it is important that their story is not lost and that the events of their life can be shared in a helpful way. This may mean there is a need to maintain a record of the person's story. Many things happen over the course of a year and many changes take place over the period of time people are supported. Staff may change, family members may move away, friends may develop different directions in life, a person's job or health may change, etc. Having the person's story told in a way that reflects and respects the person's style and identity can be a really important support.

It can help also when it comes to matching the Named Staff to the person. This is a really important support role and finding the right match is key. It doesn't mean that they are the person they have the most fun with. It is more about how they can advocate to support the person.

In this Individual Planning (IP) process, the Line Manager of the person's main service consults with them, their advocates and other services involved to select a Named Staff to coordinate the person's Individual Plan. The Line manager acts as a support to the Named Staff throughout the process of Individual Planning.

The steps involved in the Individual Planning Process for a 12 month period are:

1. Information Gathering and Discovery with the Personal Outcomes Framework
2. Organising the person's Support Network
3. Developing "My Life – My Plan"
4. Planning; holding the Annual Action Planning Meeting
5. Tracking Implementation at 4 month intervals
6. Summarising Achievements and Developing the next Annual Action Plan.

Preparation

1. Information Gathering and Discovery
This refers to the initial process of exploring with the person and those who know them best what is happening in their lives and how they are being supported. The Named Staff involves the person in a process using the Questions from the 23 Personal Outcome Measures to explore areas that are typically of importance in the lives of all people. The Information Gathering and Discovery ensures Named Staff will have a comprehensive and structured process to follow. This helps to be prepared and organised for the Action Planning Meeting with the Support Network /Circle. The Named Staff summarises the information they obtain from this preparation stage in the ***Personal Outcomes Summary Worksheet.***

2. Organise the Person's Support Network

The Named Staff explores with the person and those who know them best what the nature of their present Support Network is. This involves identifying who are the most important people in the person's life, what level of contact they have with them, what roles they play, what has changed over the course of the year, etc. Use the tools (Appendix 3 & 4) to review the person's Support Network. Discuss with the person who they might want involved in supporting them and in what way. The Named Staff contacts the members of the Support Network to agree their involvement. There is a communication plan (Appendix 5) to help organise the Support Network. Additional guidance for organising the Support Network is provided in Section 3 in this policy.

3. Developing "My Life – My Plan"

'My Life – My Plan' is a way of summarising the information in a simplified format which should be used to help include the person in preparing for the Planning Meeting. The learning that has come from the Information Gathering and Discovery process and reviewing their Social Network is used by the Named Staff and the person to develop "My Life – My Plan". This captures all the changes that have taken place in the past 12 months and describes the person's relationships, preferences, routines, activities and explores their hopes and their needs for the future.

4. The Planning Meeting; Developing an Annual Action Plan

The Named Staff and person meet with the Support Network to share the discovery process from the person's perspective using 'My Life – My Plan'. This involves creating a way for the person to share their unique identity and to place them at the center of the planning process. *This should be an open process, leaving room for the members of the Support Network to participate*. Often the process of sharing information will generate additional contributions and insights from members of the Support Network that helps create a more accurate portrait of the person. Having shared the person's information from 'My Life – My Plan' they now go on to discuss the themes and priorities that have arisen.

Following discussion at this Planning Meeting between the person, their supporters and the Named Staff, the key priorities are finalised and an ***Annual Action Plan*** is developed. This Annual Action Plan states what will be worked on for the next 12 months in broad terms and who will be responsible for different actions. The development of a more detailed short term plan of actions over the next 4 months will be assigned to the Named Staff to co-ordinate unless the Network wish to address this directly.

Therefore, unless a different approach is determined by the Support Network, in the *days immediately* following the Annual Action Planning Meeting, the Named Staff co-ordinates the development of a more detailed plan. This will state what will happen in the next 4 months using the ***Action Plan & Progress Update*** form. The Named Staff includes the person and the members of the Support Network in the development of the 4-month plan in accordance with the way they have agreed to work. This will not normally require a meeting unless the Support Network wishes for one.

5. Tracking Implementation

Every 4 months, the tasks identified in the ***Action Plan & Progress Update*** form is updated by the Named Staff. Members of the Support Network are involved in the Progress Updates based on how they have agreed to work together. Often this will involve a meeting with some or all of the Network. For others, phone / email / Skype contact may be enough. There may be a mixture of face-to-face and other types of communication. The purpose of this stage is to ensure the agreed actions are happening. Areas of progress are noted. Areas where there is a lack of progress are discussed to develop more effective solutions. The details of actions to be completed for the next 4 months are agreed and communicated. *While the Named Staff's role is to co-ordinate the planning process, the Link staff in other WCA services are responsible for communicating proactively with the Named Staff about relevant information.*

6. The Annual Planning Cycle

At this point in the Individual Planning Process will have completed its first Annual Planning Cycle. It is time to summarise the achievements of the previous 12 months and to plan for the year ahead. *The stages of Individual Planning are now repeated.*

To prepare for this, the Information Gathering and Discovery process using the Personal Outcome Measures is revisited by the Named Staff and the person. Changes in the person's circumstances are identified and the person's information is made current. Gaps in information are addressed when these are identified. The Support Network is reviewed again to see if anything needs to be done to address changes. "My Life – My Plan" is completed again to reflect evolving priorities and to prepare for the Annual Action Planning Meeting.

The Support Network meet to review the accomplishments of the last 12 months and to determine what progress has been made on the previous Annual Action Plan. The Annual Action Plan for the next 12 months based on the person's priorities is agreed.

The Line Manager supports the Named Staff at each stage and reviews the Annual Action Plan and Medium Term Plans to support solutions and to ensure the Named Staff accountability for agreed actions. The Line manager uses individual planning information for all people in their area of responsibility to plan services and to inform service developments.

An example of the sequence and the timeframes for the process of preparation, planning, tracking implementation and summarising is presented in Section 5 'Keeping Track'.

2. 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

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 every day 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 section of the policy provides some general guidance about issues that frequently arise in discussions about 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*.

However, not everyone wants an individual plan that looks the same as other people's. They may not want to have a formal Individual Plan as part of their lives. *The reason we have plans are mainly because people need support to make things happen and they need this to be done in a way that is organised*. If people can make the important things in their lives happen without being involved in a process they feel is too formal, intrusive or just not to their liking then we need to respect and honour that choice.

At the same time, this does not allow us to avoid engaging with the person in a way that addresses our responsibilities as providers of paid support. We have to remain accountable for the way we provide that support where it is required. There are a variety of ways to do this without using the Western Care Individual Planning process. However, we are obliged to follow the same *principles* of being person centred, of listening to the person, their advocates and those who know them best and responding in a way that is helpful and focussed on the person's priorities.

Where the person does not wish to use this system, the staff must engage with their manager to ensure the approach they are using as staff meets their obligations.

As staff we need to keep a record of the agreements we have with people and the work we undertake to support them. Some people have developed their own approach to how they engage with support from Western Care staff. When these situations have arisen the staff have responded to the individual situation and developed a process that works for the person but also meets their obligations as staff. One example of this is where staff developed a detailed contract with the person about the areas they needed support in and what staff were committed to do in facilitating the person to meet their priorities.

In summary, 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 be developed based on what we know 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 a clue 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. Developing a vision with the person may take time. The person's supporters may not have any clear idea of what is possible either.

The role of the Circle is to work together to help the vision to emerge. They focus on the person's strengths and capacities. 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 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.

3. THE PREPARATION PROCESS

Complete the Information Gathering with the Personal Outcomes
Using the *Information Gathering Questions* from the comprehensive framework of the 23 Personal Outcome Measures (Appendix 1), the Named Staff should involve the person in exploring how their life is at present and how things have been going and in the last year. Explore how well they are being supported. Engage with the members of the person's support network to ensure their input is obtained. Summarise the information using the *Personal Outcomes Summary Worksheet.*

This process involves a thorough exploration of the way the person is experiencing life and how effective the supports are. This process is based on the Personal Outcome Measures which give us a consistent and in depth method. By asking challenging questions about those things that are typically important in any person's life we try to come to an honest picture of how well things are going from *the person's point of view*. This includes how they are experiencing supports and services and whether these address the things of importance for the person. This is the essence of a Person Centred Approach.

Depending on how much the person can contribute and how well the Named Staff knows the person's family and other circumstances, it may be relatively straightforward to complete the Information Gathering and Discovery process. However, it may show there are gaps in our knowledge which would require contact with others to bring the person's information up to date. *In addition to the knowledge supporters have about the person, good record keeping and appropriate sharing of records will facilitate an informed process.*

Contact can take place by phone in most instances. Meetings should not be called to complete an Information Gathering and Discovery process unless this is a new person or is their first time being involved in comprehensive Individual Planning. Sometimes the person's situation will be so complex or will have changed so much in the course of a year that it may be necessary to hold a meeting. However, in general, this stage will be completed as a preparation for the Action Planning Meeting.

Information Gathering and Discovery is a continual process and does not have to be limited to the formal stages in the Individual Planning Cycle. People change through experience, learning and through alterations in their personal circumstances. Informal discussion and exchanges with people may reveal information about goals and preferences that did not initially emerge in the formal Information Gathering Process. The Support Network needs to remain alert to these changes and to be ready to respond by altering plans if need be. However, these alterations need to be included in the records which represent the evidence of work by the Network and also provide essential communication between members.

Review the Social Network
As part of the process of preparing and updating the person's information, the named staff should use the tools provided (Appendix 3 and 4) to review the person's social network with them. This process is more fully described in Section 3, Social Networks.

Complete "My Life _ My Plan"

Finally, when the person's information has been updated with the Personal Outcomes questions and the Social Network tools, the Named Staff should assist the person to complete "My Life – My Plan". This is a useful way of summarising all of the information that has been gathered. By completing "My Life – My Plan", the person with the support of the Named Staff can ensure that the information is pulled together in an easily shared format in preparation for the Action Planning Meeting with the Support Network/Circle.

"My Life – My Plan" has a number of sections. The first section "About Me" includes space to tell the person's own story, the important things in their past, their friends and family and important aspects of the person's history and identity. It is basically a way to help the person to share helpful information with others whose support they require.

Some parts of the section "About Me" will not change as their life progresses. Certain basic facts such as when the person was born, where they were born etc will always be the same. Almost everything else is subject to the possibility of change however. Family members may become ill or deceased, friends may change. The person's communication preference and style can also be subject to change for example as a result of them having a new communication system. The same is true of their strengths and positive qualities which can change due to having a new job, new friends and more confidence.

4. SOCIAL NETWORKS

Social Networks and their Potential and Importance

All of us are involved with people who we meet regularly and relate to in various ways for different kinds of reasons. Our connections with the people we know depend on the nature of the relationship and the type and frequency of interaction we have. This pattern of connections is referred to as our social network.

Some people in our network are very close to us such as family and friends. We may have close relationships to work colleagues or those that share common interests and pursuits. We may also have connections to people who we rely on for support in particular areas of our life. Other people we know are more casual acquaintances, people we may meet occasionally or have occasional dealings with.

The boundaries of these relationships within our social networks are not fixed in stone. Acquaintances may become friends. Colleagues may become spouses. We may fall out with friends, etc. Issues of choice and equality of power are also important features in our social network.

However, the key thing is that each of us to some degree has a social network and the nature of this network is an extremely important factor in the way we live. The quality of our lives depends very strongly on the quality of our relationships. Isolation is associated with many poor life experiences.

In David Pitonyak's article "The Importance of Belonging", he quotes the writer Willard Gaylin who states; "To be vulnerable is not to be in jeopardy. *To be vulnerable and isolated is the matrix of disaster*". Instinctively, we can see the truth of this.

Most of our support networks evolve naturally and develop over time into a pattern of connections we can depend on. Many of these connections and interactions are informal. Sometimes they are highly formalised. We are all involved in significant efforts to formally organise events in our social network. Weddings, christenings, anniversaries, graduations, reunions etc represent a few examples of formally organised actions within a social network.

Social networks can be organised to act on behalf of the person when they need some support. It can be as simple as a neighbour minding your house while you are away for a holiday. It could involve a network of family and friends looking after an elderly relative who needs support to live at home.

For people with disabilities, social networks are often small. Often they involve few people other that family and paid staff. There may be many different reasons for this. However, the importance of social networks is they can offer a source of organised support if they are nurtured. They can also be expanded over time if we set about it purposefully and with care.

Our challenge is to be deliberate and purposeful in nurturing social networks that draw on the wider life outside the important but sometimes constrained world of service provision. When we really see the value of people connecting with others we will nurture this. If we do not see the value of this we will miss opportunity.

Developing and Strengthening Support Networks
The starting point is to understand the person's social network, to look for potential and opportunity and to nurture this to become *an active support network*. The most common way of organising a support network is to form a Circle of Support, although it is not the only way.

Networks/Circles of Support
The term Circle of Support is simply a convenient way of describing how a person's social network becomes organised. *Circles actually come in all shapes and sizes.* It is important not to get too stuck on the term. *For our purposes, we will use the terms Support Network or Circle of Support interchangeably.* It is more important that the arrangement delivers the support for the person.

An active Support Network or Circle refers to the people who the person wants and needs in their life to help them achieve those things that really matter to them:

- To learn about and address basic safeguards such as health, rights, safety and security
- To learn about and do what is important in their everyday life
- To learn about and provide a sense of belonging, inclusion and achievement
- To learn about and work towards their hopes and dreams for the future.

Characteristics of a Support Network/Circle
A Support Network/Circle contains the people who know the person best, who understand what the person has to offer and who are committed to supporting the person.

A Support Network/Circle has to find a way to work and communicate together so they can act effectively to support the person.

A Support Network/Circle is a powerful way of mobilising the person's informal and formal supports network. This can include family, friends, neighbours, community members and advocates as well as staff. A Support Network/Circle should bring together the people who the person feels can help them most.

The work of the Support Network/Circle helps to develop a vision for what the person's life might look like now and what it might become in the future. It seeks to discover sense of direction based on the person's unique voice. This is equally true for people who do not communicate with words. One of the really key roles of the Circle is to be a powerful listening forum.

The Network/Circle learns what is most helpful in supporting the person to pursue their hopes and dreams through deep listening, planning and taking action.

The Network/Circle is a rich source of connections to others and acts resourcefully to broaden the person's network.

The Network/Circle is a way for the person's support network to listen and to communicate with each other.

Support Networks/Circles come in many different varieties. They can involve many or few people. They change and evolve over the course of their natural life.

Membership of Support Networks/Circles
Typically, a Support Network/Circle will have an agreed membership that meets on a regular basis and communicates with each other between these meetings. Some Circles are very informal, do not keep any records and do not set agendas. There may be no staff involved. This type of informal Circle is known as a Circle of Friends. Members are unpaid although they may use a paid facilitator.

For our purposes in Western Care and our accountabilities as an organisation, we are required to have a degree of formality in the style of Support Networks/Circles we develop.

A Support Network/Circle typically includes the person and some of their family members as well as the Named Staff. Other people may come on an *ongoing* basis e.g. friends, community members. A manager may participate or if there are staff from other services who have a very strong role in supporting the person, they will also be members. Very often the person attends two main services e.g. residential and day services and in these situations there will be a Link Staff assigned to liaise with the Named Staff to ensure there is the necessary level of communication and sharing of information, records, etc required to provide effective supports. Other people and staff members who play a significant role in the person's life for a period may be invited to attend one or a number of meetings for a specific purpose.

It is essential to ensure the person and their family members feel they are empowered in the Network/Circle. It is not intended to be a process directed by the staff in which the person or their advocates are passive participants.

The Network/Circle is supposed to operate on the person's terms in a ***partnership*** with informal supporters and staff. The person and their advocates need to feel it works for them.

The membership of the Network/Circle should include any friends and advocates the person wants to be present. The more people from a non-organisation perspective, the stronger the balance in the Circle.

Frequency of Meetings
A Network/Circle should have a core of regular members and should meet at regular intervals. These meetings may take place quite frequently in a very active Network/Circle. The expectation in Western Care is that there will be a meeting of the members at least every 4 months. While staff are required to commit to this expectation, the position of unpaid supporters may be different.

Although a regular meeting of the members is the strongest practice, some really strong advocates for the person may not always be available to attend face to face meetings. Also, there are times when family members or others who would play a strong role in the person's life do not enjoy formal meetings or will not commit to them on a regular basis.

However, there are alternatives to face-to-face meetings. There can be technology based options such as Skype that help overcome practical issues of distance. However, that may not always offer a solution either. Working out solutions that keep the right people involved and informed will often be a matter of being creative around individual Support Networks.

There will also occasionally be times when people do not have anyone other than staff who are involved in their lives. In these situations, we need to try to look for opportunities to expand the person's social contacts and explore how this might be deepened over time so that the possibility of unpaid participants in the person's Support Network may emerge.

Typically, a Network/Circle will need to be meeting once every 4 months to review how the Action Plan is progressing. Ideally, this will include all of the people in the Support Network. If this is not possible for all members we would ask them to commit to meeting as a Circle at least once or twice a year with communication by email and individual contact by phone, Skype, etc taking place in the interval between face-to-face gatherings.

The members of the person's Support Network may have different types of availability and may want to contribute in different ways. The key thing is for the people in the Network to agree what way they will become organised to be of help. This becomes the heart of the Individual Planning process.

Summary
It is essential that we try to grow the Support Network and organise strong Circles of Support where possible. Where this is not possible, we need to organise the Support Network so that it is connected and that the people who care most about the person can contribute in the best way possible. *This must go beyond a staff-led, programme-based Annual Review meeting.*

Using the Tools to Review a Person's Support Network
There are two tools to assist you to look at the person's Support Network so that you can be clear about the strength of this. The first tool ***My Social Network*** (Appendix 3) helps to show who is in the person's social network and the different roles they might play.

Just as in all of our lives, we know some people who provide practical support but they are not the ones who you might turn to first for emotional support as that is not how they respond to need. On the other hand, if you need to get something done they may be the very person you want in your corner.

When we explore the people in a person's support network, it can turn up an amount of detail we may not have been aware of simply because we never looked at it this way. It may not be news but it could still be a surprise. We look at how many people are in the person's network and how close they are, how long they have known each other and what roles they usually play.

My Social Network provides a list of people who may or may not be actively involved in a more formal support arrangement such as a Circle of Support.

The second tool is ***My Social Network Map*** (Appendix 4). This shows the relationships between the person and those in the Circle of Support. Quite often, it might be the case that the only people on the Circle of Support will be the family members and staff. This Map helps make it clear.

When we look at the people in someone's life as described in My Social Network, we might see that they know many people who are not involved in a Support Network/Circle who could play a part.

It may equally be clear that the person has very few social contacts and lacks a strong support network. For some people, even the act of sitting down and identifying the nature of their Support Network can be the start of rethinking how we are supporting the person and how we might help them to connect with others. This is true for anybody. It is not about whether they use words to speak or have certain abilities. It has been shown time and again that people can make connections in the most surprising and unexpected ways. The first point is to understand why it is important to the person. The next is to learn about their support network and then it is a case of exploring what will be most helpful to the person.

Once the mapping exercise is done, ask the following questions:

- What is the nature of the person's support network at the moment
- What does the person get from it at the moment
- What does the person need from their support network
- What role can the person play in expanding their support network
- Can they do new things that connects them with others in their neighborhood or community
- How can they play a helpful role
- How can they contribute to the lives of others
- Are there other people who would be willing to play a stronger role in their support network than at the moment
- How would we approach someone
- Who would be the best person to do this
- Are we asking them to play a formal role or just to increase the nature of the role they play now? For example we might just ask them to be a helpful neighbour
- If we are asking them to play a formal role then what is that? Is it as a member of a Support Network/Circle? An advocate
- If we are asking them to play a formal role is everyone on the current Support Network/Circle on board with this idea.

Calling the Support Network/Circle Meeting
The preparation work has now been done. The Named Staff works with the person to arrange to meet with the *people they would want and need to support them* to do what is important in their everyday life, for their future hopes and dreams and also for those basics that keep people's rights protected.

The person should be given as much responsibility as possible for organising the meeting. However the Named Staff should ensure that the person is supported to have a successful arrangement. They should try to arrange to meet at a location that is private and at a time that suits the people involved. They will need to agree with the people what the meeting is about if they are new.

The person can say who they want to be at the meeting and what they would like to be discussed. The Named Staff explores with the person and their Support Network how they will organise their arrangements so that it will be of the most help to the individual. This will address how meetings will happen, how often, who will attend, who will call the meeting and what other communication arrangements will be put in place, etc. An initial meeting of the Support Network is then arranged to agree a vision and to complete an Annual Action Plan.

Changing Familiar Practices

Most Networks/Circles are not new and some are very well established. However, many of them consist only of a family member and a number of staff with the person sometimes not present. These Networks/Circles may have met a couple of times a year or on an as needs basis but do not have a regular arrangement. While they represent a process for Individual Planning they may not have the more organised and intentional characteristics of a Network/Circle. Asking people to commit to a more regular arrangement may not be the place to start.

Start by asking people to share their ideas on what is going well for the person and what might be some other things to focus on over the next year. Ask the person to share the results of the Information Gathering and discuss what came up in the process of preparation using the information that is summarised in 'My Life – My Plan'. If the person struggles with this the Named Staff should help present the important issues that came out of the preparation stage.

Look for discussion on the points that have come up. Ask people to think about the person's future and if this will be the same as the past. For example ask if the person's future will be the same in 5 years time as it is today. This often opens the conversation up to possibilities that have not been previously discussed. People may have had thoughts or even dreams but these may not have been shared together in this way. Keep it directed to the person. Check with them at each stage. Make sure they remain at the center of the process even if they are not verbally contributing or even if they chose not to be physically present for part or all of the meeting.

Discuss the nature of the person's social connections and the support network. Ask people to consider how others might help the person move towards the future they want. Ask how these people can be included in those considerations.

Some additional points to consider in preparing for the meeting:

- Who will be involved? Who would the person want there? Who is important in their life? Who needs to be there? Strongly consider who attends the meeting, the numbers present and the balance of paid/unpaid support present at meeting

- How will a relaxed and informal atmosphere be created at meeting? How will the meeting be set up so there are no prior associations with meetings that people have previously experienced. To create a different way of working then it helps a great deal if the set-up is different than any previous experiences person has had

- Location of meeting. Consider venue where people have no prior associations and can be most relaxed, a place where people can freely talk and express themselves – the person and family may prefer to have it in the family home

- Invitations – Who invites people to attend? Can the person themselves do it? If not, how do you ensure it comes from person's perspective?

- Before the meeting – What is the purpose? What will be discussed? How will this be done in manner which allows for everyone to participate and keeps agenda focused on person's wants and needs? How will the person participate or have a meaningful presence?

- Consider refreshments / length of meeting / managing discussion / what contributions would be useful from people / how decisions will be made, etc

- How will a record of the key points be agreed? How will the record of the meeting be shared with the relevant people?

Agreeing the Social Network Communication Plan
The Network/Circle will have 4 formal communications each year. This includes the Annual Planning Meeting at the start and end of each 12 month period. There will also be the Action Plans & Progress Updates every 4 months. In addition to this formal schedule of meetings/communication, different members of the Network/Circle will be in contact with each other at different times. This may involve phone calls, emails, Skype or other types of communication. Therefore, the Named Staff needs to develop a communication plan with the Network/Circle so that members are clear about how they will communicate.

It is important that the members of the Circle take responsibility for whatever communication is agreed to be necessary. The Link Staff from other Western Care Services is responsible for communicating *proactively* with the Named Staff. Communication is a two-way process and it must not be simply left to one member, i.e. the Named Staff to follow up on the progress of agreed actions.

The fact that there are set times for formal communication every 4 months should facilitate good general communication in the Circle or Network**.**

The person's Priorities are agreed at the Annual Action Planning Meeting and a record of the agreed actions to achieve these priorities is shared with the members. This becomes the reference point for more detailed *Action Plans and Progress Updates*. Every 4 months there is a meeting or a process of formal communication which is coordinated by the Named Staff to obtain input from the members about progress on agreed actions and to set new actions for the next 4 months. Typically this is best done in a face to face meeting between members of the Network/Circle. However, alternative arrangements and accommodations should be made to facilitate the inclusion of people who are important to and for the person.

The plan is written up in the ***Social Network Communication Plan*** (Appendix 5).

5. DEVELOPING THE PLAN

Keeping the Person at the Centre of the Planning Meeting
Before the Action Planning moves into decision mode, it is important to pause and take stock. A lot of information has been gathered in the preparation process. It is important to now try to keep the person's voice present and clear *so that somehow this is not lost among all the details.* In many cases, the person may struggle to communicate in a meeting situation. Even with all of the preparation that has been done, the person may become passive in the process.

Even if the person chooses not to be present, it is essential to try to ensure the planning process is directed by their own unique personality. Their identity should guide the spirit of the process. This is what Person Centered Planning means.

'My Life – My Plan' provides a way of involving the person or at least in representing them in a way that reflects their identity. This tool provides an opportunity to reflect a picture of the person's life and how they are finding things at present, what is important to them now and for the future, what they love to do, who they love to be with, where do they love to be, what people like about them, what contribution they make. What is unique about them.

Discovering the positives in the person and in their life is an important stage in the process of Individual Planning. This is an opportunity to be creative and to support the person to represent their story in a way that reflects their unique identity. Find out if using pen pictures, drawings, photographs or any other means helps the person to express their situation and helps them represent their life and the important things for them. Involve the person and the Network/Circle members in finding the best way to describe the person.

'My Life – My Plan' describes what is important for others to know about the person so they have a sense of who this is, what they want, what they need and what their hopes are.

Developing the Action Plan
Using "My Life – My Plan" as the basis for helping the person to participate actively the process of Action Planning can now begin to become specific and to state some details of the priorities and goals for the person and the actions required to achieve these goals. The Plan will address the whole person in the areas of their safeguards, their daily choices and sense of belonging and their hopes and dreams for the future. Be careful to look for a balance in the Plan. The plan is written up in the ***Annual Action Plan*** (Appendix 6).

A *balanced* plan will consider:

a. The essential safeguards in a person's life to address any vulnerabilities in the areas of Health, Rights and Safety and Security. Whether the person has routine needs or major considerations will depend on their situation but these areas need to be considered and not forgotten.

b. The day-to-day life of the person:
   - What they do all day, where they do it, who they spend time with
   - What does a week look like, how do we know; is there a planner or schedule they use to help organise their week
   - Does every week look the same
   - Does the person spend most of their time with the same people

- Do these people have a disability
- Are all these people paid supports
- Does the person spend most of their time in one or two places
- How much time does the person spend in the community
- What would help the person to learn new skills to do things that interest them
- What way do they learn best
- What have they learned before.

c. Hopes and dreams for the future:
    - Does the person have a clear identity or is this a bit lost by the nature of their environment
    - Does the person have any hopes or dreams
    - Are there things about the person's future they need help to explore
    - Is the future just a continuation of the present and the past
    - Is there anything that they would love to do.

If there are no dreams or hopes that are known, where would we start to explore this possibility? A balanced plan will show that thought has been given to safeguards, everyday life and future hopes and dreams. A good way to measure this is to look at the emerging plan and to see if it leaves big gaps in the person's life.

Plans that are just about safeguards are very limited and suggest no expectations beyond basic safety and wellbeing. Plans that are all about the future may be aspirational unless it is strongly grounded in things that can start to be done in the here and now.

Life is also lived here and now so this needs to be a strong part of the plan. Things people enjoy may have little or nothing to do with the future or with big life decisions but it is important to have fun, achievement, freedom and incidental opportunity also. Having a plan for a period of time such as a typical week helps show if the person is actively engaged in things they like to do, with people they like to be with and in places they enjoy.

One useful test of how comprehensive the plan is would simply involve looking at how much time is addressed in the plan. For example, a person using day and residential services may have a medical appointment every month for a particular health priority, they may meet with family and relatives on special occasions 4 times a year around a Natural Support priority, they may spend an afternoon in town on a work experience as a Chose Work priority and they may go shopping for groceries once a fortnight. These are all legitimate priorities and activities but when you add up the time it takes in their lives spent on doing these, it would look pretty thin compared to the amount of time they receive supports.

There are 365 days in any given year. From 8.00am to 11.00pm each day there are typically 14 or 15 hours of being awake. That adds up to about 100 hours a week. If the Individual Plan tasks address on average 5 hours out of 100 hours of their lives each week, then it has to be asked what is happening with the rest of their time.

This is not at all to suggest that people need to have plans for every waking hour. That would, in fact, be intolerable to most people.

It does, however, pose the question - what is the person's time spent doing, with whom and where? How are we organised to support the person? That simple calculation asks us to think if we have a tick box plan or something deeper.

6. KEEPING TRACK

A more detailed plan of actions will be developed by the Named Staff in collaboration with the Network in the *days immediately following* the meeting which will focus on the specific actions that should be completed in the next 4 months.

This is done by the Named Staff using the ***Action Plan & Progress Update*** form (Appendix 7). There are 2 parts to this form. The first part contains the details of the actions in the plan to be taken for the next 4 months. The second section contains the Progress Update which is a record of what has been done to implement those actions stated in the plan.

The plan which is *completed in the days immediately following the Annual Planning Meeting* will set out the details for the 4 months following the Annual Action Planning Meeting. As it is the first stage, there will be no need to complete the Progress Update section of the form until 4 months have passed.

After 4 months have passed since the development of the first Action Plan, the Progress Update section is completed by the Named Staff in discussion with the Network/Circle. The Actions for the next 4-month period are also agreed at that point.

This will be reviewed and updated every 4 months over the course of the 12-month period involved in the Individual Planning Cycle year. After 12 months, the Annual Individual Planning Cycle will commence again. An example of the sequence could look as follows:

- **Preparation Sept 2013** - Complete the Information Gathering and Discovery. Organise the person's Support Network. Complete "My Life – My Plan"

- **Annual Planning Meeting of Support Network Sept/Oct 2013** - To agree priorities and decide the Annual Action Plan. Within a matter of days, the Named Staff immediately completes the section outlining the actions to be taken in the next 4 months of the first Action Plan

- **Tracking Implementation Dec/Jan 2013 -** At the end of 4 months, the Named Staff, in discussion with the person and the Support Network, completes the Action Plan and Progress Update Form for each priority. A plan of action for the next 4 months is agreed

- **Tracking Implementation April/May 2014 -** At the end of the 4 months, progress on actions in the Action Plan is reviewed. A plan of actions for the next 4 months is agreed

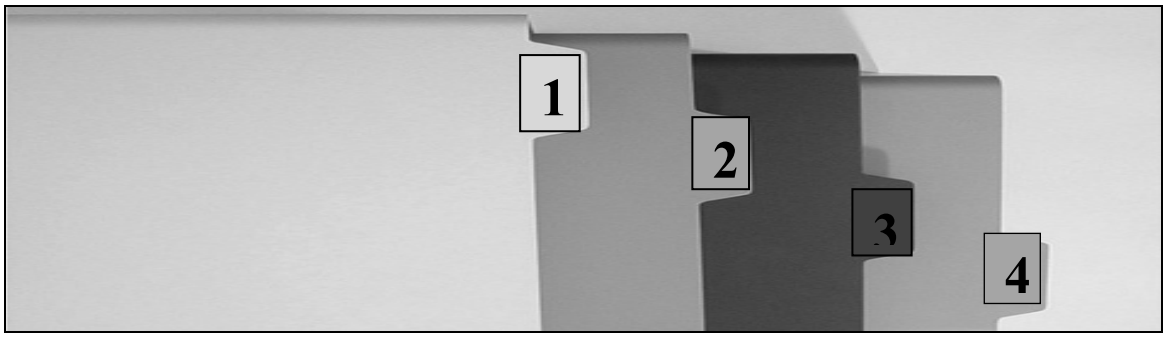
- **Preparing for the Annual Planning Meeting -** Complete the Information Gathering and Discovery. Organise the person's Support Network. Complete "My Life – My Plan"

- **Annual Planning Meeting of Support Network Sept/Oct 2014; Preparation -** The Circle/Network reviews progress against the plan for the last 12 months. The Annual Action Plan for the next 12 months is agreed based on the person's priorities. The Action Plan for the next 4 months (Sept – Dec) is developed a few days later. The Individual Planning Cycle is now repeated across the next year to Sept 2015.

7. RECORD KEEPING

Records are an essential part of maintaining good communication with Circle members. Communication must involve a lot more than records but the records are the key points of reference for agreed actions. A file structure is set out below describing the recommended contents for an ***IP*** folder, a ***Local Archive*** folder and a ***Link*** folder.

Contents of the IP Folder:



Section	Content	Document
1	This year's ***IP Forms:*** this set of information should provide an overview of all current individual priorities and progress	Personal Outcome Worksheet My Social Network & Map My Social Network Communication Plan My Life My Plan My Annual Action Plan My Action Plan and Progress Update(s) (4 monthly) Minutes of Circle of Support meetings Any other relevant evidence to **this year's goals** - match tickets / photos / certificates of achievement / courses attended, etc
2	***Daily Service Documents:*** This information should be easily accessible and will likely be accessed on a daily basis	Communication Notes/Logs or Individual Diaries Medication Prescription/Recording Sheets Daily Schedule Health Plan PRMP Food and Hydration Records Intimate Care Plan Communication Profile and Relevant Plan Behaviour Support Plan
3	***Other Service Documents***: These documents are important guides but will only be accessed as needed	PRN Protocol Physical Restraint Protocol Sensory Profile and Plan T.S.I. Plan Community Mapping Rights Checklist and RRC correspondence
4	***Incident Reports:*** Although just as important as the other documents, these are bulky and may be filed more easily in the final section	Incident Reports for One Year

Contents of the Local Archive Folder:

The IP Folder should be cleared out **once a year** to remove documents that have been updated such the Annual Plan or Action Plans and Progress Updates or documents that have been updated, such as a new PRMP or Communication Plan. Any photos or programme tickets referring to last year's goals can also be taken out and filed away. Therefore, each person will need to have a local archive box file where these records can be placed. For ease of retrieval, it would make sense to organise the archive folder using the same file structure as the IP folder:

a. IP Forms
b. Daily Service Documents
c. Other Service Documents
d. Incident Reports.

Contents of the Link Folder

Often people receive a combination of day, residential and respite supports. Where someone is receiving these services, the Named Staff should ensure that a copy of their current IP documents, any relevant service tool such as Daily Schedule, PRMP, Health Plan and Communication Profile is sent to the corresponding Link Staff so that a Link Folder is available in the relevant service. Link staff should attend the quarterly meetings and maintain a record of the actions which they have undertaken as part of the implementation of the IP.

It is very important that only documents relevant to the supports received in the Link Service are forwarded to the Link Folder so that there is not an over circulation of information. The Link Staff should review this information annually and remove any update material. The function of the Link Folder is to ensure accurate up to date information is available to support the individual in all their service environments. As a result, it is essential that the contents of the Link Folder are kept under close review and are regularly updated.

Please refer to the Association' Record Management Procedure for further information in relation to the retention and archiving of these folders.

APPENDIX 1: INFORMATION GATHERING QUESTIONS

The following document contains the Information Gathering Questions that are based on the comprehensive framework of the 23 Personal Outcome Measures.

- Each section has a description of the Values which inform our understanding of the deeper intention behind the questions for that particular Outcome.

- Use the questions to explore the person's experience of life and to establish how well the service understands their perspective and how well it is supporting them. Involve the person as closely as possible in this process. Check for new information with others who know the person best.

- Use the *Personal Outcomes Summary Worksheet* to summarise your information. Your written conclusions should describe the main points of evidence that have come from the Information Gathering process.

INFORMATION GATHERING AND DISCOVERY

Choose Personal Goals

Our goals are the things that we want for the future. We all have a unique way of expressing our desires, hopes, dreams and direction for the future. Some people want to live abroad, some people want to travel to many countries to experience different ways of life, some people like to stay at home, some people want to get married while others prefer the single life. Each person should direct their own method of selecting goals. Goals can be formal statements about what we want to accomplish in the years ahead or goals can be informal expectations or wishes and hopes about the future. Learning about goals involves us talking to the person and, when appropriate, to others who know the person well. We must not prejudge what people say as unrealistic or unachievable. We respect what we learn as a guide to what is important to the person**.** We should be supporting people to experience a variety of options so that they can make informed choices about the future. We must actively explore with the person their needs and wants. If we are not sure of a person's goals, we must try harder to provide more experiences or learn how the person defines this outcome for themselves. Think about this in terms of winning the lotto. What would I want if I had no limitations?

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• How do you want your life to be in the future? • What is important to you to accomplish or learn? • Whom do you talk with about your future? • What are your hopes and dreams for yourself? • What assistance (if any) do you need to make these things happen?	• What are the person's goals? • What leads you to think that? • How is the person working towards the attainment of his or her personal goals? • How have you explored hopes, dreams and desires for the future with the person? • What are you doing to support the person? • Why did you select this action? • How to you learn if the supports/activities are effective? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Choose Where and With Whom I Live

Choosing where to live and who you live with is an important personal decision that everyone should have the opportunity to make. We need to learn about people's preferences in relation to where they live. This will mean providing people with opportunities to try out different living situations. The value of this outcome is to actively learn about where the person might live in the future. This requires a lot of exploration of the person's wishes in relation to where they might like to live.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• How did you choose where to live? • What options did you have to choose from? • How did you decide who would live with you? • What do you like about your living situation? • What would you like to be different?	• Who decided where and with whom the person would live? • What options and experiences did the person have in order to make choices? • If the person did not chose, why not? • How do you learn about the person's preferences for the type of living situation? • How do you present options to the person so he or she can make informed choices? • Is the person living where and whom he or she wishes, If not, what is the barrier? • What are you doing to overcome this barrier? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Choose Work

Choosing a job and a career is an important life decision for people. We know that work is an important part of who we are and increases our ability to purchase the things we want. Work also gives us status and increases our self-esteem. Work colleagues provide us with an opportunity to make friends and enrich our lives. Some people work because they love the job and others work because they have to. Whatever our reasons, we all like to be engaged in something that has purpose and meaning in our lives. Not everybody chooses to work. Some people are happy not to work but even then as when people retire, it is important for them to have meaningful activities that provide the same social and personal rewards that a job offers. This can be achieved through volunteering, continued learning or leisure activities. This is the important message for supporting service users with choosing meaningful work. We need to know therefore, we need to be clear that we as the individualised supports must provide the person with a variety of work experiences so that they can make an informed choice about the type of work they want to be engaged with.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• What do you do for your work or career? • What options did you have? • Who chose what you do? • Can you do something different if you want to? • How did others help you with this? • Are you satisfied with the decision either you or others made? • If not, what would you like instead?	• How was it decided where the person would work? • What options/experiences did the person have? • Who made the decision about where the person works? If it wasn't the person, why not? • Is the current work situation satisfactory to the person? If not, what is being done? • How are the person's concerns being addressed if there is not a good match? • How does the person's current job relate to his or her preferences, skills and interests? • How do you learn about the person's preferences for work? • How do you present options to the person so that he or she can make informed choices? • Is the person working where he or she wishes? If not, what is the barrier? • How do you learn about the person's job satisfaction? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Intimate Relationships

Intimacy is present when people care and feel deeply for each other. Trust and respect are key values in the people we share intimate feelings with. We are confident that they have our best interests at heart and they will not let us down when we need them most. Sometimes intimate relationships are of a physical nature. Physical closeness is only one aspect of intimacy. Intimacy can be spiritual. Prayer, confession or meditation can be an intimate dimension of somebody's life. Intimate relationships are a very important part of our lives. For some people the closeness that they experience with members of their families meet their needs for intimacy. However, we must be careful to remember that people with disabilities have the right to an intimate relationship and therefore, we need to find ways to assist people to explore feelings and desires so that they can make choices about intimate relationships. We must also find ways to address training needs in the area of sex education.

Questions for the Person	***Questions for those who Know the Person Best***
• Who are you closest to? • Is there someone with whom you share your personal thoughts or feelings? • Who do you trust to talk with about private concerns and feelings? • Who is there for you when you need to talk? • With whom do you share your good and bad feelings? • Is this enough for you?	• Do you know how the person defines intimacy? • Do you know if the person has the type and degree of intimacy desired? • How do you support the person's choices for intimate relationships? • How do you learn about the person's desires for intimacy? • How do you know if the person needs support to develop or maintain intimate relationships? • If the person needs support, what has been arranged? • Are there any barriers that affect the outcome for the person? • How do you assist the person to overcome barriers to forming intimate relationships with others? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Daily Routine

We all have our own routines for getting ready to face the day. If we work, we usually rise at a certain time, shower (or not), eat (or not) etc. Some people like to make use of the mornings by getting up early and take some exercise or housework as they find that their concentration is better at that time. Others however, prefer to stay in bed until the last possible minute, while they may have lots of energy in the evenings. Everybody has their own routine that is personal to them. We can usually choose the type of work or leisure activity that we want to engage in. If we work, there are certain routines and deadlines that we have to adhere to. However, we can usually control our activities around those routines and deadlines. This outcome is about who is in control of setting the routine. Do we consider each person in the service and their preferences or are routines set for the convenience of the service? It is not about getting what you want all of the time, but it is about listening to what everybody wants and finding a way to organise the activities so that each individual has had a chance to direct those activities in a way that suits their personal preference. We must be aware that people need experiences of how things can be different in order that they can make informed choices about their routine.

Questions for the Person	***Questions for those who Know the Person Best***
• What is your day usually like? • What do you do and when? • Can you make changes in the times you do things to suit your needs? • Who decides when you get up in the morning and retire at night? • Who decides when you eat your meals? What you eat? • Who decides when you can relax, nap and enjoy your hobbies? • Who decides when and how often you bathe? • Who decides what chores you do and when (cooking, cleaning, laundry, grocery, shopping)?	• Who is responsible for deciding the person's routine? • How are the person's preferences and choices solicited? • Have you made adjustments when the person has indicated a desire for change? • What is done to encourage greater expression of choice? • How do you know what the person likes to do and when he or she prefers to do it? • How do you learn about the person's preferences for routine and leisure time? • How are options explored and experience provided? • How do you honour the personal preferences of the person? • Are there any barriers that affect the outcome for the person? • How is the person supported to address barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Privacy

Privacy means different things in different situations. For example, some of us like privacy when we are on the phone and that may not apply to all phone calls but some in particular may be of a certain private nature. Some people like lots of interaction with other people while others find that annoying. Privacy on the phone is different again to privacy when using the bathroom. We all have different needs for privacy at different times. We decide when we want to be alone - if you live with lots of people, you may want to go for a walk on your own so that your need for privacy is met. This is important for us to consider in services where groups of people are together. We must not impose our values on privacy on the people that are receiving the service - we need to understand their need for privacy so that we can support them. When people live together it may be difficult to find enough individual private time. We must learn about each person's need for privacy so that we can negotiate for private time for each individual according to their needs. It is particularly important where staff are supporting a person with their personal hygiene that we are sensitive to the preferences and dignity of the person.

Questions for the Person	***Questions for those who Know the Person Best***
• Are there times when you want to be alone? • Where can you go when you want to be alone? • Where do you visit with your friends and family in private? • How do you have privacy when you make personal phone calls? • Are there times when you don't have the privacy you want? • If you need help with personal hygiene, how do you decide who will help you?	• What are the person's preferences regarding privacy and private time? • If the person wanted to be alone, where could he or she go? • What do you do to respect those preferences? • How do you decide who will assist the person with personal hygiene if help is needed? • How do you learn about the person's desires and needs for privacy? • How do you accommodate his or her desires and needs? • How are methods to address opportunities for privacy individualized for this person? • Are there any barriers that affect the outcome for the person? • How is the person supported to address barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Personal Information

There are many records held about people across the organisation. This information is private and confidential. Therefore, we must make every effort to help people understand why we keep information on them and that they can see it whenever they want. Some people will require a lot of support to help them understand what is written about them. It is up to us to break down the information into the form that the individual can understand. This may be written, pictures, tapes, videos etc. This includes the record of their Individual Plan. Helping people understand their information should be happening each time we record something about that person. They should be engaged wherever possible in recording their information. Some people do not tolerate paper in any form. These people will depend on their staff to record information positively about them and keep it confidential to others. Remember, sharing of information about a person applies to our conversations as well as the written word. We should speak about people in a positive way and only share confidential information with the person's permission.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• Do you know if there is a record (journal, file, book) that has information about you? • What is in that record? Has anyone told you what information is in it? • How do you know if anyone reads, hears or receives information about you? • How do you decide who reads or gets information about you? • Is there information about you posted where others can read it? • Has anyone talked with you about confidentiality? • Is there any personal information about you that you do not want shared with others?	• Does the person know that information about him or her is kept on file? • Who has access to information about the person? • Has information about the person been shared with others? With whom? For what purpose? • Does the person know what specific information is shared with others? • Do you know if there is specific information the person does not want shared with others? • How is the person informed about what is in his or her record? • Who consents to the sharing of information about the person? • How is the person protected from violations of confidentiality both within and outside the organisation? • Are there any barriers that affect the outcome for the person? • How are barriers to this outcome addressed? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Use Environments

Our environments are the places we spend time in i.e. work, home, leisure, community. When we have full access to our environments this increases our opportunity to experience new things. Some people may need specialised adapted equipment in order to make full use of their environments. We must ensure that we help people to advocate for specialised equipment which will enable them to access more opportunities in their community. Advances in technology have led to the development of more accessible options for people with disabilities. This outcome also applies to the restriction of environments through rules imposed on people. Are there rules that don't allow people access to their full living area? We need to be aware of how our rules, which may be "unwritten", affect people fully using their environments.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• Is there something you wish you could do, but can't? • Is there anything you can't do or use because you don't have the proper equipment or modification (using the kitchen, bathroom or telephone, job duties, personal care)? • Do you know how to use appliances and equipment (microwave, stove, telephone, washer, dryer)? • Are there things that you are prevented from doing due to rules, practices, regulations or staff behavior? • Are there locked areas? If so, do you have a key? • Is there anything that would make it easier for you to get around your home, school, place of work, or community? • Is transportation available when you want to go somewhere?	• Is there anything the person has difficulty doing or cannot do because of the lack of modifications or adaptations? • What assistance do you provide to the person when modifications are adaptations are needed? • What resources are available within the organisation and the community when modifications and adaptations are needed? • Is transportation available to help the person access places and activities outside his or her home? • How do you determine the extent to which the person can use his or her environments? • How do you determine if adaptations or assistive technologies are needed? • What adaptations or modifications have been made for the person? • Are there rules, practice or staff behaviours that interfere with the person using his or her environments? • How are barriers to this outcome being addressed through supports for the person? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Live in an Integrated Environment

People with disabilities have the same rights as everyone else to access the same environments. When we work and live in the community we meet new people and this can keep us from feeling isolated. Integration means that we are physically present and accepted as a valued member of that community with our unique differences. Physical presence in the community is best achieved when we take part in activities with people without disabilities. Real integration requires that we understand, accept and value the diversity and uniqueness of each individual. The challenge for us is in finding ways to support service users to take part in activities with people without disabilities in home, work and community environments. This will lead to people making informed choices about how they want to be integrated into the community.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• Where do you live and work? • Do other people with disabilities live and work with or near you? • Where do you go to have fun? • Are these places where other people in the community would go? • Do you spend time in other places used by people without disabilities? • How did you select these places?	• Does the person live in typical community housing? • Does the person work in a building in which people without disabilities work? • Do leisure activities take place in setting used by people without disabilities? • Do sport and work teams consist of people with and without disabilities? • How have you determined what integration means to and for the person? • How do services, supports and activities promote and encourage integration? • What supports are provided to increase efforts towards physical integration in public education programmes, work, social activities, and/or leisure activities? • Are there any barriers that affect the outcome for the person? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Participate in the Community

The community is rich with activities where we find and develop interests, enjoy leisure opportunities or have our personal needs met. When we take advantage of the activities that the community has to offer, we meet other people and this helps to broaden our experiences, which helps us to grow and develop as people. We need to learn about how each individual wants to use the community. We all spend varying amounts of time engaged in community activities. The type and frequency of community activities needs to be explored for each person in our service.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• What kinds of things do you do in the community (shopping, banking, church, hair care)? How often? • What kinds of recreational or fun things do you do in the community (movies, sports, restaurants, special events)? How often? • How do you know what there is to do? • Who decides where you go and with whom you go? • Is there anything you would like to do in the community that you don't do now? What do you need to do to make this happen? • What supports do you need to participate as often as you would like?	• Do you know what the person would like to do in the community? • Is the person encouraged and assisted to use a broad variety of community resources? • Is training provided if the person needs it? • Is support provided if the person needs it? • How is the person informed of options available in the community? • How do you learn about what the person prefers to do? • How do you learn about how often the person wants to engage in community activities? • What supports does the person need to participate in community activities? How are those provided? • Are there any barriers that affect this outcome for the person? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Interact in the Community

When we think about some of interactions in the community, we may find that we developed lots of contacts and indeed friends from such interactions. While chatting with neighbours, the local shopkeeper, doctor, dentist or hairdresser we develop friendships of varying degrees of contact and depth. This usually leads to developing a network of contacts within that community which we may call on for various reasons. People in our services should have the same opportunities to interact and develop contacts and friendships as we have. This is a challenge for us to ensure that interaction can take place should the person wish for that to happen. We need to figure out how we can support people to spend time with community members not affiliated to Western Care. These opportunities are more accessible when we focus on an individual rather than a group of people.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• Who do you know in your community? • With whom do you like to spend time? With whom do you spend most of your time? • When you go places, whom do you meet? Talk with? • What kinds of interaction do you have with people (order food in restaurants, pay for purchases, talk with people in church)? • If you work, what kinds of social contacts do you have there, lunches, breaks, parties after work? • What barriers do you face? With whom do you talk about this?	• What opportunities does the person have to interact with others? • Do you know that the person's current situation is satisfactory to him or her? • Is there anything the person needs to support current relationships or develop new ones? • What is the person's preference for interaction? • How do you support the person to have opportunity to meet and interact with others? • How do you determine the person's preference for interactions? • How do you know if the type and frequency of interactions are satisfactory to the person? • Are there any barriers that affect the outcome for the person? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Social Roles

The roles we fill in life as a child, as a sister, nephew, partner, worker, volunteer, church goer express what is important to us. They define our expectations that we have for ourselves and that others have for us. Many of us play different roles at different times in our lives i.e. student, worker, parent, football coach etc. These roles change from when we are at the workplace, to when we are at home or in the community. Having a valued social role means that we have status in society. We feel good about playing that role because it is important to us. Some people may choose not become deeply involved in their community and that's okay. However, the challenge for us is to encourage people to find a social role that expresses their unique qualities so that they can make an informed choice about the type and amount of roles they would like to play in their life.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• Do you know about different clubs or groups you could get involved in? • What kinds of involvement and responsibilities do you have in your community (volunteer, church)? • What kinds of things do you do with other people? • Is there something you would like to be doing that you don't do now?	• What social roles do you think the person performs? • Why do you think these are social roles for the person? • What roles do you see the person having the potential or interest to perform? • If the person stopped participating, would he or she be missed? • Have the person's interests been identified? • How do you know what social role the person would like to perform? • What opportunities have been provided? • What supports does the person need to develop or maintain social roles? • Have those supports been provided? • Are there any barriers that affect the outcome for the person? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Friends

Friendship is a mutual and two way process. Friends are not paid. Friends are people who choose to be with us and we choose to be with them. Friends provide us with a shoulder to lean on when things are not going well for us and equally they provide us with enjoyment when we have something to celebrate. People are not required to have friends. However, we must actively support people by providing social opportunities so that they can develop and maintain friendships.

Questions for the Person	***Questions for those who Know the Person Best***
• How do you define friendship? Who are your friends? • With whom do you like to spend time? • What do you like to do with friends? • How often do you see your friends? • Do you spend enough time with them? • Besides seeing your friends, what other kinds of things do you do to stay in contact? • Do you have enough friends? Would you like more?	• With whom does the person spend time? • Who are the person's friends? How do you know? • What contact does the person have with his or her friends? • Are the interactions and contacts the person has with friends similar to typical friendships that you or people you know have? Are they voluntary, mutual and interactive? • How do you determine the importance of friendships to the person? • How do you know if the person needs support to develop or maintain friendships • Are there any barriers that affect this outcome for the person? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Respect

Respect is how we show our regard for each other. It indicates that we believe someone is a valued person. Respect is demonstrated in how we write about, how we speak about and how we respond to people. Respect is reflected in how we interact with people and in everything that occurs in a service relationship. People with disabilities are treated as people first. It is critical that we always promote interactions with the person in a positive regard so that the person's self-esteem is increased. This is demonstrated by meaningful work and activities, privacy and advocacy.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• How do staff treat you? • How do people talk to and about you? • Do people call you by your preferred name? • How do you know if your opinions are valued and respected? • What do you think about the activities that you do at home, school, work? Are they interesting? Boring? • What do you think about the activities that you do? Are you learning or gaining things from these activities? Do they make you feel important? Is it a good use of your time? • Do people listen to your comments and concerns? • Do you think people treat you as important?	• What is important to the person with regard to respect? • What has been done to personalize the activities or intervention to the person? • What benefit will these activities or interventions provide for this person? • Is the person involved in all decisions affecting his or her life? • How do you know if the person feels respected? • How is respect considered in decisions regarding supports, services and activities? • Are there any barriers that affect the outcome for the person? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Choose Services

Services and supports are the processes through which people achieve what they want. When we plan to go out for a meal, the restaurant we choose will depend on what we want at that particular time. When we apply this to support services, we need to consider how people can let us know about what services they want and their preferences for how these services should be provided. This outcome also applies to services in the community such as doctors, dentists, hairdressers, beautician, bank etc. We must actively learn about preferences and support the person to make informed choices about the services they receive.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• What services are you receiving? • When, where and from whom do you receive the services? • Who decided what services you would receive? • If you did not decide, what was the reason? • How did you decide who would provide the service? • Are these services the ones you want? Do you have enough services? • Are they meeting your needs and expectations? • Can you change services or provider if you so choose?	• What services does the person use? • What services were identified as beneficial by the person? • What options for services where presented to the person? • How do you determine the services desired by the person? • How were options for services and providers presented to the person? • How were the person's preferences considered when presenting options? • If the person has limited ability to make decisions or limited experience in decision-making, what do you do? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Realise Personal Goals

By accomplishing something we see as important we can get enormous satisfaction. We feel good about ourselves and this increases our self-esteem and our ability to reach higher and try and achieve more for ourselves. This is all very personal to us. It can be anything from celebrating a birthday with friends to learning to drive of climbing the reek! There is such a sense of satisfaction and accomplishment from achieving your own piece of success that you feel the world is at your feet. We must understand what people want to accomplish in their lives and help them to achieve it. Most importantly, this requires that we have a sense of celebration which indicates that we value what the person has accomplished. It doesn't matter how big or small the achievement was in our view, rather that we understand and value the success that the person has achieved.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• What have you done that you feel good about? • What have you accomplished over the past few (one to three) years that has made you feel good about yourself? • What accomplishments have pleased you most? • Sometimes things happen that make life better; has that happened to you? • If you did not accomplish something important to you, what got in your way? • What assistance or support do you think you need?	• What personal goals has the person achieved? • If any were not achieved, what is the reason? • How do you know if the person accomplished something personally significant? • What did you do to assist the person to experience personal success? • What barriers to goal attainment does the person face? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Natural Supports

Some people have a large network of family members, neighbours and friends while others have a smaller group. Some people have their network all around them living close by while others may have family living in many countries and they remain connected through phone or email contact. Even though they may be some distance away, there is an understanding that should anything happen they will be there to provide support if and when it is required. The type and frequency of these relationships are decided by each individual. Some people are likely to have daily contact with their support network while others would vary from week to week or monthly. When supporting people in this area we must appreciate the importance of building relationships with families so that we are creating a sense of trust and openness in order to best support people.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• Who are the people in your life that you can count on? • Who do you want to talk to or be with when you go through tough times? • Who do want to share your successes with? • How do you maintain contact with these people? • Have you lost contact with family members or others? • Is the contact you have enough for you? If not, what is the reason? • What type or frequency of contact would you prefer? • What do you think could be done to change the situation?	• Do you know who is part of the person's natural support network? • Do you know if the person is satisfied with his or her contact with these people? • What assistance is provided to maintain the person's contact with his or her family and others who provider personal support? • How do you learn about the person's support network? • What do you do to support contact? • If there is no contact, what is done to assist the person to reestablish contact if desired? • If contact is with parents only, what do you do to expand the network to extended family? • What do you do if the extent and frequency of contact is unsatisfactory to the person? • Are there any barriers that prevent the person from remaining connected with the person he or she identified as part of this support network? • How do assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Safe

Feeling safe and free from danger is important to all of us. Our personal safety can be threatened by a number of things in our home, workplace, neighbourhood or wider community. Personal safety may be threatened by our physical surroundings, buildings, other people or a lack of supports. In some cases, we rely on safety standards such as fire drills, health regulations, and building inspections to assure our safety. In addition, we may also take personal action to feel safer such as smoke detectors, personal alarms, mobile phones, first aid training, training in self-defence, car alarms etc. We usually try and remember key phone numbers such as 999 and local doctor, guard etc. These are all ways of helping us to feel safer. It is important to remember that each person is an individual and will take different kinds of risks in their lives. Feeling safe is about ensuring that you understand the risks involved in whatever you are doing and take reasonable steps to ensure that nothing bad will happen. Taking risks is how we learn in life and there is a risk attached to almost everything, because anything can happen. Some things we can predict because they may have happened before or because they are particular to a certain situation. Then, there are other risks that we cannot possibly predict because they are out of our control. What this outcome asks us to do is to make sure that we have a process for learning about people's safety wherever they go, i.e. day service, residential, home, work, community.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• What kinds of safety risks are you concerned about? In your home? In your community? • Do you feel safe at home? At work? • Is there any place you don't feel safe? • What would you do if there were an emergency (fire, illness, injury, severe weather)? • Do you have a safety equipment at home (smoke alarm, fire extinguisher)? • Do you have safety equipment at work (protective ear and eye wear)? • Do you feel safe in your community? • How would you react if a stranger approached you? • Is your living and working environment clean and free of health risks?	• Does the person know what to do in an emergency? • If the person doesn't know what to do, what do you do to ensure safety? • Does the person need any special equipment in order to respond to emergencies? If so, does the person have these things? • How do you know that the person is safe (at home, work, school) • How do you learn about safety issues that are of concern to the person? • What do you do to ensure that places where the person spends time are safe? • Are there any barriers to this person's safety? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Exercise Rights

Rights include basic protections and guarantees afforded to all citizens through the Constitution. Going for a walk, using the phone, deciding what to buy are everyday things that we take for granted. We usually do not think about our rights on a daily basis because it is a natural part of our lives, listening to the type of music we like, reading the paper, choosing to vote in the elections or writing to the paper is we feel strongly about something. Often, we may only start to think about our rights if they are restricted in some way. With rights come responsibilities, therefore we must help people understand the meaning of both. People with limited knowledge and or experience about their rights need training and support in order to make choices and exercise rights. It is important to provide people with opportunities to exercise the responsibilities that accompany rights.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• What do you know about your rights as a citizen? • Do you have access to information about your rights as a citizen? As an employee? As a person receiving services? • What rights are most important to you? • Are you able to exercise your rights without difficulty? • What information or support do you need to help you to exercise your rights? • With whom can you talk about your questions or concerns regarding rights?	• What rights are important to the person? • How do you know that? • What rights does the person exercise most? • How is the person supported to learn about his or her rights? • Does the person need support to exercise rights? • If so, what are the supports and who provides them? • Are there any barriers that affect the outcome for the person? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Treated Fairly

Total freedom to act as we wish is not an option in society. We must have due regard to the rights of others and to the wellbeing of people who cannot manage certain freedoms. When restrictions are placed on me is there some due process to ensure that it is not because someone in charge was having a hard day. Is it based on some kind of evidence and a rationale? Is there a real intention to review the situation in a reasonable time especially if it is a restriction that really matters to me? Also, are staff trying to teach me new skills or understand me in a way that may help to overcome the restriction. We must be very clear as individual supports about the restrictions we place on service users. Sometimes, people are experiencing restrictions that are not written down, but happen on a day to day basis e.g. rules about when to have a cup of tea or not allowing people into a certain room in the house. We must try to examine our practices to include highlighting where people's personal freedoms are being restricted.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• Have there been times when you thought you were treated unfairly? • With whom can you talk when ou have concerns about your rights or how you were treated? • Are any of your rights formally limited? • If yes, did you agree to the limitation? • What is being done to change the situation? • What assistance are you getting so that you can exercise this right in the future?	• Has the person shared any concerns about his or her treatment or violations of rights? • What recourse does the person have when he or she has concerns? • Have any rights limitations been imposed on this person? • What is the reason for the limitation? (Individual need? Staff practices? Organisational policy?) • Who consented to the limitations? • Does the person have rights limitations? • What is the reason for the limitation? • Who consented to the limitation? • Who reviewed the limitation? • What is the plan to remove the limitation? (Training? Support? Change in policy or practice) • How long will the limitation be in place? • What are the barriers that affect the outcome for the person? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Best Possible Health

The meaning of best possible health varies from person to person. Some of us might view best health as freedom from illness, while others may be worried about being overweight or smoking. Some people may be concerned about medication that they are taking so that they may want to review that regularly. The goal of the health intervention is for each person to have the best possible health given his or her own health status. We need to know what's important to each person in order that they feel healthy. This will be different for everyone but there are some things that we must inform people about in relation to the desired regular health checks that people should aim for in accordance with best practice. People have the right to decline medication and treatment if they feel that it is not suitable for them. If they do this we have a responsibility to support them through providing information and options about other treatments.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• Do you feel healthy? If no, what bothers you? • What do you do to stay healthy? • What health concerns (physical and mental) do you have? • Do you discuss your health concerns with anyone? • How are your questions or concerns addressed? • Are you seeing a doctor, dentist, other health care professional? • Do you take any medication? If so, what is it and how does it help? • What advice has your health care professional given you? Are you following it? If yes, is it working? If no, what do you think the problem is?	• How has the person defined best possible health? • How is the person involved in his or her health care? • Is the person following the health care professionals' recommendations. If no, why do you think that is? • Do you think the person feels health interventions are working? • If not, what is being done about it? • How have you explored health issues with te person? • What supports does the person nee to achieve or maintain best possible health? • Who provides the support? • How as this decided? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Free from Abuse and Neglect

Treating people with dignity and respect requires that they are free from abuse and neglect. ABUSE AND NEGLECT ARE UNACCEPTABLE CONDITIONS. Many actions may constitute abuse and neglect. Failure to act can also constitute abuse and neglect. Abuse includes verbal, physical, sexual and psychological aspects. Neglect occurs in areas such as lack of basic sustenance (food, clothing, shelter), failure to provide needed services and failure to provide and maintain adaptive equipment. When people experience abuse and neglect, they feel physical and emotional harm that can stay with them for a very long time. Abuse is defined and measured according to the person's experience, regardless of when it occurred. The effects of abuse on people may leave a long lasting, devastating legacy. Some people may never be free from abuse and neglect, but they need our support on a day to day basis to help them deal with life. We must be aware of how each person copes with an abusive situation and provide supports accordingly. It is the responsibility of every staff member to report any allegation of abuse through the organisation's procedures.

Questions for the Person	***Questions for those who Know the Person Best***
• Do you have any complaints about how you were treated by anyone? • Have you been hurt by anyone? • Has anyone taken advantage of you? • Does anyone yell or curse at you? If so, whom do you tell? • What was done to address your concerns? • Who would you tell if someone hurt you or did something to you that you didn't like? • Do you know what abuse is? Do you know what neglect is? • Have you been abused? Have you been neglected? • Where are the safe places, people, o other resources that you can get in touch with if you have been abuses, mistreated, or feel threatened?	• Has the person indicated or reported concerns about how he or she was treated by others? • If so, to whom were the complaints reported? • What was done about the complaints? • If allegations were substantiated, what action was taken? • What is the area of greatest risk for the person? • If the person cannot verbalize concerns, what do you do to determine whether or not abuse or neglect has occurred? • What is done to inform people about abuse and neglect and what to do if it occurs? • Does the person understand abuse and neglect. If yes, how do you know that? • What has been done to inform the person? • What activities/practices are in place for the person to prevent abuse and neglect? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

INFORMATION GATHERING AND DISCOVERY

Continuity and Security

Change is a fact of life. Some people deal with it very well. Others need it to be well managed in the way they can best cope with it. Understanding different people's needs in coping with change is vital information for all relevant decisions that affect people's lives. Having a disability is frequently associated with dependence on human service organisations for shelter, food, clothing, work, transportation and other forms of support. This dependence on the organisation often links changes in people's lives to changes in staffing, funding and other organisational priorities. We must be aware of how the day to day changes that we take for granted can be upheaval in people's live.

Questions for the <u>Person</u>	***Questions for those who Know the Person Best***
• How long has your support staff worked with you? • Do you have consistency you need in the staff who work with you? • What would cause you to make changes in your current situation? • Is there anything you do not want to change? • What is your source of income? • Do you have enough money to pay your expenses? • How do you protect your personal property and other resources? • Are there things you have to do without? If so, what are they and why can't you have them? • Is your financial situation acceptable? If yes, why? If no, what do you want to change? • Have you experienced any changes? How do you feel about those changes?	• What does the person consider to be important issues that would affect his or her continuity and security? • Does the person feel secure in his or her living and working situations? • Does the person feel secure financially? • What has the person told you is important for continuity and security? • If the person has indicated concerns, what are they and what was done about them? • How are changes handled and planned for? • How is the importance of staff continuity defined for the person and addressed through the support process? • How is the sufficiency of the person's economic resources determined? • What supports are provided if they are insufficient? How is the person assisted to obtain additional resources? • How does the organisation ensure that the person has protection for his or her personal resources? • How do you assist the person to overcome barriers to this outcome? • What organisational practices, values and activities support this outcome for the person?

APPENDIX 2: PERSONAL OUTCOMES SUMMARY WORKSHEET

PERSONAL OUTCOMES SUMMARY WORKSHEET (Adult)

NAME: _____ DATE OF BIRTH: _____
MAIN SERVICE: _____ DATE COMPLETED: _____
NAMED STAFF: _____

OUTCOMES (Record the key pieces of information you have gathered under each relevant Outcome)
1. People choose personal goals
2. People choose where and with whom they live
3. People choose where they work
4. People have intimate relationships
5. People choose their daily routine
6. People have time, space and opportunity for privacy

OUTCOMES (Record the key pieces of information you have gathered under each relevant Outcome)
7. People decide when to share personal information
8. People use their environments
9. People live in integrated environments
10. People participate in the life of the community
11. People interact with other members of the community
12. People perform different social roles
13. People have friends

OUTCOMES (Record the key pieces of information you have gathered under each relevant Outcome)
14. People are respected
15. People choose services
16. People realise personal goals
17. People are connected to natural support networks
18. People are safe
19. People exercise rights
20. People are treated fairly

OUTCOMES (Record the key pieces of information you have gathered under each relevant Outcome)
21. People have the best possible health
22. People are free from abuse and neglect
23. People experience continuity and security

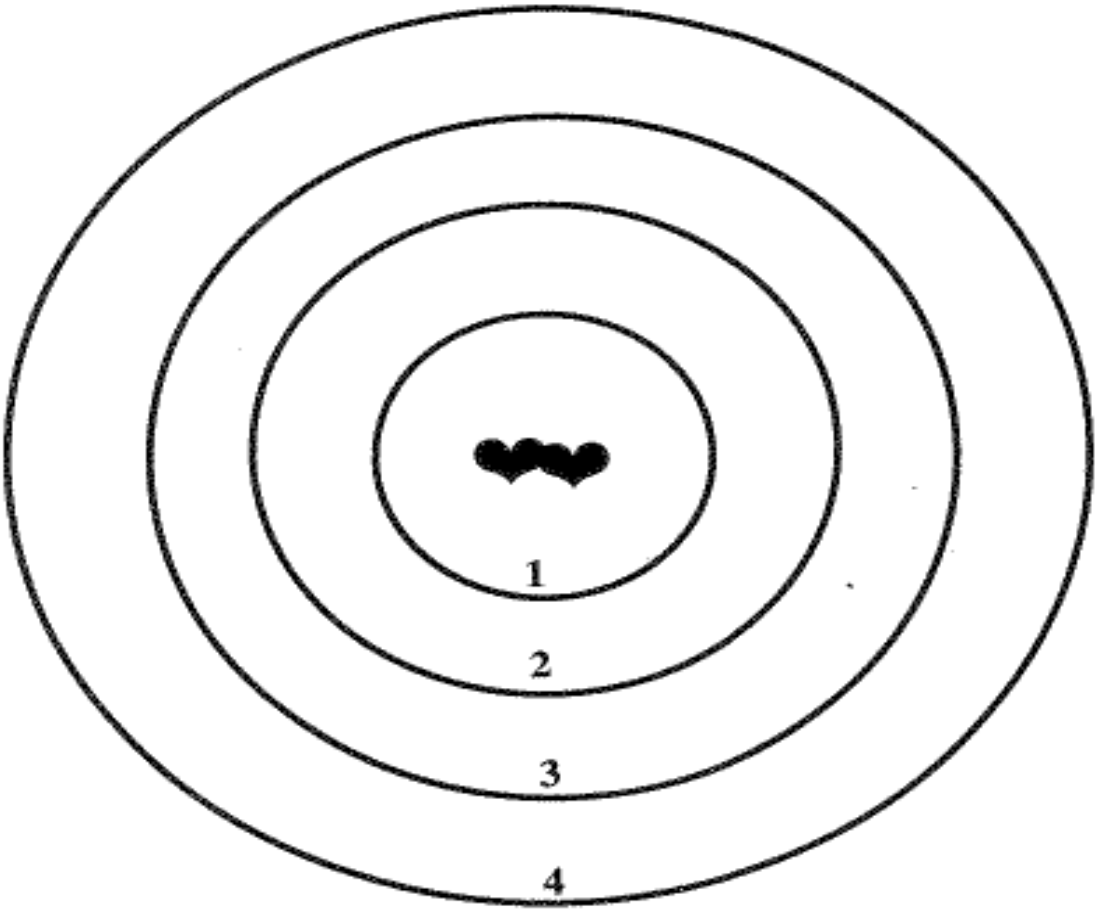
APPENDIX 3: MY SOCIAL NETWORK

Network Member *Write Name Below and Complete Columns Across as Per Examples*	**Role** *Family* *Friend* *Staff* *Other*	**Provides Practical Support** *Always* *Sometimes* *Not really*	**Provides Emotional Support** *Always* *Sometimes* *Not really*	**Provides Informational Support** *Always* *Sometimes* *Not really*	**See Each Other** *Daily* *Weekly* *Monthly* *Few times a year*	**Close to Each Other** *Not very* *Quite* *Very*	**Know Each Other** *< 1 year* *1 to 5years* *>5 years*

APPENDIX 4: MY SOCIAL NETWORK MAP

Having identified those currently active in the person's network on the previous page, please mark each network member in the circle that corresponds to their role. Network members should be assigned to as follows:

- Circle 1: My family members and people I am close too.
- Circle 2: My Friends, people that I have reciprocal relationships with and see regularly.
- Circle 3: My Community Members, people I know through my involvement in community groups and other clubs
- Circle 4: My Staff or paid other supports



First Circle: ***Circle of INTIMACY***
Second Circle: ***Circle of FRIENDSHIP***
Third Circle: ***Circle of PARTICIPATION***
Fourth Circle: ***Circle of EXCHANGE***

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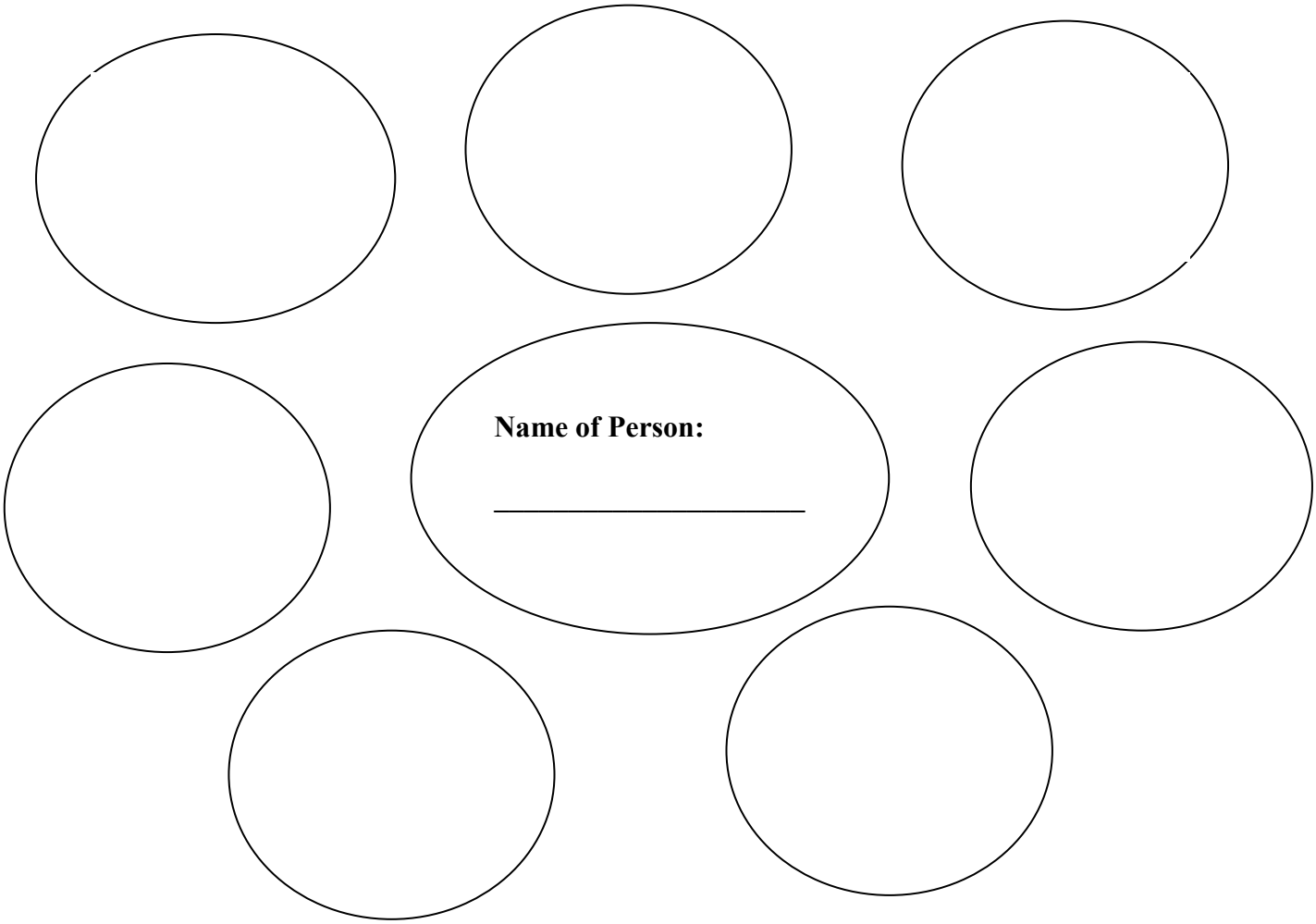
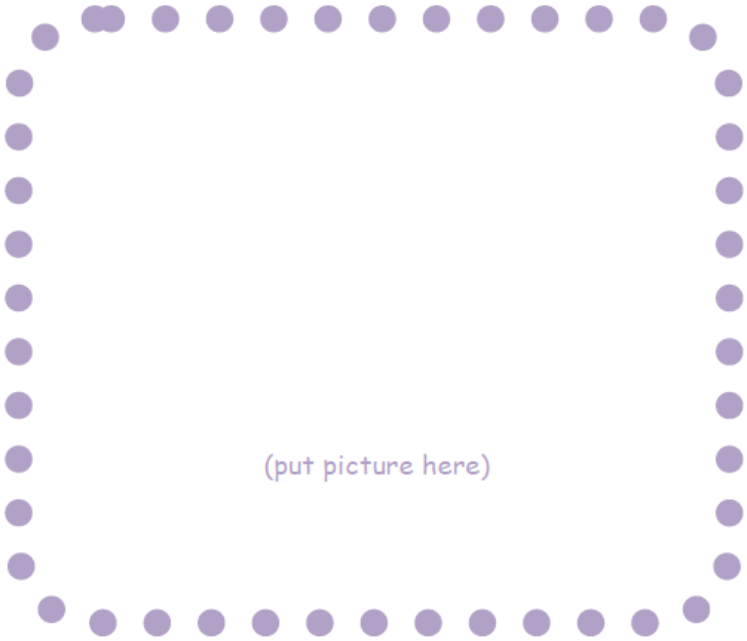
APPENDIX 5: SOCIAL NETWORK COMMUNICATON PLAN



Name of Supporter:	Preferred method & frequency of communication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

APPENDIX 6 – MY LIFE MY PLAN

My Life – My Plan



Name.....

.....

This is a booklet to help you think about your life and plan your review.

You can put information in this booklet in whatever way you want, you can write, draw, use photos or pictures - its up to you ! . You can tell everyone about…

The things you like and things you don't like

Things that are important to you, things you want to stay the same and those you want to change.

Your hopes and dreams for the future

Use the blank pages or add more pages if you need to.

You may want to take copies of the pages to stick on the charts at the meeting

About Me

This doesn't have to be repeated every year but if something important needs to be added it should be

Introducing Myself

Where I was born, where I lived in the past, where I live now, important events in my life, things I need people to know about me so they can understand and support me.

Meet my Family

Meet my Friends

How I Communicate

For help with this, click on the Communications Resources on the A.T. Section of the WCA Intranet


What are the best things about me
Appendix 6 - My Life My Plan
6

A Summary of the important people in my life

Put names or pictures
in the spaces.....

Family

Other important people

Me

Staff and paid supporters

Friends

Appendix 6 – My Life My Plan 7

What is important to me now

My favourite things where I spend my day

What is important to me now

My favourite things I like to do where I live

My favourite things I like to do at the weekends

What is important to me now

My favourite things I like to do for fun, how I socialise, other important places in my life.

What I like to do with my friends….

What is important to me now

Everyday things I enjoy

Food

Drink

Music

Hobbies

Tv programmes

Appendix 6 – My Life My Plan 11

What I really don't like about where I spend my day, where I live and other places I go

How do I get to the places that I need to go?

This is how I spend my time now

My Weekly Planner

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

What is important to me now

What has improved for me in the last 12 months?

What I would like to see improved in the next 12 months and what is the help I would need to do this?

Important to me for the future

What I really would like to do in the future?

What I would be unhappy with if this continued in the future?

Staying Healthy, Safe and Treated Fairly

To have the Best Possible Health I need…….

To be Safe I need……

The Rights that matter most to me now are……

What is working in my life right now that I want to keep?

What is not working in my life right now and I want to change

Questions to ask
Issues to resolve

Make a list of anything you want to find out about

\

Planning My Review

Who do I want to invite to my meeting

Planning My Review

How to make sure I am comfortable and at the centre of the meeting

Where I would like the meeting to be held…..

Snacks

Music

Drinks

Other things I would like to have or do at the meeting

APPENDIX 7: MY ANNUAL ACTION PLAN

Person's Name: _____ Date Plan Written: _____
What are the main priorities in my life? What is the picture for the future? What is the Plan to make this happen? Give a broad outline of the main actions that will take place to address the person's priorities over the next 12 months. State who will be responsible for each action.
Signed by Person: _____ Signed by Named Staff: _____

APPENDIX 8: THE ACTION PLAN AND PROGRESS UPDATE:
Period 1 – 2 – 3 (Circle as appropriate)

To be completed by the Named Staff every 4 Months in consultation with the Person and the Support Network/Circle; state who was present at the Network / Circle meeting and who was contacted to input to the process.

Person's Name: _____ **Date of Update: _____**

State the Priority clearly	***Action Plan; What specific actions will happen in the next 4 Months to achieve or advance this Priority?***	***Who will do this and When?***	***Progress Update; What was done to achieve each of the agreed actions in the last 4 Months?***	***Who did this and When?***
Signed by Named Staff: _____			**Signed by Named Staff: _____**	