A Guide to Goal Setting in Person-Centred Planning

New Directions

Building a Better Health Service

Seirbhís Sláinte Níos Fearr á Forbairt

Contents

1. Introduction

The National Framework for Person-Centred Planning in Services for Persons with a Disability refers to:

- Personal Plans
- Person-Centred Plans
- Personalised Care and Support Plans.

All staff working in disability settings should understand the difference between a person-centred plan (what is important to the person) and personalised care and support plans (what is important for the person). Please read the Framework document along with 'A Guide to Understanding the Difference between the Person-Centred Plan and Personalised Care and Support Plans' and 'A Guide to Circles of Support' before you start working with an individual on their person-centred plan and goals.

Setting goals is a key part of all planning. This guide describes a best practice approach to goal setting within the person-centred planning (PCP) process.

The Person-Centred Plan

Person-centred planning supports and enables a person to make informed choices about how they want to live their life, now and in the future. It supports the person to identify their dreams, wishes and goals, and what is required to make those possible. Person-centred planning requires the supports available to be responsive to the person and to focus on the outcomes they want to achieve. The framework organises the person-centred planning process into four main stages:

- Stage 1 - Getting ready to do a person-centred plan
- Stage 2 - Putting a person-centred plan together
- Stage 3 - Putting a person-centred plan into action
- Stage 4 - Finding out if person-centred planning is working

It is important to consider goal setting at all four stages of the process.

A goal is a desired result a person wishes to achieve. Goals can be short or long-term. Goals are set to reach an outcome. Outcomes are a positive change in a person's life. For example, the goal may be to undertake an education or training programme/qualification. The outcome may be new career opportunities and better financial prospects.

A Quality of Life Outcomes Domain Framework for Disability Services

The Outcomes Domain Framework and the National Framework for Person-Centred Planning in Services for Persons with a Disability complement each other. Together, they can have a strong influence on work practices and on accountability. They encourage service providers to develop a clear system to monitor and evaluate services and supports. This should include outcome measurement; checking if each person has the right supports and opportunities, and if these make a real and positive difference in the lives of persons with disabilities.

In 2016, the National Disability Authority (NDA) identified nine outcome domains or high level measures for person-centred disability services. These align with the Health Information and Quality Authority (HIQA) Residential Standards, the Interim Standards for New Directions, and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

They reflect areas of life that are important to us all. They are a useful reference point to support a person to set their goals, and to understand how these goals may lead to positive changes in their life.

The outcome domains

The nine domains (high level measures) identified by the NDA are:

The persons who use disability services:

1. Are living in their own home in the community
2. Are exercising choice and control in their everyday lives
3. Are participating in social and civic life
4. Have meaningful personal relationships
5. Have opportunities for personal development and fulfilment of aspirations
6. Have a job or other valued social roles
7. Are enjoying a good quality of life and well being
8. Are achieving best possible health
9. Are safe, secure, and free from abuse.

The individual stories at the end of this guide show how you can map personal goals to the nine outcome domains during the different stages of the PCP process.

New Directions

For persons with a disability who use day services and supports, the twelve supports and HSE Interim Standards for New Directions is an additional support to facilitate goal setting and the identification of individual outcomes. The National Framework for Person-Centred Planning in Services for Persons with a Disability was developed to support the implementation of the supports and standards in New Directions.

2. Who should be involved in Goal Setting?

- The person who owns the person-centred plan
- The person who supports them to put their person-centred plan together
- The person or persons who support them to put their person-centred plan into action
- The Circle of Support
- At times, it may be appropriate to involve others that know the person well or support them with a particular skill, interest, or activity, for example, tutor, multi-disciplinary team member, colleague, family member, volunteer.

The person who owns the person-centred plan should make a choice to have a plan and should be central to all decision-making from the beginning. Wherever possible, the person who owns the person-centred plan should set their own goals. Some persons with a disability might need support to communicate their dreams and wishes and translate these into goals. This support should involve creative communication, observation, active listening, consultation with others that know the person well, and reflection. Some persons will need time to understand the PCP process; knowledge may be gained through practical experience of goal setting and achievement. Goals should not be set on behalf of the person who owns the person-centred plan by one staff member alone.

3. What are the Key Principles of Goal Setting?

The principles of goal setting reflect the beliefs and foundations in the National Framework for Person-Centred Planning in Services for Persons with a Disability:

- Appreciation for each individual and the contributions they make
- Active listening – both to verbal and non-verbal information
- Individuality – goals reflect the interests and choices of the person
- Focus on ability; process promotes independence and self-direction
- Process supports social inclusion and the development of valued social roles.
- Positive risk taking
- Focus on benefits and opportunities rather than barriers and challenges
- Honesty
- Shared expectations
- System supports recording and review; information is accessible to all
- Time and space for reflection
- Outcomes focused
- Accountability.

4. Good Practice approaches to Goal Setting

Start with a person's dreams and wishes

This task will be undertaken at Stage 1 of the PCP process, primarily by the person supporting putting the person-centred plan together. There should also be input from the Circle of Support and the person supporting putting the person-centred plan into action. Consultation with others that know the person who owns the person-centred plan well may also be required.

The first step in goal setting is to understand the perspective of the person who owns the person-centred plan – what is really important **to** them. The person will be respected as the expert in their own life. Good communication and active listening are the foundation. All forms of communication should be responded to and valued. Start by spending quality time with the person. Over time, you must get to know each person as an individual with their own life experience, preferences, interests, talents, dreams, and aspirations. There is no substitute for spending time 'in the moment' with the person, observing how they react, interact, and communicate. If the person uses alternative or augmentative ways to communicate, it is essential that you understand and can use their system, for example, Lámh signs, visual symbols, objects, and non-verbal behaviours. It is important to record information, for example, the responses of the person to different experiences. You should support the person who owns the person-centred plan to share this information with other communication partners.

Profiling tools may be really helpful at this point:

- 'About Me' books
- Communication passports
- Life stories and histories
- Personal photo or video albums
- Templates such as 'Good day / Bad day'
- Memento boxes.

Turn dreams and wishes into goals

This is about acting on what you have heard from the person who owns the person-centred plan in Stage 1. At Stages 2 and 3 of the person-centred planning process, the planning team and Circle of Support must work closely together. Information gathered with the person who owns the person-centred plan on a continuous basis is used to develop personal goals, for example, information on their strengths, likes and dislikes, interests, dreams, daily routine and activities, and opportunities.

It is important to know what is and is not working well in the person's life at present, and what the person would like to change.

Person-centred plans should describe a vision of a more positive future for the person together with a goal-based action plan for the attainment of this more positive future. The person supporting the individual to put the person-centred plan together and the Circle of Support should assist the person to work out what they want in their lives, and to select and prioritise aspirations and goals. They should explore how a dream or goal can be achieved - what supports would be needed and who might help. Innovation and positive risk taking are key. Every effort should be made to address barriers.

Person-centred planning tools and approaches may be used to plan with the person who owns the person-centred plan. The planning team and Circle of Support should bring together those that will support the person who owns the person-centred plan to achieve their goals. A person-centred planning meeting may be organised to support the development of an action plan. Informal, relaxed environments have been shown to facilitate engagement and participation.

The person who owns the person-centred plan and the person supporting them to put their plan together will develop an action plan. The action plan will include the person's goals, the names of those responsible for supporting them to achieve the goals, and timeframes. The person who owns the person-centred plan should have a copy of their action plan in a format which they understand. They will be supported to communicate the information to the person supporting them to put the plan into action.

Make the goals SMART

The goals in the action plan should be SMART.

The term SMART was first used by George Doran in 1981. SMART goals allow you to focus on what is most important and on what you want to achieve. SMART goals provide a structure so you can work in the most efficient way. They are used in business, management, education, as well as health and social care.

SMART stands for:

S	**Specific**
M	**Measurable**
A	**Attainable**
R	**Relevant**
T	**Time-anchored**

In the context of person-centred planning:

- **Specific:** Goals must say clearly and concisely what the person intends to do. It should be possible to answer what, who, and where questions. Goals should be set out in language that everyone can understand; written in the person's words where possible.
- **Measurable:** It is important to have a way to judge if the person is successful with their goal. Identify the evidence that will be collected to demonstrate change. Track, record, and evaluate progress. If the person sets out interim

steps in a long-term goal, how you will know if these are achieved? Measuring progress motivates us to continue and to reflect.

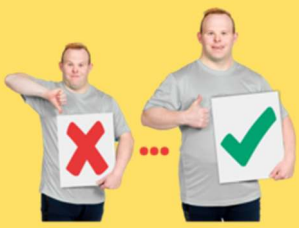
- **Attainable:** This helps us answer the 'how' questions. Goals should be challenging but possible. Is the goal realistic in the person's current circumstances? Do they need to make any life changes, learn new skills, or organise resources so they can start this goal? Can a long-term goal be broken down into smaller more achievable steps? The person who owns the plan and those supporting them should be aware of risks and barriers and should consider how to manage or overcome them.
- **Relevant:** This helps us answer the 'why' questions. The goal must be meaningful to the person and be worth the time and effort. It should align with their values and fit with other parts of their life. Relevant goals support a person to live the life they want.
- **Time-anchored:** This helps us answer the 'when' questions. Every goal should have a clear start and end date. Timely goals encourage us to focus and prioritise. They encourage accountability. If you cannot put a time limit to a goal, then it may need to be revised. You may want to set individual target dates if you have interim steps in a goal.

The blank template overleaf will assist you to support an individual to develop their goal into a SMART goal.

There is an example of this template in practice in one of our individual stories at the end of this guide.

Setting SMART Goals

What is your Goal?

S 	**Specific:** What do you want to achieve? Who can support you? Where do you want to work on this goal?
M 	**Measurable:** How will you know if you are successful? How will you record your progress?

A 	**Attainable:** How will you achieve this goal? Do you have the skills you need to reach this goal? If not, can you get them? Do you have the supports you need to reach your goal? Is it the right time in your life to work on this goal? What barriers and challenges will you face?
R 	**Relevant:** Why did you pick this goal? Why is it important to you? Does it fit with other important things in your life?

T 	**Time-anchored:** When will you start working on this goal? When will you reach this goal?

My SMART Goal:

Outcome - the good change I would like:

Use Differentiated Learning

Some service providers use differentiated learning to assist with goal setting, measurement, and achievement. Differentiated learning is a teaching philosophy that emphasises the importance of supporting learners to access information, learn, and develop ideas in a wide variety of different ways. It is inclusive and respects each learner's personal history, culture, abilities, disabilities, learning style, motivation, and interests. It acknowledges that learners interact and respond differently with different people and in different contexts.

The learner-centred culture focuses on what is meaningful to the learner at a specific time in their life. Sometimes, the obvious next step in learning or skill development is not what is required by a learner. Flexibility is key, along with the recognition that learning is not always predictable or sequential.

Differentiated learning reinforces good practice in goal setting as it enables each person to reach their goal at their own pace and in their own way. Aspects of differentiated learning that can be incorporated into goal setting include:

- Individualised teaching and instruction
- A holistic assessment of each person's knowledge, skills, and strengths at the start of their learning journey
- A clear understanding of what each person wants to learn
- Developing an understanding of how each individual learns best
- Identifying appropriate ways for each person to show their learning
- Ongoing assessment and review. Assessments facilitate each learner to show their knowledge and skills
- Quality learning environments
- Creative approaches to teaching and learning, for example, multi-sensory approaches
- Learning opportunities are meaningful and engaging

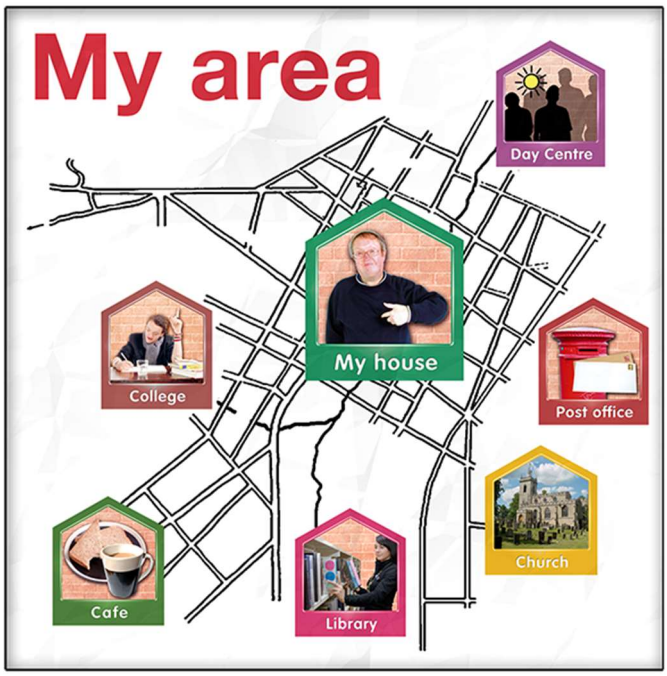
- ‘Just enough challenge’ - tasks or learning goal are not too difficult or too easy
- Reflective practice.

Goals support independence, community engagement, and valued social roles

Person-centred planning provides opportunities for persons with disabilities to achieve more independence in their daily lives, for example by setting goals relating to specific skill development. These may include goals around finances, employment, travel, relationships.

Those supporting the person who owns the person-centred plan should explore opportunities for engagement in the community. The person who owns the person-centred plan should be encouraged and supported to access the community as an individual, and to develop meaningful roles and relationships. Holding valued social roles enables individuals to be seen positively and to be valued by others.

Goals relating to education, training, work experience, career guidance, and paid employment can all form part of a person-centred plan.



Review and evaluate

This will happen primarily at Stages 3 and 4 of the person-centred planning process.

Person-centred plans and the goals within them should be reviewed and updated on a regular basis. Monitoring evidence should be collected so a formal record of progress towards goals can be collated; the person supporting putting the person-centred plan into action will be the lead support on this. There should be clear evidence to show whether or not goals were achieved, for example written examples and notes, photos, or video evidence.

Reflective practice, where staff are enabled to look back critically and constructively at their actions and interventions, should form part of any evaluation process. In relation to goal setting and implementation, consistent review and evaluation can enhance learning and skill development and direct future goal setting. It also supports the person who owns the person-centred plan to reflect on and understand their own achievements, and to identify changes for the future. The planning team and Circle of Support should reflect on their own individual roles and on their work together.

If goals are not achieved or if the person is encountering difficulties, there should be the option of a review. The person should not have to wait for a defined time period before this can happen. The person that supports putting the person-centred plan together should assist the person who owns the person-centred plan to co-ordinate reviews.

Outcome measurement is an essential element at this stage in the process. Organisations need to measure outcomes identified by persons with disabilities and become accountable for the achievement of these outcomes. The evaluation methods used to assess outcomes should be reliable and valid and be able to accurately provide the information sought.

5. Things to avoid when Goal Setting

- Low expectations, rigid thinking, or a lack of creativity from those supporting the person with their plan, can limit the range of options available to the person who owns the person-centred plan
- Goals should not be vague or too general; this may make it hard to focus and difficult to achieve
- Focus on aspirational goals rather than achievable activities. Activities of daily living do not constitute goals in person-centred planning
- Goals should not concentrate on the healthcare needs of the person. These should be addressed in personalised care and support plans
- Goals should not be constrained by the services provided by an organisation, or by the resources available to an organisation. Goals should not be secondary to the established routine of a service
- The status, interests, or availability of staff supporting the individual with their person-centred plan should not determine whether a goal is set or realised
- Do not set goals for a group; goals should be personal and individualised
- Goals should target community participation rather than community presence
- Avoid carrying goals over from one year to another with no review or update. Do not allow goals to drift on for months or be dropped without explanation
- Lack of information and responsibility leads to unmet goals; say how and by whom goals are to be implemented
- Quality risk assessment and positive approaches to risk-taking are important. Risks and challenges are a normal part of life. Don't ignore them. Plan for them. Find ways to remove barriers and to overcome them.
- Having a person-centred plan or a person-centred planning meeting is not in itself either a goal or an outcome; rather they are a means to achieving goals and outcomes.

6. Examples of Goal setting in practice

Daniel's story - Finding out what a person's dreams and wishes are:

Daniel recently moved into a new community house. He does not use a day service. Michael, the Person In Charge (PIC), is putting together a planning team for Daniel. Jean has taken on the role as Daniel's keyworker and will support him to put his person-centred plan together.

The whole staff team will support Daniel to put his person-centred plan into action, with assistance from family members.

Daniel is non-verbal and communicates mostly through body language, vocalisations, and behaviour. Jean needs time to get to know Daniel before she can support him with his person-centred plan. She discusses this with her manager. Michael suggests that Jean start by reading Daniel's communication passport and PCP plan from last year. He tells Jean that Personalised Care and Support Plans are also being developed for Daniel and asks Jean to contribute to this process.

Michael explains that Daniel has a supportive family that visit regularly. Jean agrees to talk to the family and to develop a sensory life story for Daniel. This will consist of photos, music, sounds, smells, and tactile objects. The life story will give Jean, and others supporting Daniel, a better understanding of his personal history, identity, and life experience. It will also be an opportunity to talk to people that know Daniel well about his likes, dislikes, and interests.

Jean will involve Daniel as much as possible in the development of the life story. She hopes this might involve visiting family members, catching up with old friends, or revisiting familiar places. She will actively listen to Daniel by observing, recording, and responding to his reactions to different stimuli, places, and people. Jean will draw ideas from these observations for new activities or experiences that Daniel might like to try.

She will consult with others that know Daniel well before trying new things. She will record Daniel's actions and interactions through photos, videos, and written notes, and will continually reflect and learn.

Jean will also get to know Daniel as she supports him with everyday routines and activities. Over the next three months, she plans to complete a number of tools developed by Helen Sanderson Associates:

- A one-page personal profile
- What a good day looks like / What a bad day looks like
- A relationships circle which shows the key people in Daniel's life
- Important to / Important for

When Jean has gathered all the necessary information, she will meet with her manager to reflect on her work to date and to agree next steps. At this point, Jean and Michael will consider establishing a Circle of Support for Daniel. This might be made up of a small number of people initially but could grow over time.

Jean and Michael will also review Daniel's Personalised Care and Support Plans. If appropriate, they will access multi-disciplinary supports for Daniel. Jean anticipates that specialist advice may be required to maximise Daniel's communication and to advise on technology to increase Daniel's independence.

Daniel will not put together a new person-centred plan until his planning team have a good understanding of what is important **to** him. The PIC and planning team are aware that this may take time. They set a small number of interim goals to reflect the exploratory work undertaken by Daniel and Jean.

Jean and Michael identify two key outcomes for Daniel at this time:

1. *Living in their own home in the community*; a priority short-term is to ensure Daniel settles into his new home and is happy

2. *Exercising choice and control in his everyday life*; the work undertaken to learn about Daniel and his interests and preferences will support the achievement of this outcome in the longer-term.

Ciara's story: Setting SMART goals

Ciara lives at home with her family and attends a day service from Monday to Friday. Lisa, her PCP facilitator, is supporting Ciara to put her person-centred plan together. Ciara has had a Circle of Support for the past two years. The Circle of Support is made up of Niamh (sister), John (uncle), Caroline (volunteer from a youth group), and Lisa.

Lisa introduces Ciara to the nine outcome domains for disability services. They talk about the things that are most important to Ciara and the changes she would like to make in her life over the coming years.

Ciara would eventually like to move out of the family home, but she decides this is an outcome for longer into the future. Ciara identifies that the most important outcomes at this point in her life are:

- Having a job or other valued social role
- Participating in social and civic life

Getting a paid job is the number one priority for Ciara. She feels this will bring positive changes in other parts of her life too, for example, meeting new people. Ciara wants to work with animals. This has been her goal for two years and she is a bit frustrated by the lack of progress. She agrees with the members of her Circle of Support that this goal is long-term and need to be broken down into more achievable steps. This way, barriers can be recognised and addressed as they arise.

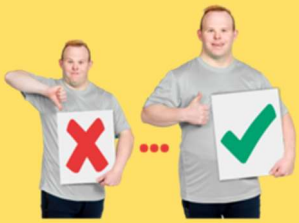
Ciara and Lisa organise a meeting of the Circle of Support. The focus of the meeting is to support Ciara to set SMART goals. The Circle of Support help Ciara to fill in the template 'Setting SMART Goals' for each goal - see example overleaf.

Lisa supports Ciara to share this information with the people that will support her to put her person-centred plan into action – her keyworker, the day service staff team, and family members.

Setting SMART Goals – Ciara's example

What is your Goal?

I would like to get a paid job working with animals.

S 	**Specific:** What do you want to achieve? Who can support you? Where and when do you want to work on this goal? I would like to work with animals. I would like to be paid for this work. My keyworker, day service manager, and employment services could support me. I might need some staff support at college too. I would like to find a job near home. I want to travel on public transport on my own to get to my job. I would like experience of working in a team.
M 	**Measurable:** How will you know if you are successful? How will you record your progress? I will be successful when I have a paid job working with animals. I will be paid at least the minimum wage. I would like to work at least two days a week. I will keep a diary, college work, photos, and have regular review meetings with my keyworker. I will break my goal into smaller steps. When I finish each step, I will record my progress.

A

Attainable:

Do you have the skills you need to reach this goal?

If not, can you get them?

Do you have the supports you need to reach your goal?

Is it the right time in your life to work on this goal?

What barriers and challenges will you face?

I have never had a job before, but I feel ready now.
I need to get some new skills, so I feel confident.
I have lots of pets that I take care of.
I am good with animals, but do not have any experience working with them.

Short-term goals:

- I will do a work preparation course in a local college
- I will put together a CV
- I will volunteer with a local animal charity to get more experience
- I will find out about the different animal care courses and qualifications that I can do at college
- I will talk to the manager in my day service and plan for the supports I need to achieve my short-term goals.

The barriers I might face:

- Available staff to support me
- Getting a place and the right support in college
- Transport to college
- Employers might not give me a chance.

R 	**Relevant:** Why did you pick this goal? Why is it important to you? Does it fit with other important things in your life? It is my dream to work with animals. I want to have a paid job so I can buy nice things for myself and my family. I want to save so I can move out of home in a few years. I want a new challenge. I don't want to be in a day service every day. I want to keep learning about animals so I can get better at looking after them. My person-centred plan is about being more independent, using my skills, and meeting new people. Having a job is a big part of this. I am also working on travelling independently which will help me with this goal.
T 	**Time-bound:** When will you start working on this goal? When will you reach this goal? I will start working on this goal in November. I want to have a paid job working with animals at the end of two years. Some steps might take longer than others. I will set a time plan for each one. I will achieve all my short-term goals by the summer next year. I hope to start an animal care course in September next year. I will start getting information on these straight away. I will apply for courses in the New Year. I will have a review meeting every three months.

My SMART Goal (long-term):

I will get a paid job working with animals.

I will get this job by November 2022.

I will work at least two days a week and will travel to work independently.

Outcome – the good change I would like:

Having a job or other valued social role.

Brendan's story: Checking on goal achievement

In March, Brendan set the goals in his person-centred plan with his facilitator, Ann, and his planning team.

One of Brendan's goals was to organise a weekend in Killarney to attend a concert in September. Brendan wanted to organise this trip for himself and his sister, Nuala, to celebrate her birthday. He was determined to do as much planning as possible independently.

Ann supported Brendan to break the goal down into a number of smaller, more manageable steps. These included:

- Brendan set up and managed a budget and savings plan for the trip. He decided how much money to spend, how much to save, how often to save, and where to save. He recorded his savings using a symbolised spreadsheet. Brendan's keyworker, Elaine, supported him to put this goal into action within a month and together they reviewed progress every month.
- Brendan made sure there was enough money in his account to book the concert tickets using his debit card. Elaine supported him with this. The tickets went on sale on 20th June. Brendan used the phone to book tickets. A staff member was available to support Brendan on the day.
- Once the tickets were booked, Brendan and his keyworker met to look online at the hotels in Killarney. Brendan decided which suited his budget best. He booked a hotel by phone at the end of June.
- Brendan organised train tickets and seats for Nuala and himself during the month of August.
- Elaine supported Brendan to pack for his trip. They went shopping the week before to buy a present for Nuala and new clothes for his trip.

Ann and Brendan met every six weeks to check on progress and to solve any problems that arose. They linked regularly with Elaine and the PIC in Brendan's centre throughout.

Brendan had a copy of his short-term and long-term goals in an easy to read format. Brendan finds time concepts difficult to understand and follow. Ann supported Brendan to set up a photo diary which he kept on a desk in his room. The diary was a visual reminder for Brendan of the tasks that had been completed, the tasks that still needed to be done and when they need to be completed by. It also included a checklist of the supports Brendan needed for each task. Brendan used this to remind the PIC in his centre a few days before this support was required, for example, assistance from a staff member to book the concert tickets on day of sale.

The diary and photos provided a clear visual timeline and evidence of short-term goals being achieved within the agreed timeframes. The diary included receipts, emails, confirmation letters etc. as appropriate. Brendan plans to put together a slideshow for his next person-centred planning meeting. This will show how he achieved his short-term goals in planning for the trip. It will also share photos of the trip itself, demonstrating the achievement of the longer-term goal.

The goals achieved by Brendan supported positive changes in his life. These changes relate to a number of the nine outcomes:

1. Exercising choice and control in my everyday life
2. Participating in social and civic life
3. Having meaningful personal relationships
4. Having opportunities for personal development and fulfilment of aspirations
5. Enjoying a good quality of life and well-being.

7. Bibliography

- Doran, G. T. (1981). There's a S.M.A.R.T. Way to Write Management's Goals and Objectives. Management Review, 70, 35-36
- Guidelines on Person-centred Planning: The National Disability Authority, 2005
- National Standards for Residential Services for Adults and Children with disabilities: HIQA, May 2013
- New Directions Personal Support Services for Adults with Disabilities: HSE, 2012
- Outcomes for Disability Services: National Disability Authority, 2016
- United Nations Convention on the Rights of Persons with Disabilities: United Nations, December 2006
- www.helensandersonassociates.co.uk
- www.photosymbols.com

Contact details:

www.hse.ie/newdirections

Modern Printers 056 7721739