# A National Framework for Person-Centred Planning in Services for Persons with a Disability Summary Version

New Directions

Building a Better Health Service

Seirbhís Sláinte Níos Fearr á Forbairt


This report was commissioned by the HSE on behalf of the National New Directions Implementation Group, and produced by ACE Communication Ireland.

This document is a summary version of the National Framework for Person-Centred Planning in Services for Persons with a Disability.

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# 1. Introduction

## Why do we need a framework for person-centred planning?

This document is a summary version of the National Framework for Person-Centred Planning in Services for Persons with a Disability. The framework contains more detailed information, along with two evaluation tools – one for the person who owns the plan and one for the organisation. Specific resources to support organisations and staff at the different stages of person-centred planning are identified. The documents and resources are available at www.hse.ie/newdirections.

Person-centred planning focuses the delivery of services and supports on the person and how they want to live their life. This framework aims to inform and guide how person-centred planning is carried out across services for persons with a disability in Ireland.

## Who is the framework for?

The framework is designed to support adults with disabilities with person-centred planning, when it is carried out within an organisation. It will be of interest to anyone involved in the person-centred planning process, including persons with a disability, staff, managers and circles of support. The framework is relevant for all services for persons with a disability, including day, residential, home and community.

This framework caters for a wide range of needs. At all times, the user must decide if the guidance is meaningful to the person and their context, and to improving the effectiveness of person-centred planning for the individual.

### The structure and content of this summary version of the framework

This section outlines the rationale for the development of a national framework for person-centred planning. In section two, a number of key terms are explained. In section three, the beliefs and foundations that underpin person-centred planning are summarised. Section four briefly outlines organisational culture, structures and processes, which strongly influence the quality of the process and the achievement of outcomes. In section five, person-centred planning is broken down into four stages. There are examples at each stage to show person-centred planning in practice.

## 2. What is person-centredness, person-centred planning and a personal plan?

### Person-centredness

Person-centredness is an overall approach that recognises the uniqueness of every individual, whether availing of or providing a service. This approach is possible through the development of relationships that enable everyone to achieve their personal best and flourish. The values of person-centredness underpin person-centred planning; respect, self-determination, empowerment, understanding.

### Person-centred planning

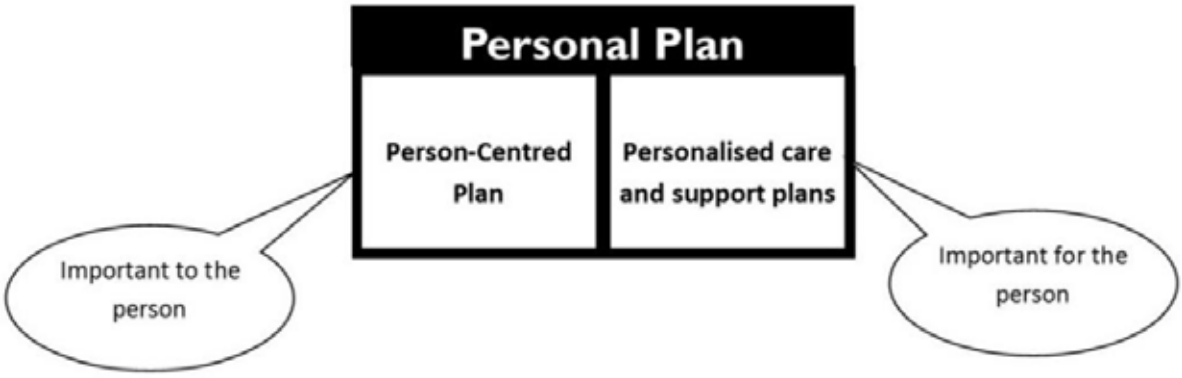
Person-centred planning supports and enables a person to make informed choices about how they want to live their life, now and in the future. It supports the person to identify their dreams, wishes and goals, and what is required to make those possible. The framework for person-centred planning sets out the key stages of the process and what is important at each stage for person-centred planning to be effective. However, the best measure of success for person-centred planning is whether the individual at the centre of the person-centred planning process has experienced a real change for the better in his or her life, as a result of their person-centred plan being implemented.

## Personal Plans

The standards and regulations for residential services for people with disabilities in Ireland require each person using residential services to have a personal plan. The overarching personal plan can contain a number of different types of plans, including the person-centred plan and personalised care and support plans.

'Personalised care and support plans' cover a range of different support plans that respond to a person's everyday needs, for example, a communication passport, intimate care plan, medication management plan or positive behaviour support plan. Recognising what is important to a person and what is important for them can help to understand the difference between person-centred planning and personalised care and support plans. Person-centred planning is about what is important to a person, what really matters to them, from their perspective. Personalised care and support plans are about what is important for the person, the support they need to stay healthy, safe and well.

**Figure 1.1: Illustration of personal plan containing personalised care and support plans and the person-centred plan**



# 3. The core beliefs and foundations of person-centred planning

## Beliefs

### These beliefs are at the centre of good person-centred planning and need to be adopted at every stage of the process:



**Individuality**; each person is an individual with their own life experience, skills, gifts, talents and culture.

**Equality**; each person with a disability has the same rights as all others in society. Each person is given information and support to understand and claim their rights.

**Respect**; each person is treated as an adult. Relationships are built on respect.

**Dignity**; the privacy and dignity of each person is respected. Each person with a disability is given the chance to take risks and try new things.

**Empowerment**; person-centred planning supports the person to take control of their life. Each person is supported to have their say and their views are respected.

**Choice**; everyone is given the chance to make choices and decisions about their person-centred plan and about their lives. Individuals are supported to communicate their choices and decisions.

**Inclusion and active citizenship**; each individual is an important member of their community, trusted to hold valued social roles. Person-centred plans support the person to take part in their community, to make new friends and have new experiences.

**Independence**; each person is supported to be as independent as they can be.



## Foundations

### These foundations are the building blocks at each stage of the person-centred planning process:






**Beliefs**; organisations have a person-centred culture. They believe in individuality, equality, respect, dignity, empowerment, choice, inclusion and independence.

**Person-centredness**; services and supports are built around the needs of each person rather than a group.

**Outcomes**; person-centred planning is about achieving outcomes for the person. Outcomes are good changes that give each person a better life.

**Planning across an organisation**; person-centred planning is important at all levels of an organisation. It is part of how the whole organisation works and is not a new or separate service.

**Every plan is different**; every person-centred plan is a one-off. It shows the individual's strengths, needs, goals, dreams and wishes.

**Listening**; individuals, staff teams and managers really listen to and respect the choices that each person makes. They accept and respond to the decisions of the person, and their family where appropriate. The person decides if they want their family to be involved.

**Responsibility**; individuals, staff teams and managers show how they support each person to achieve their personal goals and outcomes. They answer any questions that a person may have about their supports.

**Expectations**; there are high expectations and hopes for each person. Person-centred planning encourages each person to believe in themselves and supports the person to be the best they can be.

**Relationships**; individuals, staff teams and managers make sure that each person has the time, space and chance to build meaningful relationships.

**Partnership**; individuals, staff teams and managers work together with persons with a disability – this is called partnership. Power is shared and there is open communication. Each person can get the information they need to have a say in services and supports.





## 4. Organisational Culture, Structures and Processes

The culture, structure and processes in an organisation can strongly influence the quality of person-centred plans and the achievement of outcomes. Many of the aspects listed below are addressed by the HIQA National Standards for Residential Services for Children and Adults with Disabilities, and the HSE Interim Standards for New Directions.

Organisational culture is strongly linked to the beliefs and foundations in section 3. The culture of the organisation should encourage individuals to reflect on their practice and to make changes. All those involved in person-centred planning should take part in continuous learning and development. In addition, the following elements are highly influential to the person-centred planning process:

- **The environment and approach to services and supports;** person-centred planning is more likely to be successful for persons with disabilities if they live in pleasant, stimulating environments, which offer new and different experiences and support meaningful engagement, independence and community participation.
- **Governance and leadership;** a clear structure with defined roles and lines of accountability. A proactive, confident management style, where leaders help change thinking and practice.
- **Good communication;** between persons using services, families, advocates, staff, community members and key stakeholders.
- **Support for staff;** a performance management system and environment where all staff accept accountability for their work, and feel valued, respected and supported.
- **Working collaboratively;** persons with disabilities participate in decisions that affect their lives and are viewed as experts by experience. They are consulted on and involved in the day to day running of the organisation.

- **Access to self-advocacy and advocacy supports;** self-advocacy is promoted and there is access to a range of supports, including independent advocacy supports and wider self-advocacy networks.
- **Positive risk management;** persons with disabilities are afforded the 'dignity of risk'. A step by step approach enables the person to gradually build the skills necessary to take part in different tasks, activities and experiences.
- **Resources and finances;** adequate funding and resources support the development and implementation of quality person-centred plans.
- **Supporting service improvements and managing complaints;** there is a formal complaints policy and procedure which is accessible to all.
- **Community engagement;** individuals, staff teams and managers strive to develop circles of support beyond staff and family members.

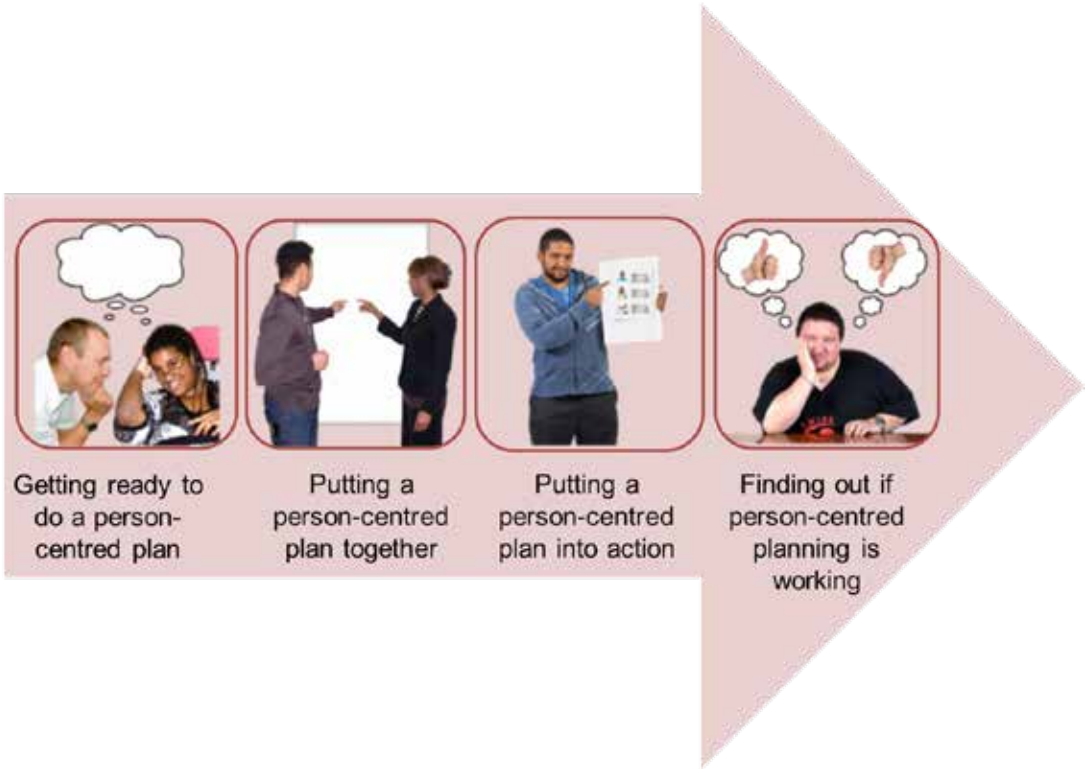
# 5. Key elements in person-centred planning

In this section, the essential steps to achieving good practice in person-centred planning are highlighted.

Person-centred planning has been divided into four main stages:

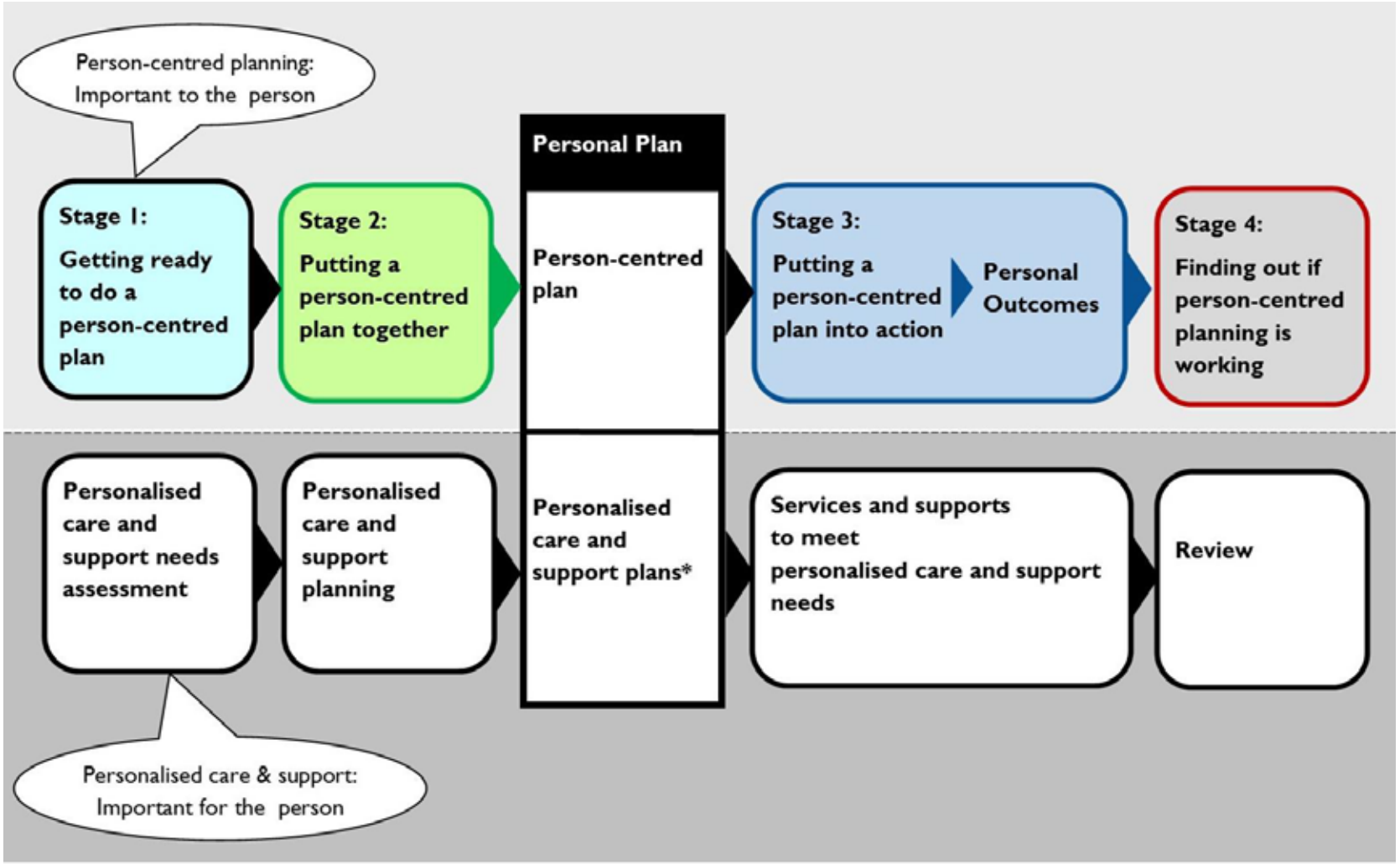
- **Stage 1 - Getting ready to do a person-centred plan**
- **Stage 2 - Putting a person-centred plan together**
- **Stage 3 - Putting a person-centred plan into action**
- **Stage 4 - Finding out if person-centred planning is working**

**Figure 1.2. The four stages of Person-centred Planning**




It is essential that all aspects of person-centred planning are accessible to the person. This enables them to fully engage in the process from the outset. Figure 1.3 shows the person-centred planning process, including how person-centred planning fits within a personal plan. It also highlights how person-centred planning and personalised care and support work together to achieve the best outcomes for the individual.

**Figure 1.3. How person-centred planning and personalised care and support work together**

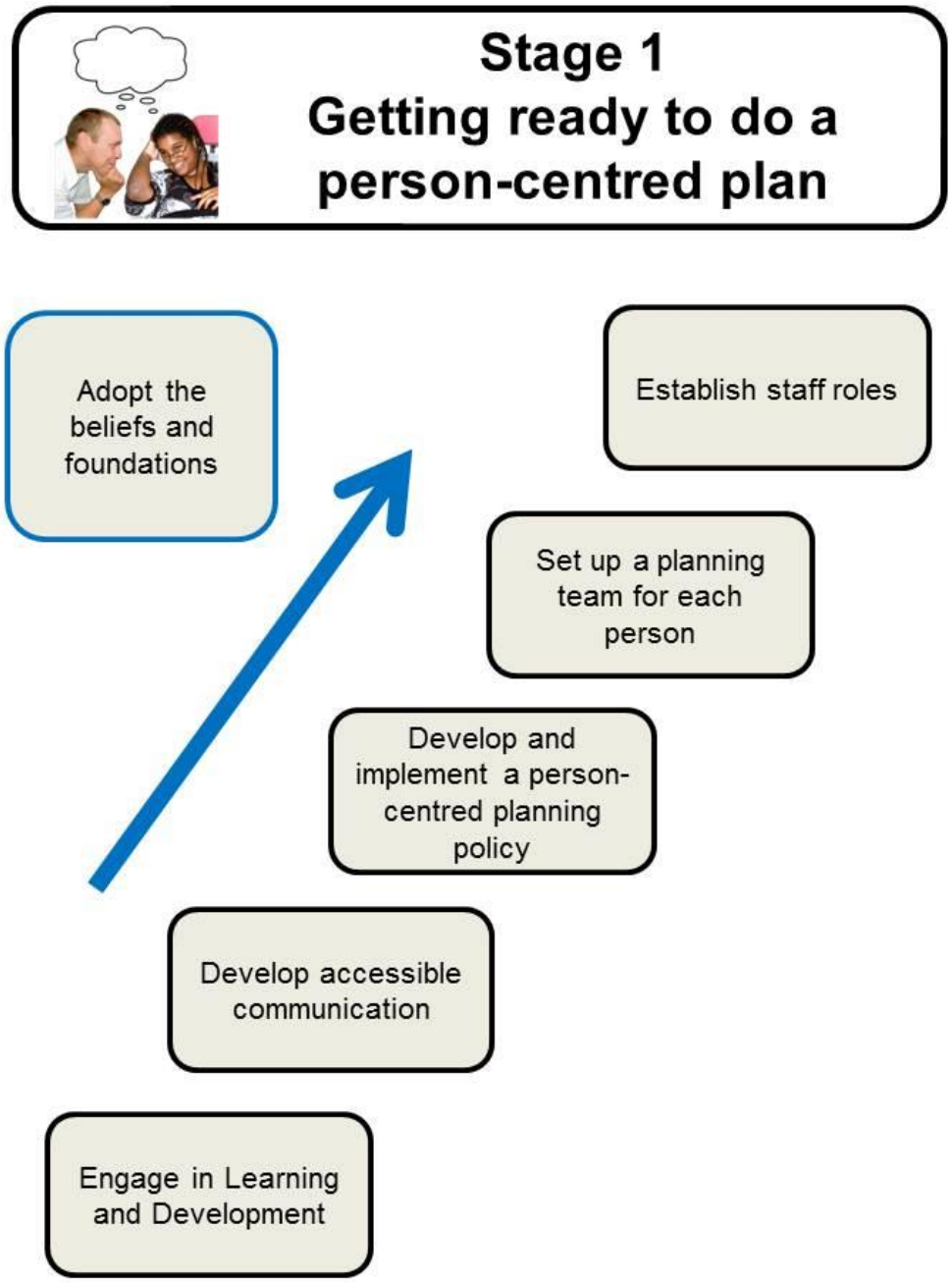



*Personalised care and support plans should be developed within 28 days of a person starting to use a HIQA-registered residential service. Person-centred planning may take considerably longer, depending on the individual.

## Stage 1 - Getting ready to do a person-centred plan

During this stage, the individual is supported to understand what person-centred planning is about and how it might work for them. The person decides if they wish to have a person-centred plan. If they do not want a person-centred plan, the organisation should put alternative supports in place to assess and meet their needs and wishes. A record should be kept of all attempts to engage each person. The person can change their mind about having a person-centred plan at any point.
It is essential that the beliefs and foundations are adopted at the start of the process.

**Figure 1.4. Stage 1 of person-centred planning**




## Learning and Development

- Opportunities for learning and development are crucial to support the person to engage fully in person-centred planning. Opportunities should be available not only to staff, but to those who own the person-centred plans, their family members, circles of support and communities.

## Accessible communication

- Individuals and teams should ensure that person-centred planning is meaningful and accessible to each person.
- For some individuals, the key to developing a good person-centred plan lies in the establishment of meaningful relationships, where those supporting them are familiar with their communication strengths and needs.
- The person who owns the person-centred plan may need access to supports such as the expertise of a multi-disciplinary team, skilled interpreters, communication assessments, communication passports and technology.
- Information should be provided in ways that the person can understand, using 'Total Communication', for example, objects, photos, video, audio, Easy to Read materials, Plain English materials, Lámh, Irish Sign Language.

## The person-centred planning policy

- Organisations should have a person-centred planning policy in place across the service.
- The policy should recognise that while there can be more than one organisation supporting a person, a person should have just one person-centred plan, which they own. The policy should state who takes overall responsibility to support the person-centred planning process when a number of organisations are supporting the person.
- Staff and managers should ensure that person-centred planning does not become a paper exercise, but that the focus remains on outcomes for the person.

## The planning team

- A planning team should be identified for each individual. This team is made up primarily of individuals or staff members who are paid to support the person with their person-centred plan, and so assist the person to achieve dreams and wishes from a service or support aspect.

- The planning team could consist of:
  - the person who owns the plan
  - the person who supports putting the person-centred plan together
  - the person who supports putting the plan into action
  - family (if the person wants this)
  - multi-disciplinary team (if appropriate)
- The person who owns the plan should lead out on the person-centred plan as much as possible and should decide the membership of the planning team.
- Ideally the establishment of a planning team should ultimately lead to the formation of a circle of support for the person who owns the plan.
- The support and involvement of family members (where this is the choice of the individual who owns the person-centred plan) is key to good person-centred planning. Quality person-centred planning should maintain and strengthen relationships with family.
- Where the person has no family or community involvement, the organisation should prioritise and seek to address the lack of social relationships at an early stage of person-centred planning.

## Staff roles

- The support of staff in person-centred planning has been found to be one of the most powerful enablers of outcome accomplishment.
- There are two distinct roles for staff in person-centred planning:
  - The person who supports putting the person-centred plan together
  - The person who supports putting the person-centred plan into action

  It is recommended that these roles should be undertaken by different people.
- Best practice says that the person who supports putting the person-centred plan together should be independent from the organisation, as this ensures the person is not influenced by service needs and constraints. However, it is acknowledged that this can be difficult to achieve in practice. Where a person-centred plan is being facilitated within an organisation, the autonomy of the person who supports putting the person-centred plan together must be adequately assured.
- The person who supports putting the person-centred plan into action may be the individual's keyworker.
- All those involved in putting the person-centred plan into action should be engaged at the stage where the person-centred plan is being developed.

## This is an example of how learning and development can support a person who owns a plan to engage in the person-centred planning process:

Emma is a nineteen-year-old woman, living at home with her family. She recently started to attend a small day service in her local community. She has profound and multiple disabilities.

Joanne is responsible for supporting Emma to develop her person-centred plan. Joanne is employed by the organisation which provides Emma's day service, but she does not work in the day service. Joanne is looking at different ways to increase Emma's understanding of person-centred planning and control over the process. She talks to a number of people who know Emma well including her family, the staff that support her in the day service and clinical staff. Some people feel that Emma does not have the ability to understand what person-centred planning means or to make choices and decisions about her life. Most of Emma's needs are anticipated by those supporting her and her communication is described as 'very limited'.

Joanne is keen to make sure that Emma is given an equal opportunity to learn and develop skills which can help her to engage with the person-centred planning process. She notices that Emma makes very few decisions in her life and decides to start by increasing the opportunities that Emma has to make choices during the day. Joanne feels that this will allow Emma to experience control and to communicate her likes and dislikes. It will also be a way for Joanne to get to know Emma better and to find out about her preferences.

She liaises with clinical and day service staff, and with Emma's family, and they decide that choice making through objects would be the most appropriate way forward for Emma. Emma is given the opportunity to engage with objects by looking at them, holding them, touching them and smelling them. Over time, Joanne and others notice that Emma will hold on tightly to objects of interest but will drop to the floor objects that she does not like. Emma selects the clothes she will wear each day, her preferred shower gels, sensory objects and favourite blankets in this way. Those supporting Emma build up a small set of objects to represent different activities and locations. Eventually, it is hoped that Emma will use these to select activities or places to visit, and to develop person-centred planning goals.

Emma is a sociable young woman but her communication circle is largely confined to paid staff and family members. Joanne would like to support Emma to develop new social relationships. This may allow Emma to build a better understanding of community and to develop a circle of support. Working with those supporting Emma, she identifies a number of opportunities in Emma's community, including regular visits to a local community centre and coffee shop, joining a youth group and taking part in the Tidy Towns organisation. Those supporting Emma will observe her interactions and responses in these settings to see her interest and levels of satisfaction over time. Evidence will be recorded through photos, videos and observation notes.

## This is an example of technology in use to support person-centred planning:

Keith is a 38-year-old male with excellent communication skills, who can fully articulate his needs and wants. He has a mild intellectual disability. Keith meets with his person-centred planning facilitator on a regular basis to discuss his life and his goals.

In the 20 years since he left school, Keith has been supported in various ways by a large disability service provider. He has had an opportunity to complete training courses, participate in social and leisure activities in his local community, engage in supported employment and experience the world of work. Most significantly, he has had the opportunity and support to move into his own home; a one-bedroom bungalow, situated around the corner from his parents' house. He is very proud of this achievement.

When Keith first moved into his house, he had some home support to help with shopping and cooking, but as he grew in confidence and skills, he identified that he no longer needed this support and now he manages to run his home independently with minimal encouragement and support from his family and key worker.

Over the past few years, Keith has embraced technology as a way of helping him in his daily life. He has a video monitor on his front door so he can see who is outside before he opens his door, this helps him in feeling safe and secure in his own home and helps him maintain his independence. Keith also has a smart phone, which he uses to keep in touch with his friends and family through calls and text messaging. He also uses the internet to help plan his social life, for example, cinema times or things to do at the weekend and to keep in touch with friends through social media.
In the area of technology Keith has embraced a web-based planning tool, used by his service provider as a means to record important information about his support needs, and to help inform the people who support him about the actions that need to happen to help him achieve his goals for the future. Keith believes the advantages of using this web-based planning tool are that it can make his plans come alive through videos, photos, pictures and sound, and make it more likely that his plan happens as staff focus on those things which are really important to him.

The web-based planning tool also facilitates Keith to decide what information goes into the plan and who sees the information, so he is fully in control. It can support him to keep track of outcomes - what he is achieving and doing.

Keith's story on how he uses the web based planning tool has been made into an information video for those who may be interested in using technology to help them plan for their lives.

## These are examples of how a person who owns the plan can lead out on the development of their person-centred plan:

Rob is a 23-year-old male who uses a powered wheelchair, has excellent communication skills and can fully articulate his needs and wants. When Rob initially engaged with adult services, he attended a local day service. Through sampling activities and participating in the local service programme, Rob decided that the local service was not for him. Rob was supported by his person-centred planning facilitator to identify opportunities outside of the traditional service model.
At this stage of the process, Rob was not completely leading the person-centred plan. Although he was advocating for himself in terms of what he did not want, he was unsure as to the direction he wanted to take. Rob continued to meet with his facilitator to explore potential goals and trial various possibilities.

Rob decided to pursue further education and was accepted into a local University as part of an Inclusive Learning programme, where he studied Geography & Music Technology. Rob was supported to interview his own personal assistant and to get involved in every aspect of college life. Over the course of his time at the University, Rob's self-confidence and self-awareness increased dramatically. It was particularly significant that he was in a fully accessible environment where he could get himself around independently without staff support. Prior to this Rob had never been in an environment without staff support. Rob consistently passed all assignments and exams, surpassing all expectations including his own. Realising his potential and capabilities has greatly helped Rob to have the confidence to lead his own plan. Throughout the past 3 years, Rob has taken ownership of his life goals and has directed staff in relation to the opportunities he wants to pursue. He regularly meets with the staff that support him and is now comfortable and confident enough to lead meetings, follow up on actions and instruct staff as to the support he requires. Rob now has greater aspirations for his life; he plans to get a job, go on a sun holiday (without his mother) and most notably will be moving into his own apartment towards the end of this year. Rob has faced many barriers and obstacles over the years including transport, managing personal care support needs, inaccessible living environments and housing.

Rob's story is an example of how an individual can be supported to live the life of their choosing and take full control of leading their own person-centred plan.

Tony is sixty-three years old. He lived in campus residential services before moving to a home in the community 15 years ago. Tony has been living with dementia for 7 years and is now at the end stage of his dementia journey. Previously he was a very independent, sociable man with lots of friends. He worked for many years in a local shop but gave this up due to ill health. Tony has a close relationship with his sister. Previously Tony led out independently on his person-centred plans. However, his ability to communicate and engage in the person-centred-planning process has changed dramatically. Tony is now reliant on his communication partners to read his body language, facial expressions and vocalisations, understand his preferences and ensure he is comfortable. Tony has a life book which documents his life history using photos. Staff report that he enjoys looking at this with familiar people. In addition, staff have gathered all of his favourite music on an IPad which he enjoys listening to. From time to time, Tony may hum along to the lyrics or try to sing.

This year, Tony's keyworker Rebecca gathered all of the information relating to his life, previously expressed preferences and the choices in his person-centred plans. Tony completed an end-of-life care plan shortly after he received his diagnosis and this was reviewed. Staff spoke with Tony's sister and others who know him well. Information gathered was used to put together a person-centred plan which has a focus on end-of-life care.

The plan includes Tony's key preferences for where he lives (at home and not in hospital or campus style accommodation), to have his favourite possessions with him and to have his favourite music playing. Tony has access to a local palliative care team to support him to achieve his goal of living and dying in his home comfortably.
It focuses on maintaining relationships: Tony's friends and colleagues from his work were important to him. Because Tony is no longer able to communicate in the way he did before, staff now support his friends and colleagues with visits to ensure Tony can enjoy their company (e.g. by suggesting they share Tony's life book, listen to music and sing with Tony, ask Tony if he might like a hand massage or a walk).
Tony's person-centred plan is reviewed and updated on a monthly basis to ensure that he is supported to live life the way he chooses and that his end of life plan is followed. Communication partners, that know Tony well, observe his communication closely, so they can be responsive and recognise changing needs.
Through the process of getting ready to do the plan, staff identified their need for additional training to communicate effectively with Tony. Through an approach called 'adaptive interaction'[1], staff learned to be 'in the moment' and to 'connect' with Tony.

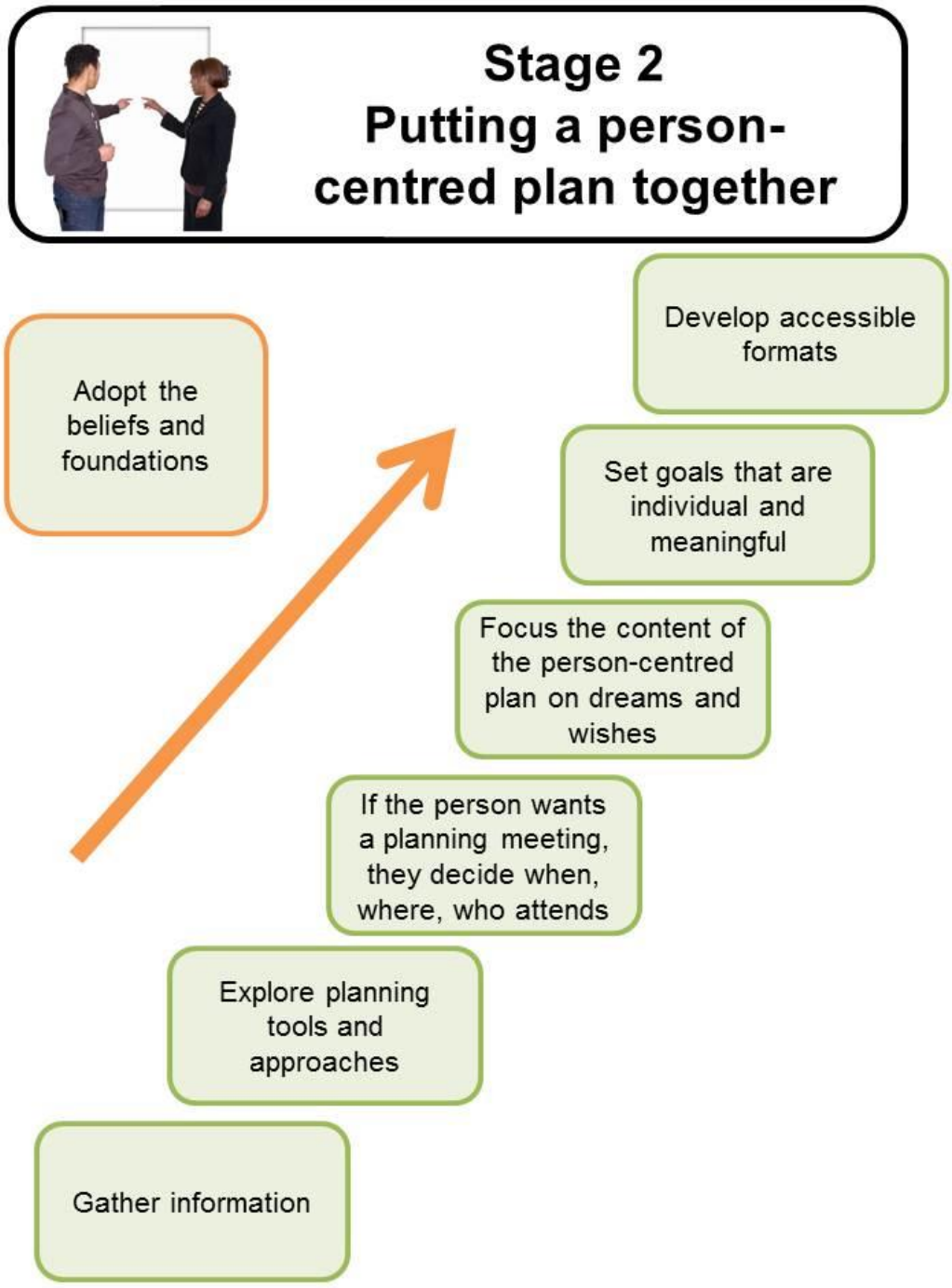
[1] Ellis, M. and Astell, A, (2017) **Adaptive Interaction and Dementia.** 1st ed. London: Jessica Kingsley Publishers

## Stage 2 - Putting a person-centred plan together

During this stage, the person who owns the person-centred plan is supported to gather information, to decide on their goals and to develop an action plan for achieving goals and outcomes. Individuals will need different levels and types of support, and different timescales, to find out what they want for themselves and what is important in their lives.

The beliefs and foundations should be adopted during this stage of the process.

**Figure 1.5. Stage 2 of person-centred planning**




## Gathering information

- Person-centred planning is a continuing process and not an annual event. Information should be gathered with the person throughout the year with opportunities for constant review, reflection and evaluation.

- Information should be gathered on the person's current routine, activities and the opportunities available to them. The person's strengths, likes and dislikes, dreams and hopes should be identified.
- Information for person-centred planning is gathered by providing opportunities for new experiences, observing, actively listening to and responding with encouragement to all communication attempts from the person.
- Creating an environment that is relaxed and informal is considered more appropriate for undertaking person-centred planning and may enable the natural authority of the person to be more easily recognised and appreciated.
- Person-centred planning should be formally recorded in some way, for example in a written or accessible person-centred plan, goals, update notes, review notes and evidence of evaluation.

## Exploring person-centred planning tools and approaches

- Planning tools can be a useful part of person-centred planning, however there should not be over-reliance on standardised tools that could restrict individualisation, and challenge the core beliefs and foundations necessary for the development of quality person-centred plans.

## The person-centred planning meeting

- The person who owns the person-centred plan should decide if they want a person-centred planning meeting. If they do, they should be given the time, space and necessary tools to prepare for their meeting. If the person does not wish to have a meeting, then alternative ways to support the development of a person-centred plan should be explored.
- The person should decide when and where to have a person-centred planning meeting; they choose the type of meeting, the time and the venue. They should decide who attends their meeting; they choose who they feel can best support them to achieve their goals.

- The person who owns the person-centred plan should have the chance to attend all meetings if they wish to. The person who supports putting the person-centred plan together should ensure that the meeting is accessible to the person, for example through the use of sensory materials, objects, mementoes, signs, photos, DVDs, PowerPoint presentations, music.
- Members of the circle of support should be facilitated to attend all person-centred planning meetings. The person who will support the individual to put their person-centred plan into action should also attend the meeting.

## The content of the person-centred plan

- Person-centred plans should be personalised and unique to the individual.
- They should focus on the personal aspirations of the individual and on outcomes for the person. They should describe a vision of a more positive future for the person.

## Setting goals

- Goals should be specific, person-centred, longer-term and developmental. Long-term goals should be broken down into a series of steps or smaller goals.
- Goals are individual and meaningful to the person, and should not be constrained by the services provided by an organisation, or by the resources available to an organisation.
- The person supporting the individual to put their person-centred plan together should assist them to select and prioritise aspirations and goals. Where the person needs a high level of support to select their goals, consent should be viewed as an ongoing process.

## Accessible formats

- The person who owns the person-centred plan should hold the main copy in a format and place which is accessible to them. The organisation(s) will have a copy of the person-centred plan.

## This is an example of goal setting in action in collaboration with circles of support:

Anna is a 45-year-old woman living in a community residential setting, Anna attends a local day service. Anna communicates through body language and movement, facial expression, eye gaze and vocalisations.

Anna has a circle of support to assist her to develop and action her person-centred plan. This team includes her person-centred planning facilitator, sister, niece, residential keyworker, a staff member from her day service and neighbours. The circle of support are anxious to ensure the goals they select with Anna accurately reflect her choices and wishes.

Over the past few months, the members of the circle of support have taken photos and video of Anna reacting and responding to different people, places, activities and things. They have gathered information from people who know Anna well and interact with her on a regular basis, and from those with 'fresh eyes' who are just getting to know her. They have shared their learning and understanding of how Anna communicates and of her choices and preferences.

The information and evidence gathered shows a number of important things for Anna. Anna seems happiest when she is outside – she shows this in her relaxed body posture, smiles, increased eye contact and in the sounds she makes. She loves trees, enjoying the movement of the leaves and the changing light patterns. Anna loves the smell of particular flowers and likes to hold the petals in her hands. Anna is most communicative when she is outside, enjoying nature, and she likes to share this experience with the people closest to her, for example her family and close friends. She shows this in her excited reactions to their arrival and presence.

The circle of support would like to extend the opportunities Anna has to engage with nature and her physical environment. They would like to include this in some way in her person-centred plan and goals. The first step is to extend the range of gardening and horticultural activities which Anna participates in at her day service. Then the circle will explore Anna's community to find out about local garden centres, accessible walks and trails, sensory gardens etc. The next step will be to arrange more frequent visits to such locations and to observe Anna in these environments. Anna's neighbour and family members offer to accompany her on these visits.

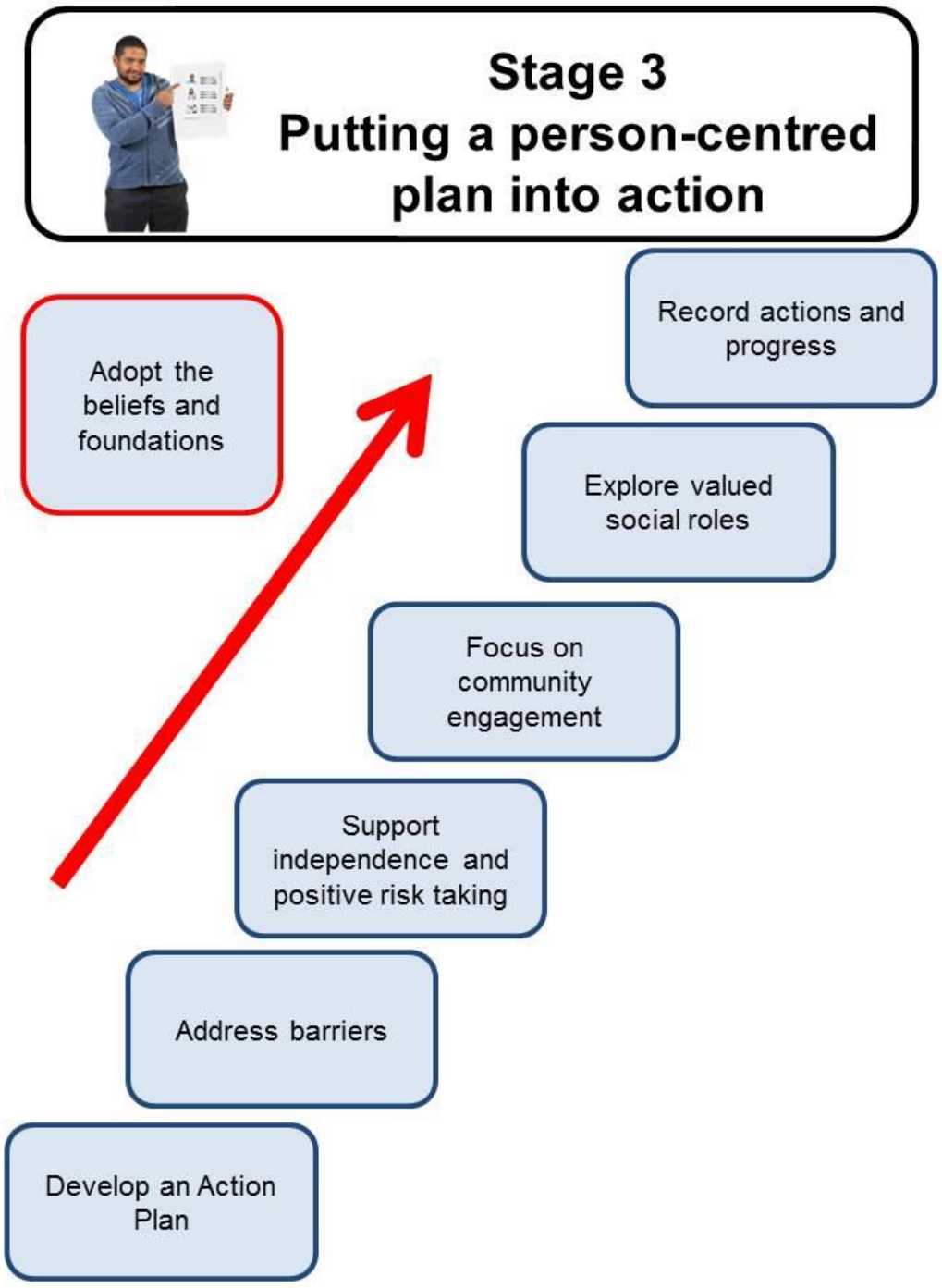
The circle of support will review progress on a regular basis and talk about longer-term goals for Anna such as joining a community gardening group, volunteering with an environmental group, or employment in a garden centre or florist.

## Stage 3 - Putting a person-centred plan into action.

At this stage, it is important to identify those who are key in supporting the person to implement their person-centred plan. It is critical to have constant review and reflection, and that barriers are identified and addressed.

The beliefs and foundations continue to be important at this stage of the person-centred planning process.

**Figure1.6. Stage 3 of person-centred planning**



## Action plans

- The person who owns the person-centred plan and the person supporting them to put their person-centred plan together should set out a clear, accessible action plan.
- Clear timeframes and those responsible for supporting the person to achieve their goals should be identified in the action plan.
- The action plan should be communicated clearly to the person who will support putting the person-centred plan into action.

## Addressing barriers

- Planning teams and circles of support need to be committed to finding ways to achieve the person's goals, even if this is a challenge.
- Where barriers are identified during the implementation of person-centred plans, these issues should be addressed initially at the local level. Where barriers cannot be addressed at the local level, a process should be in place to allow barriers to be brought to the attention of appropriate senior managers. Every effort should be made to successfully address the issue.
- If the person does not feel that their issue was appropriately handled they should be given the opportunity to express this and if necessary be facilitated by the team to use the complaints policy and procedure in the organisation to express their dissatisfaction.

## Supporting independence

- Person-centred planning should provide opportunities for persons with disabilities to achieve more independence in their daily lives, for example by setting goals relating to specific skill development such as in relation to finances, employment, travel, relationships.

## Managing risk

- Individuals, staff teams and managers should set out to afford those using their services the 'dignity of risk'. The dignity of risk is the right to take risks when engaging in life experiences, and the right to fail in those activities.
- Person-centred plans should address, as appropriate, positive risk taking and risk management.
- Where risks pose a barrier to an individual achieving their goals, a proactive and flexible approach is required. A step by step approach is recommended which encourages and enables the individual to gradually build the skills necessary to take part in different tasks, activities and experiences.

## Community engagement

- The person who owns the person-centred plan should be supported and encouraged to explore their community, and to access that community as an individual, developing meaningful roles and relationships.
- Individuals should be supported to hold valued social roles. These are roles that enable a person to contribute in a meaningful way to their family and their community.
- Person-centred planning can be an important tool in the exploration of employment options and career choices for persons with a disability, if this is one of their goals. Person-centred planning can be complementary to other employment supports such as supported employment.
- Individuals and staff teams should seek to increase the involvement of community members and supporters from outside the service in person-centred planning and in circles of support.

## Recording actions and progress

- All reviews of the person-centred plan, including ongoing informal reviews, should be formally recorded.
- Person-centred plans should be updated and amended to account for changing circumstances, new developments and reviews.
- There should be clear evidence to illustrate whether or not goals were achieved, for example written examples and notes, photos, or video evidence.
- The person supporting putting the person-centred plan together, and the person responsible for making sure the person-centred plan is put into action, should communicate and share relevant information and learning in relation to the person and their person-centred plan.

**This is an example of how one person, with the support of their circle of support, addressed barriers to their plan. In doing so, they were supported to be more independent.**

Laura lives at home with her family and attends a community-based service in the nearest town. She is twenty-two years old and has a moderate intellectual disability. At a recent review of her person-centred plan, Laura explained that she would like to increase her fitness. She would like to make it into a gymnastics squad for a national competition. Laura would like to attend a gym during the week as she feels training at the gymnastics club at the weekend is not enough. Laura would like to use a local leisure centre as she knows some of the members and feels she would be comfortable there. She aims to go to the gym twice a week. Laura's keyworker and the service manager feel she would need support at the gym, as she is not familiar with the building or equipment. They do not have enough staff to support Laura to attend the gym twice a week. The staff are concerned that Laura may waste money on a gym membership if she cannot attend regularly or does not like it.

Laura's mother is concerned about her safety in the gym. She is worried about health risks and injury. Laura thinks her mother is being overprotective. Laura's circle of support talk about her goal and explore ways to overcome the barriers. Laura and her mother agree to visit her Physiotherapist to get advice and reassurance about her health and exercise regime. The Physiotherapist suggests that initially one session a week is spent in the gym and one in the pool. Laura is happy with this.

Laura's sister agrees to accompany Laura to the local gym so she can get information. They talk to the manager in the gym about a trial membership for a month or two. The service manager agrees to provide a staff member to go to the gym with Laura four times to support her to become familiar with the facilities. Laura's sister and neighbour agree to back up this work with a number of evening visits to the gym. Laura's facilitator finds out about a local council scheme, which supports people with disabilities to use leisure facilities. A personal trainer would be available to work with Laura in the gym to develop her personal programme. The service manager agrees to explore the possibility of finding a volunteer to accompany Laura to the gym.

Laura asks her keyworker for support to develop a visual checklist so she knows what to pack in her gym bag. She would like to learn how to wash her gym gear after each visit. Her Mother agrees to support her to learn to use the washing machine. Six weeks on, Laura is walking from home to the leisure centre on her own. Once a week, she goes independently and has a swim. Laura has a personal gym programme. On Wednesday morning, a volunteer meets Laura at the gym and supports her to complete this. Laura hopes that this support can be reduced soon as she is getting to know the gym instructors and is more confident to ask questions and ask for help if she needs it.

## This is an example of person-centred planning in action where positive risk taking, supporting independence and employment options are addressed:

Harry recently left school and started receiving supports from a community-based service in his local town. He has a moderate intellectual disability. Harry can communicate verbally, and has expressed the desire to be more independent and to be treated as an adult. Harry would like a job but there are limited opportunities locally. He is aware of jobs available in the next town, twenty-minutes away by bus. Harry would like to work in retail. He is excited about earning and spending his own money. It is likely that he would need some job coaching and support initially but Harry feels confident that over time, he would be able to work in paid employment independently.

Harry's parents and keyworker are concerned about his road safety and travel skills, and feel it may be too big a step for Harry to travel independently on the bus to work.

Harry and his person-centred planning facilitator talk about his goal. They complete a risk assessment. They break the journey to the next town down into clear steps. They agree to look at one step at a time. Initially, they will complete a skills analysis on the walk to the bus stop. Harry will participate in road safety training in the service. They will need to focus on using the pedestrian lights, as there is one main road to cross on the way to the bus stop. Harry will complete this step with support at first, which will be phased out over time. Harry's mother is reassured that phasing out the support will include staff shadowing Harry for a time as he learns to use the crossing, and peer support to use the crossing, before he walks fully independently to the bus stop. Once this step has been achieved, Harry will work on the next step in the journey.

Harry and his facilitator talk with his mother about her concerns, and she explains that her main worries centre around Harry's ability to problem solve. She worries about things like a change to the bus route, if a problem arises or if Harry gets anxious and needs support. Harry has recently started using a mobile phone and they agree to explore this as a potential way to address some of the barriers.

Harry and his father will look at an interactive website at home which promotes road safety skills and provides a learning record which can be shared with service staff. On Saturday, Harry and his father walk to the local GAA club. Harry's keyworker shares their approach to using a pedestrian crossing so Harry gets consistent information. Harry's father is pleasantly surprised by his son's level of skill and determination. In a short space of time, Harry is walking to the bus stop safely and independently. He quickly masters the skill of hailing the bus and of using his bus pass when he gets on the bus. He is presently working on the skills needed during the journey.

The plan is that Harry will get on the bus by himself soon and staff will join him later in the journey to support him to get off at the right stop.

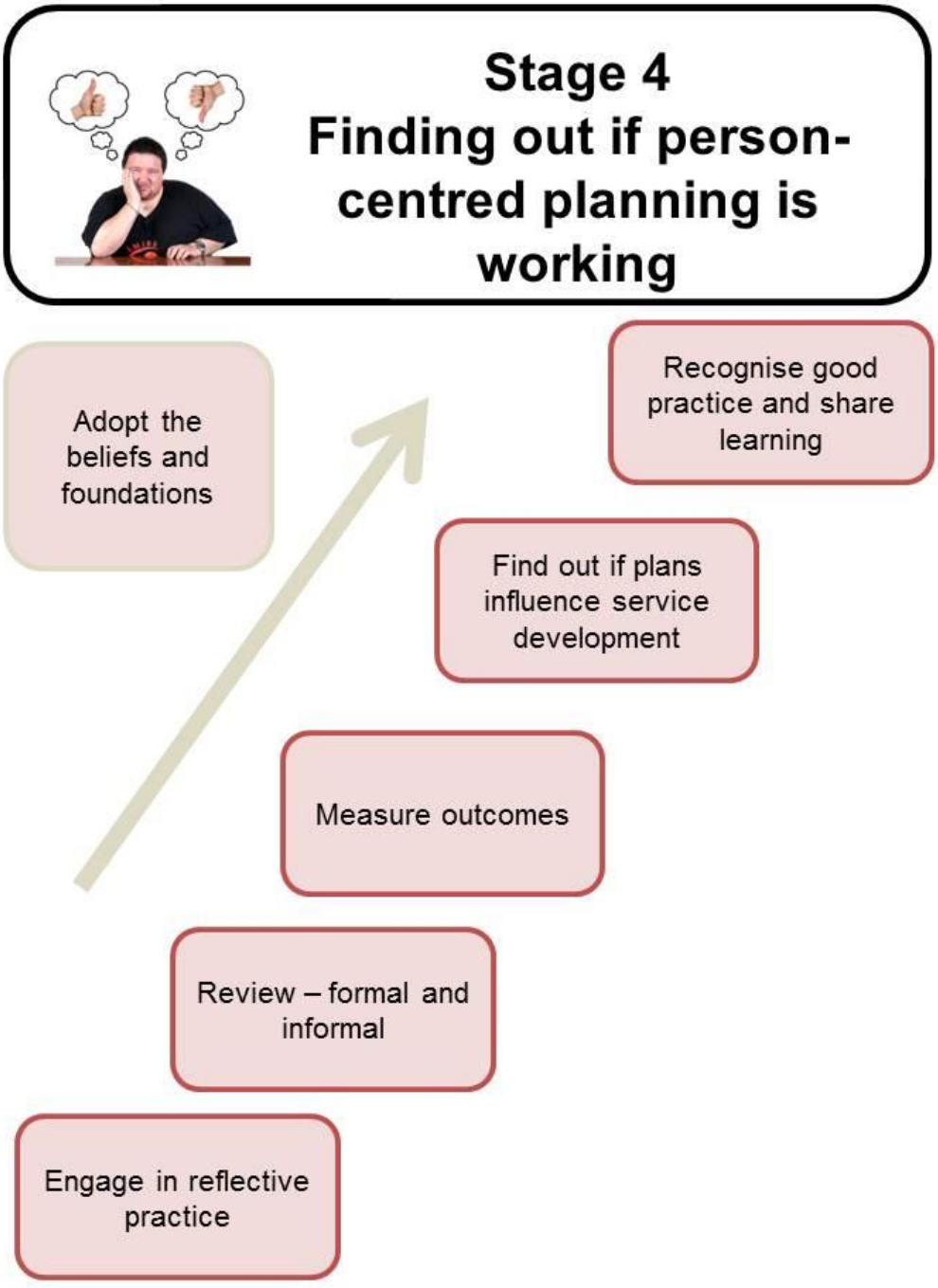
There is constant communication between Harry, his facilitator, keyworker and family. Harry is proud of his achievements so far and of his growing independence. He is glad that he persevered with this goal and persuaded others to support him to take up the challenge.

## Stage 4 - Finding out if person-centred planning is working

Monitoring and evaluation should form part of the ongoing process of person-centred planning. However, once the plan is developed and implemented, there are a number of actions that should be taken to determine the success of the plan. This is stage four of the process.

At this final stage, the beliefs and foundations are still essential and should be adopted.

**Figure 1.7. Stage 4 of person-centred planning**



## Reflective practice

Reflective practice is a way of thinking about your own actions and experiences to find new insight and understanding, and improve the way you work.

- Every organisation should engage in critical reflection and evaluation of their practice; this should include all staff, both managers and frontline, as well as multi-disciplinary teams, the person who owns the person-centred plan, their family members and circle of support.
- Staff should feel confident to reflect critically and constructively on their practice as a team and be able to supportively challenge practice that is not person-centred.

## Systems of review

- Person-centred plans should be reviewed on a regular basis, with both formal and informal review encouraged.
- Formal and informal review should provide for the maximum participation of the person, their family and their circle of support.
- The person's achievements and outcomes should be recognised and celebrated.

## Measuring outcomes

- There should be an overall system of evaluation in place across the service. This should include the measurement of outcomes; positive changes in a person's life as a result of person-centred planning.
- Regular feedback opportunities should be in place with the person, their family (if the person chooses) and/or circle of support to find out if they are satisfied with the person-centred plan and its implementation. Feedback can then be used to ensure that person-centred planning is leading to action.

## Person-centred plans and service development

- Individual person-centred plans should inform the delivery of services and supports, influence service development and the allocation of resources. The link between person-centred plans and organisational planning should be obvious.
- Person-centred plans can be the catalyst for change and provide an opportunity for organisations to be creative and look at how they can support individuals through unique arrangements.

## Recognising good practice

- Where good practice in person-centred planning exists, it should be recognised. Persons who own the plans, their supporters and the wider community should have the opportunity to share knowledge and experiences.
- Individuals, staff teams and managers should be willing to embrace new learning and to use this to make positive changes in the services and supports they provide.

## This is an example of one organisation's experience of using reflective practice:

Reflective practice is lifelong learning through the analysis of our experiences. It allows us to learn from these experiences, to analyse the work we are doing and to determine if it meets the required practice standards. Through reflection, we can decide if our practice is in line with our principles and values.

In our service, each member of the team participates in a specific reflective practice session every two weeks. During these sessions, staff get the opportunity to talk about their experience of a work-related issue - this could be something they are struggling with, or an interaction that left them feeling they could have done something differently. It is an opportunity to share a work-related issue which may be on their mind.

For example, one staff member discussed an identified change in the behaviour of a person who is non-verbal following a visit to their family home. When they returned to the residential service, the staff member noted that this person became very upset and withdrawn. The staff team used reflective practice to discuss, observe, and analyse why this was happening and looked at more supportive options for the person and their family. They were able to use this practice model to offer more frequent opportunities for family visits and smoother transitions for the person when they returned from family visits. This led to a very positive solution; a better understanding of the individual's communication, a reduction in behaviour that could be perceived as challenging, and higher levels of engagement with the individual's family.

# 6. Evaluating person-centred planning

## Why is evaluation important?

If the framework is put into action and planning is done well, it should lead to high quality person-centred plans and the achievement of outcomes for individuals. Organisations can use an evaluation approach to look at how the framework is being implemented and to review current person-centred planning practices. It can also be used to determine planned changes and actions.

## Who should be involved?

Evaluating person-centred planning in an organisation involves all the key stakeholders in the process - the person, their family and/or circle of support, staff. They review the findings together and agree any actions needed to improve practice. Managers and leaders are very important to the evaluation process. They should make sure that the evaluation process facilitates learning for the organisation about how they can improve their person-centred planning policy and practices.

## How can you evaluate person-centred planning?

Evaluation should involve different methods such as:

- gathering feedback from the person who owns the person-centred plan, their family, circle of support and staff, on their experience of engaging together in person-centred planning
- measuring the outcomes achieved for individuals; it is important to remember that the best measure of success for person-centred planning is whether the individual at the centre of the planning process has experienced a real change for the better in his or her life
- reflective practice – staff should consider their values and beliefs about person-centred planning, review the way they currently work, and look at how they can make positive changes to the process

- examining the impact of person-centred planning on service planning and delivery; it is important to find out if individual plans can influence the delivery of services and supports, service development and the allocation of resources
- implementing the evaluation tools designed to accompany this framework; there is one tool for the person who owns the person-centred plan and one for organisations
- reviewing learning and development programmes which support person-centred planning
- reviewing documentation to identify any gaps in the process.

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