## 1.0 Policy Statement

Peckys Limited recognises that each person with a disability is unique and has the right to receive a service that is designed and provided in a way that supports them to meet their individual needs and goals and maximise their opportunities for positive life outcomes.

**1.1** All people with a disability accessing services provided by Peckys Limited day programs will have an individual personal plan. The individual personal plan will be coordinated on an annual basis and evaluated every three months for day programs and every 6 months for recreation programs in accordance with client lifestyle plan agreement form to ensure the plan reflects and supports the person's preferences and lifestyle choices.

**1.2** Brokerage service provision is a flexible support for clients. Peckys Limited is not responsible for executing individual personal plans for clients who decide to broker Peckys Limited.

**1.3** This policy is underpinned by a set of guiding principles that are fundamental to a person centered approach to planning. The practice guidelines steer the planning and review process in a sustainable and coordinated way. The individual personal planning guiding principles incorporate the following:

- The person with a disability is central in the planning process;
- Planning is orientated towards present and future priorities, and focuses on the person's capacities, abilities and aspirations;
- Create an environment of continuous listening, learning and understanding. Personal planning is not a one of event, it assumes that people with disabilities have futures and their aspirations will change and grow with their experiences;
- Be a supportive and empowering experience that focuses on the person's ability and capacity;
- Involve people in the person's life to work together and create a partnership and interdependence throughout the process, encouraging the growth of informal networks of support and community engagement;
- Planning takes into consideration the cultural, language and religious needs and priorities of the person;
- When a person with a disability refuses to participate in the planning process or is unable to communicate their wishes or aspirations, the family and other people important to person will develop a lifestyle plan based on their particular knowledge of the person and in the best interests on the person;
- Plans are reviewed with the person on regular intervals to ensure the goal related activities are being achieved and are still relevant to the final goal.

## 2.0 Purpose

The purpose of this document is to provide framework for services provides by Peckys Limited that facilitates in a planned and purposeful way the support each person will receive in line with relevant legislative requirements.

**2.1** The lifestyle plan provides guidance for Peckys Limited staff to support the person with a disability to plan and achieve their life and goals. This policy and procedure describes what is required to help people identify their preferred lifestyle as well as the individuals and supports their needs to realize their preferences.

**2.2** The ability to communicate is integral to a person centered philosophy and lifestyle planning. All person centered approaches to planning and practice must reflect the person's own communication methods in order to establish a shared understanding about the person's needs, goals and aspirations. All people supported by Peckys Limited will have a communication profile developed prior to developing the lifestyle plan.

## Document References

- Disability Discrimination Act 1992
- ADHC Lifestyle Planning Policy and Practice Guidelines (2010)
- Anti Discrimination Act 1977
- NSW Disability Services Act and NSW Disability Standards 1993
- Occupational Health and Safety Act (NSW) 2000
- Occupational Health and Safety Regulations (NSW) 2001
- United Nations Convention on the Rights of People with Disabilities 2006

## Forms

- Personal Plan portfolio
- Communication profile
- Client risk assessment profile
- Swallowing checklist
- Epilepsy management form
- Behaviour Support Plans
- Medication booklets
- Consent forms
- Mealtime management plans
- Mobility management plans
- Monitoring and Review form
- Individual personal plan record and plan of actions form
- Individual personal planning checklist
- Client individual plan agreement

## 1.0 Procedure

The practice guidelines in this procedure are for use by disability support workers and others who support people with a disability, to help them plan a good life.

**1.1** They refer to the processes for gathering information about the person. The information assists disability support workers to develop a Lifestyle Plan in partnership with the person with a disability.

**1.2** With the person's consent, lifestyle planning includes the person's family and others who are important in helping to develop a Lifestyle Plan that is centered on the person's interests, wishes and preferences.

**1.3** Planning is completed within six months of any person with a disability entering Peckys Limited services or with the person on an annual basis if they already have a lifestyle or individual plan.

**1.4** The type of planning referred to in these guidelines is done with the person with a disability to discover what kind of life they aspire to, and how they can be supported to achieve their preferred lifestyle.

**1.5** The focus of planning is on the capacities, abilities and aspirations of people. It identifies what is important to people now and in the future, and balances this with the supports they require.

**2.0** There are different types of plans for documenting what is important for and to the person. These include:

- Service delivery plans that identify the support services a person will receive and how they will be provided;
- Routine plans and lifestyle preferences;
- Management plans for particular issues – behaviour, epilepsy, diabetes and medication;
- Records of specific issues – swallowing, mealtime management and mobility plans.

**3.0 Communication**

Communication is the key to inclusion. Through communication we build relationships with other people. People who do not use verbal speech to communicate or who do not speak English well, need to let others know what they think or feel to have control over their lives.

**3.1** Communication methods used by non verbal people are varied and include signing or pointing to images, symbols, photographs or objects. Gestures, body or facial movements, different behaviours or sounds may also be used to express needs or wishes. All of these are equally valid and should be equally valued.

**3.2** The first step in lifestyle planning is to establish the person's communication method or style by developing a communication profile. This will tell you how the person receives and interprets your message (receptive communication) and how the person sends a message to you (expressive language). It will tell you how the person expresses feelings, makes choices and requests and expresses likes and dislikes.

**3.3** The communication profile is also a starting point for developing resources that the person can use to communicate with others, for examples pictures or sign language.

**3.4** The Communication profile and resources are living documents and are updated as the person develops and grows. Communication documents encourage a shared understanding between the person and other people in his or her life and should be used by all people who need to relay information or to seek information from the person.

**4.0 Risks**

Peckys Limited risk management policy requires that risks to the person be identified and recorded on an annual basis in the client risk assessment profiles.

All clients' entering Peckys Limited services where required will have a risk assessment profile completed within the first month of entry to our services. The risk profile helps identify aspects of the person's life where support is required to achieve a chosen lifestyle, while maintaining the person's health and safety.

**4.1** Understanding the risks and being able to manage them will also help to reassure the person. Some risk areas will involve the development of specific management plans. It may be necessary to refer the person to a specialist who develops a management plan, especially if the risk is around behaviour and some health conditions.

**4.2** All risk management plans must be reviewed annually.

**5.0 Developing the Individual Personal Plan**

Any person entering Peckys Limited services must have a lifestyle plan developed within the first six months for day services and at the scheduled months of February and August for the recreation programs.

**5.1** A person centred planning method is to be utilised when developing a person's individual personal plan. The following are the essential elements of a person centred approach to planning:

- Learning about the person;

- Inclusion of the family and people important to the person;
- Knowing the person's abilities;
- Including partners in problem solving;
- Communication by listening and learning.

**5.2** The Peckys Limited lifestyle planning template incorporates person centred approaches and where required is to be completed annually in line with the person's lifestyle plan.

**5.3** Each person accessing Peckys Limited services will be allocated a key worker. The key worker is responsible for gathering the information that is important for and to the person we are supporting.

**5.4** The person will be the primary source of information unless he or she is unable to communicate, in which case you will need another source. The person's family, previous service providers or friends in the community, who know the person well, should be approached for additional information.

**5.5** Information about the person can be collected in various ways, informally or formally. The following are suggestions for gathering information in order of its priority for the person:

- Daily routine – Determine the person's preferred daily routines;
- Weekly routine – Learn about a typical week for the person;
- Skills – Find out what things the person does well, learn about their strengths and positive things in their lives;
- The family and people important to the person – Ensure we first have consent from the person to approach the other people in their life;
- Knowing the person's abilities – Draw and expand on the person's abilities;
- Include partners in problem solving – By helping the person build a network of supporters in problem solving, the opportunities for a meaningful and fun life are enhanced;
- Communication – Communication is a complex and dynamic process and once the person's style is understood it requires constant listening and learning by people who are providing support to the person.

## 6.0 Preparing for the Individual Personal Plan Meeting

While the purpose of lifestyle planning is to identify the things in life that are important for the person, you must also know the things that are important for the person.

**6.1** Where required the following areas of support plans should be reviewed and completed in time for the lifestyle plan meeting:

- Swallowing checklist;
- Epilepsy Management plan;

- Behaviour Support plans;
- Medication book;
- Consent forms;
- Annual individual personal evaluation form;
- Client Risk assessment profile;
- Mealtime management plan;
- Mobility management plan.

**6.2** Although the management plans are relevant to the proceedings of the lifestyle plan meeting and may impact on how the person's goals or preferred lifestyles are achieved, discussions about their implementation should not become the focus of the lifestyle plan meeting. Remember the person is at the centre of the planning process.

**6.3** In the context of individual personal planning, a goal is an activity, event or achievement that has been identified by the person as something important to experience in her or his life. Personal goals contribute to the quality of life enjoyed by the person.

**6.4** There are no time constraints on achieving a goal, it can take as little or as much time as it requires. The person may identify one or more goals during the planning process.

**6.5** The key worker should begin talking with the person about what goals she or he is interested to pursue. If the goal has been reached recently the discussion could be about how that achievement could be the next stage in working towards another goal.

**7.0 Organising the Meeting**

Help the person identify key people in his or her life and discuss organising a meeting for them to talk about the goals and the help the person may require.

**7.1** Start planning the meeting. Make it a happy occasion and something for the person to look forward to with pleasure. Help the person decide on the venue, catering and the guest list. Provide some guidance to ensure that there are enough people at the meeting who can support the person to achieve goals.

**7.2** If a written invitation is extended to families it should give them plenty of notice and a choice of dates. It is worthwhile to follow up with a phone call and check that families understand the purpose of the meeting and to answer their questions before the meeting day.

**7.3** If you are aware that there could be conflicting views about any of the goals or content, try and address them before the lifestyle plan meeting. If

signatures or consent is required for any planning activities, these should be obtained without causing undue distress to the person.

**7.4** When the person has close relationships outside the family these must be recognised and valued. The person may want to invite a close friend to the lifestyle meeting as well as, or instead of the family.

**7.5** In order to maintain the person in the centre of the planning process consideration should be given, prior to the meeting, of the person's capacity for participating in the meeting.

**7.6** When planning the meeting the following should be considered:

- Speak directly to the person in the meeting, the meeting is about them and they should be included;
- Have a preliminary to table any issues that are complex or long;
- Decide on an agenda and how long the meeting will run with reference to the person's ability to remain involved;
- Respect the views and contributions of all the people at the meeting;
- Decide how to resolve conflict about goals or activities;
- Prepare the person for the meeting so there are no unwelcome surprises;
- Make the meeting fun for the person and their guests.

**8.0 The Individual Personal Plan Meeting**

The role and who is the facilitator should be decided prior to the meeting. Provide a written agenda for the meeting. If possible send the agenda to the people attending the meeting before the meeting date. The following are suggested for inclusion on the agenda:

- The goal or goals the person wants to achieve;
- A strategy detailing how each goal will be approached;
- The steps and processes that are required to achieve each goal;
- The material and support required to achieve each goal;
- Any potential risks;
- Strategies for eliminating or reducing risks;
- Barriers to achieving goals;
- Strategies for overcoming barriers and preventing failure;
- A review timetable for all activities in each strategy for each goal.

**8.1** If you have already identified some goals with the person and others before you have the lifestyle meeting, the main purpose of the meeting will be to determine who and what is needed to help the person achieve those goals.

**8.2** If the person has not identified any goals before the lifestyle plan meeting, the focus of the meeting will be on what the person wants to do or achieve in her or his life.

**8.3** Once the strategies and activities for realising a goal are known, the required materials and personal supports can be identified.

**8.4** Remember that the person centred practice looks to mainstream services and community resources for creative solutions and does not limit possibilities to what is available within the disability system.

**8.5** The services own capacity to support the goal should be determined first. The capacity could relate to the availability of support staff, rostering issues or the services budget.

**8.6** At the individual personal plan meeting, the actual activities required to achieve goals should be nominated. If possible, the level of involvement of support people and the type and number of resources needed for each step are also identified in the meeting.

**8.7** As far as possible, barriers to success and risks should be known at this point at avoid failure and to provide an opportunity to develop an alternative approach.

**8.8** This is also the time to agree to milestones in the goal setting process so that timeframes for achieving goals are known to the person and a review schedule may be set up.

**8.9** A summary of the lifestyle meeting is outlined as follows:

- Identified goals;
- Identified actions and strategies for goals;
- Identified materials and resources required;
- Identified processes and timeframes for each goal;
- Recorded barriers and risks;
- Support people identified in planning meeting.

**9.0 Monitoring and Review**

When the plan of actions is completed it includes a series of activities to be carried out by support staff and others who are part of the person's support group. As the key worker it is your responsibility to monitor these activities and to make sure they are delivering against the strategy that has been documented in the plan.

**9.1** Monitoring is a continuous process and is incorporated into the daily routine. This means that all support staff will be aware of each person's goals and related activities and of the stage they have reached.

**9.2** If an activity is not been done as planned for any reason:

- Remind the person who is responsible for the activity that it is due, or
- Determine if there is a barrier and if it can be resolved – If the barrier cannot be resolved discuss it with the person and others in the person's support group to identify and alternative approach.

**9.3** Goals are supported by short or medium term activities that are essential to achieving the final goal. It is these activities that are regularly reviewed and reported on as indicators of progress.

**9.4** Reviewing activities is a way of determining if they are being done as planned and if they continue to be aligned with the original goal strategy.

**9.5** The timeline for review of goals and strategies is every three months. It may not be necessary to have a formal meeting to discuss the results of every review. This can be decided on a case to case basis depending on how much change or adjustment is required.

**9.6** Results of the review are discussed with the person and members of the person's support group and provide an opportunity to adjust activities if necessary, or to replace them with alternative activities if they are not working as planned.

**9.7** Any changes to activities or readjustments of goals must be done with the agreement of the person and the support group.

**9.8** All reviews are recorded on the lifestyle plan review form.

**9.9** Regular reporting is required from the key worker and this can occur at team meetings or whatever local arrangement exists for the person. It is important to have regular reporting forums where problems and issues are identified and resolved as soon as possible.

**9.10** A summary of monitoring and reviewing is outlined as follows:

- Activities are monitored and progress recorded every three months;
- Barriers are identified to progressing activities;
- Barriers are discussed and resolved with the person and others in the person's support group;
- Reviewed activities and agreements with the person and others to make changes where necessary.