ST. PATRICK'S CENTRE, KELLS ROAD, KILKENNY

Policy Document

Personal Plan Policy

Prepared by: Liz O'Neill Mirjam Lettner	Approval Date: 31.07.2020	Review Date: 31.07.2022
Policy Number 37 – Other Policies	Approved By: Signed: _____ CEO (Interim) Signed: _____ Board Member	

Vision

People supported will live a good life, in their own home, with supports and opportunities to become active, valued and inclusive members of their local communities.

To enable a supported self-directed living (SSDL) model of provision which is underpinned by SPC beliefs, values and vision.

Review Date: 31.07.2020 Revision No:_____	Amendments Required Development of Policy	New Revision Status 31.07.2022
Reviewed by: Liz O'Neill Mirjam Lettner	Approved By: Signed: _____ CEO (Interim)	

Table of Contents

1. Policy Statement

St. Patrick's Centre (Kilkenny) Enriching Lives and Communities

Mission
Utilising our resources and skills to provide intentional supports for People with disabilities; enabling them to live full and inclusive lives by contributing and enriching the fabric of their local communities. SPC partners with external agencies and community services to facilitate '*ordinary lives in ordinary places'.*

Vision
People supported will live a good life, in their own home, with supports and opportunities to become active, valued and inclusive members of their local communities. To enable a supported self-directed living (SSDL) model of provision which is underpinned by SPC beliefs, values and vision.

Values
We will honour the Person by listening to & learning from them through:

- Respect, Dignity & Privacy
- Inclusion
- Diversity
- Self-Determination

2. Policy Scope

This policy applies to all employees in St. Patricks Centre (SPC) and any other person required to or wishing to support each individual person to achieve the goals of the personal plan.

3. Policy Purpose

The purpose of this policy is to clearly outline to all staff SPC Personal Plan Framework, and to ensure they adhere to same. The policy is informed by legislation, regulation, standards and Social Role Valorisation as the theory of practice.

3.1 Comply with **Regulation 5** "Individual assessment and personal plan", **Regulation 6** "Healthcare" and **Standard 2.1 "**Each person has a personal plan which details their needs and outline the supports required to maximise their personal development and quality of life, in accordance with their wishes".

3.2 Outline the personal planning process, procedures and associated paperwork required to provide an evidence-based service.

3.3 Set out the Social Role Valorisation (SRV) theory of practice and Outcome Measurements to guide the development, implementation and review of the personal plan.

4. Guiding values and models

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

Each person is treated as an adult and relationships are built on **respect**.

Person centred planning and supports shall **empower** the person to take control of their life and respect the person's views and wishes.

Each person is an important member of their **community** and has valued social roles.

Each person is enabled to make **choices** and decisions about their lives.

4.1 Person centred approach and planning

Person centeredness recognises the uniqueness of every individual. This approach is possible through the development of relationships that enable the person to achieve their best and flourish.

Person centred planning is based on the values of respect, self-determination, empowerment and understanding.

Person centred supports enables a person to make informed choices about how they want to live their life. The person is supported to identify their wishes and goals and what is required to make those possible.

The best indicator of success for person centred planning is whether the person has experienced a real change for the better in their life as a result of this plan being implemented.

4.2 Outcome Measurement

Person centred planning is about achieving outcomes for the person. Outcomes are positive changes in a person's life. Personal Outcomes are an essential part of the recommended service delivery framework under Transforming Lives. The National Disability Authority has developed a framework for outcomes measurement for the model of person-centred disability services.

Nine outcome domains that have been identified, are all linked to quality of life indicators:

1. Living in the community
2. Exercising choice and control
3. Participating in social and civic life
4. Personal relationships
5. Education and personal development
6. Employment and valued social roles
7. Quality of life
8. Health & Wellbeing
9. Safe and secure

The *Guidelines to develop the Personal Plan* (Appendix 01) is a tool to support staff teams with questions for each of the outcome domains though out the personal planning process/steps. All 9 outcomes relate to the HIQA's Regulations and National Standards for Residential Services.

4.3 Social Role Valorisation

SPC have committed to underpinning their practice using the Social Role Valorisation (SRV) theory of practice in order to achieve sustainable and valued outcomes for the people we support as they take their place within their communities.

Wolfensberger's (1999) theory is based on the idea that when people hold valued roles, they are more likely to receive the opportunities that will help them to achieve 'the good life' that goes along with those roles. The theory offers strategies to address devaluation and increase the chances of developing social valued roles and in turn to have access to the good things of life.

4.4 Connectivity:

As outlined in the figure below the person supported is the centre of all planning. The outer circle is the framework, tools and theory of practice used to facilitate person centre planning for the people supported in SPC.

4.4 Assisted Decision Making

In December 2015 the Assisted Decision Making Capacity Act (2015) was signed to maximise a person's right to make their own decisions, with legally recognised supports. This Act applies to everyone and is relevant to all health and social care services. The Act is about supporting decision-making and maximising a person's capacity to make decisions.

SPC is fully committed to adhere to the guiding principles and content of this Act while supporting the people living in SPC:

- To honour the "will and preference" of each person supported
- To safeguard the autonomy and dignity of the person with impaired capacity.
- Presume that the person has decision-making capacity.
- No intervention should take place unless it is necessary and unless all practical steps have been taken – without success – to help the person make the relevant decision themselves.
- In addition, any act done or decision made under the Act must be done in a way that minimises restrictions on the person's rights and freedoms of action and gives effect, as much as possible, to the past and present will and preference of the person.

4.5 Positive Behaviour Support

Positive Behaviour Support (PBS) is an evidence-based approach with a primary goal of increasing a person's quality of life and a secondary goal of decreasing the frequency and severity of their distressed behaviours.

It is important for the support team to find out why the person is distressed and what they can do to support the person's needs to live a better quality of life.

Positive Behaviour Support, or PBS is a systemic approach across three core levels or tiers:

1. Tier 1: Universal supports – Service level positive behaviour support culture – keyworker led proactive approaches for all supported persons focused on enhancing quality of life and quality of supports
2. Tier 2: Unit level collaborative professional supports for positive behaviour – team leader led supports incorporating functional assessment of distress and clinically valid PBS support plans
3. Tier 3: Specialist level PBS – behaviour specialist led individualised supports for at risk supported persons

As part of Person centred planning SPC is committed to implementing Positive Behaviour Support Culture in supporting staff teams to develop a shared understanding about why the person is distressed and how to support the person to live a better quality of life.

For further guidance around Positive Behaviour Support please refer to SPC Positive Behaviour Support Policy on the Q drive.

5. Definitions

5.1 Regulations and National Standards (*Appendix 09*)

The regulations may be cited as the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons with Disabilities) Regulations 2013, came into operation on 1st November 2013.

Additionally, the National Standards have been developed to support providers to achieve a high standard of care. These standards are designed to safeguard the rights and interests of people with disabilities in residential centres, to enhance their quality of life and to support the development of person-centred care. The standards flow from a human rights perspective and are based on the principle that people with disabilities in residential services should be enabled to lead full lives, comparable to those of their fellow citizens.

5.2 Personal Plan:

This means a personal plan is prepared in accordance with Regulation 5 (4), which has assessed the person's needs and outlines the supports required to maximise the person's development.

5.3 Roles

The definition of a role is the concept of having meaning in something you do and partake in. An example of a role might be the role of a sister, this role doesn't have a start and finish date, to fulfil this role you must be active in it i.e. remember important dates like birthdays , anniversaries and being there as support.

5.4 Goals

A goal is defined as a desired result a person wishes to achieve. Goals can be short or long term and are set to reach an outcome. Goals are identified through the person-centred planning process and shall capture people's engagement and activities.

Examples of person-centred planning goals are:

- having a job
- making new friends
- taking up a new hobby
- planning a holiday

5.5 Outcomes

An outcome is defined as the possible end result of what someone wants to do. An outcome can have many goals. For the purpose of this policy, outcomes are a positive change in a person's life. The Personal Plan is a meant to achieving goals and outcomes to support the person in achieving a better Quality of Life.

6. Roles and Responsibilities

6.1 The Personal Plan team

The person supported is leading out with maximum participation in their person-centred planning process. They are supported to develop their personal plan by their keyworker, PIC, CSM, staff team and family members or friends of their choice.

The person supported is the focus of their personal planning and shall be involved in all reviews

6.2 Director of Services

The Director of Services (DOS) is responsible for and must therefore ensure whenever possible the appropriate level of accessible allied professional resources within SPC to meet the assessed needs of each person supported. If resources are not available, the DOS must advocate for same.

6.3 Person in Charge

- The Person in Charge is responsible for the development of fit for purpose Personal Plans no later than 28 days following all new admission (Regulation 5 (4)).
- The Person in Charge will ensure that all personal plans are developed using a person-centred approach capturing the wishes, hopes, dreams and goals of each individual so that ultimately, they maximise their personal development and quality of life, in accordance with their wishes.
- The Person in Charge shall ensure, that the person supported is provided with a copy of the personal plan in accessible format and where appropriate to his/her representative.
- The Person in Charge will ensure the overall quality and continual review of personal plan.
- The Person in Charge shall ensure that the personal plan has an annual review and more frequent if required, be multidisciplinary and be conducted in a manner that ensures the maximum participation of the individual
- The person in charge appoints a key worker in agreement with each person and/or their representatives, whose primary responsibilities are to assist the person, in accordance with their wishes, in developing their personal plan and to oversee its implementation. Other key staff participate in the planning process as requested. (*HIQA* **2.1.9** *National Standards for Residential Services for Children and Adults with Disabilities (2013)* 2013)

6.4 Staff Team

- The staff team has to be familiar with the assessed needs of each person they are asked to support to include the nuances within their personal plan and the strategies therein to support them achieve their individual roles and goals.
- The staff team will support the person supported to develop their personal plan. This personal plan will detail their needs and outline the supports required to maximise their personal development and quality of life, in accordance with their wishes.
- Staff nurses and Social Care Workers are to support the PIC and staff team in ensuring the completion of person centred planning as per this policy and build capacity.
- The staff team has to ensure a total communication approach is being within the person centred planning (e.g. pictures, I-pads, posters, videos, etc.).

6.5 Key-worker

***Key worker**, is the member of the staff in the service who carries particular responsibility for the person with a disability, liaises directly with him/ her, coordinates health and social services, and acts as a resource person. (HIQA National Standards for Residential Services for Children and Adults with Disabilities 2013).*

- The Key Worker will support the person supported to develop their personal plan. This personal plan will detail their needs and outline the supports required to maximise their personal development and quality of life, in accordance with their wishes
- Once a personal plan has been developed and details the person supported needs and outlines the supports required to maximise their personal development and quality of life, in accordance with their wishes. The Key Worker will work diligently in the interests of the person supported to facilitate and support them to achieve their goals and they will assist the person to demonstrate progress during scheduled Personal Plan reviews
- In consultation with the person supported agree on goals and assist the individual in achieving these goals.
- Support the person supported to break down actions from their development plan into monthly targets
- Recognise that the key working relationship is not an exclusive one and the key worker is not the sole arbitrator in decisions concerning the person supported care.
- The key-worker is not solely responsible for delivering the service; this is the role of every member of the support staff on duty.

6.6 Community Service Manager

The CSM is supporting the PIC and staff team as practice leaders in person centred planning for the people supported living in SPC and ensure the personal plans are completed as per regulations to provide all necessary supports for the people supported.

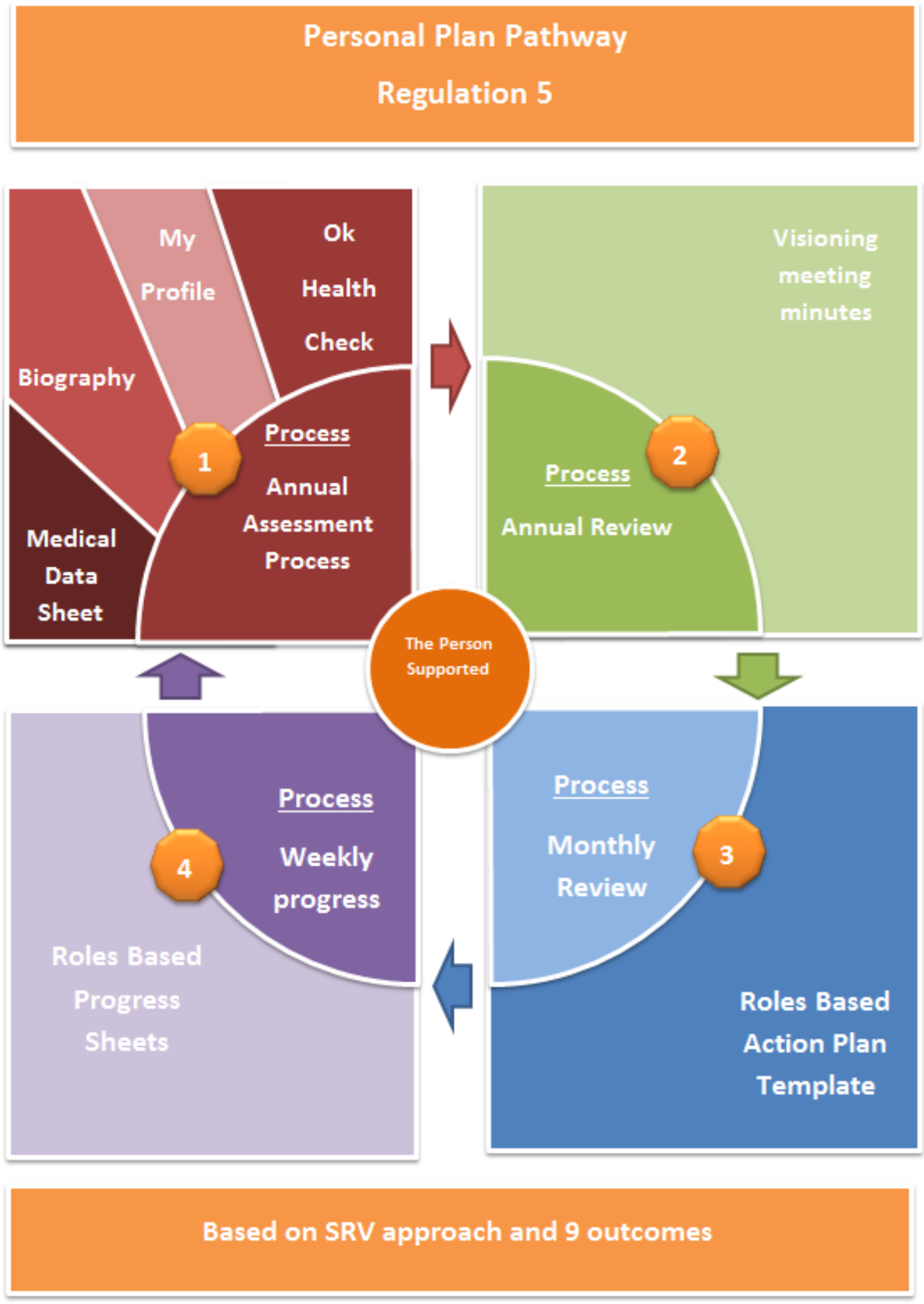
The CSM is to be involved in the relevant people supported's annual review meetings, which will be scheduled through an annual planner on the One drive for each person supported, SPC house and cluster.

6.7 Central Functions SPC

The Quality & Therapeutic and Practice Development teams are providing all necessary supports for the PIC, staff team and person's supported to ensure person centred planning is completed and standards are improved and adequate knowledge and documentation available to all people involved.

HR and H & S Department providing all necessary supports to the PIC and staff team in fulfilling identified actions to ensure each person is supported in line with their personal plan.

7. Personal Plan Pathway



8. Personal Plan Pathway

8.1 Overview

The personal plan is a live document supported by person centred planning which is an **ongoing process** and not just an annual or monthly event of completing a document. Information should be used and developed throughout the year with ongoing reviews, reflection and evaluation.

Although the Pathway is outlined in 4 Steps, those steps might be carried out parallel, depending on the stage of planning and necessary amendments to be included.

The **Personal Planning Process** for each person supported in SPC consists of 4 processes/steps:

- Assessment Process
  Preparing for the Annual Review using a set of documents (*Appendix 06*).
  - My Profile (*Appendix 02)*
  - Biography (*Appendix 03*)
  - OK Health Check (*Appendix 04*)
  - Medical Data Sheet (*Appendix 05*)

- Annual Review
  Facilitate a visioning meeting with the person supported
  - As per scheduled meeting calendar
  - Reviewing previous years goals and outcomes
  - Using the Annual Visioning Meeting Minutes Template
  - Complete the action plan

- Monthly Review
  Complete monthly review meetings with the person supported
  - Using the Monthly Roles Based Action Plan Template (*Appendix 07*)
  - Based on identified socially valued roles and goals

- Weekly Progress
  - Using Roles based Progress Sheet Template (*Appendix 08*)
  - Document actions and steps being taken daily and weekly to evidence progress on how to achieve roles and goals.

For each of the 4 processes a set of documentation has to be completed to evidence review and progress of the personal plan for each person supported.

Please remember the following:

- It is essential that the PIC is leading out on the development of an annual **schedule** for each person's **annual review** meetings. A schedule of all people supported's annual review meetings is available via One Drive. The PIC has to ensure that the person's annual review is scheduled and the relevant CSM and necessary MDT are available to attend.

- Annual review meetings ensure **outcomes** are met and further development enhanced

- It is essential to give the respectful amount of time to each of the 4 steps of person centred planning. Review meetings should be scheduled as celebration with the person to look back on experiences & achievements and plan for future outcomes (e.g. plan lunch as part of the review day, invite family and friends, tea & coffee, etc.).

- Monthly and weekly progress documentation shall feedback into the annual reviews

- Ipads for each person supported to be used to evidence roles and progress of goals

8.2 Step 1 - Annual Assessment Process

To prepare with the person supported for their annual review meeting (*Step 2 of Pathway*), it is essential to ensure the following documents are in place and reviewed beforehand and identify any necessary actions or people who need to be involved to ensure the best possible supports:

- My Profile
  To introduce a person supported.

- Biography
  Any necessary changes in a person's life have to be captured in the Biography, which is outlining the story of a person (e.g. if a person has become an aunt, is now using a wheelchair….).

- OK Health Check
  Capture all necessary health related information on an annual basis or review as needed. Identify any necessary actions and referrals.

- Medical data sheet
  Overview over all medical needs and appointments on a yearly basis.

If you have reviewed the above documentation with the person supported, don't forget to prepare for the visioning meeting:

- Adherence to the scheduled date, time, and place for annual visioning review meeting
- Besides the PIC and staff members, discuss and agree with the person supported who needs to be invited to their Annual Review.
- Invite necessary MDT members, if involvement is necessary to provide supports for the person.
- Create appropriate space and atmosphere to facilitate the annual review.

8.3 Step 2 - Annual Review

Having a vision of what is important in having a Good Life lets us take control and be clear about the direction we are heading and directly influence our imaginations of what is possible. This is why it is so important that the vision not only reflects the person, but is full of hope and possibility of a life that is rich with hope, possibility and potential.

The *Annual Visioning Meeting Minutes Template* is to be used to document the annual review for the person.

- Ensure a total communication approach is used.
- Supporting your keyperson to have a clear idea and some positive dreams about what we want someone's life to be like.
- Explore valued social roles with the person supported in each of the 9 qualities of life outcome domains.
- Record actions in relation to the identified roles, goals and opportunities for the person to achieve more independence in their daily lives.

The following points will help the staff team and person supported to start the visioning meeting and explore the person's life, roles and goals:

Firstly consider the following three domains:-

Home

- Concrete description of what represents home for the person now
- The person's satisfaction & dissatisfaction with current home situation
- How the person's experience of a 'home of one's own' might be enhanced

Relationships

- Composition of current relationships; nature of, quantity, and quality
- Past relationships that could be revisited
- Relationships that could be improved; what would enhance the relationship
- Relationship voids; vivid description of who would ideally fill the void

Occupation

- How does the person spend their time?
- Education
- Employment
- Active citizenship
- Leisure
- Personal and spiritual development
- Schedule of a typical week
- What constitutes a good investment of time; what constitutes life-wasting

Health & Wellbeing

- How does the person need to be supported to enjoy a greater quality of life?
- Is the person in good health?
- Is the person's health acting as a barrier to getting what he/she wants in his/her life?
- What could be done to maximise the person's wellbeing?

At the end of the *Annual Visioning Meeting Minutes Template* the action plan has to be completed to ensure an review of:

- Identified Roles and Goals
- Actions that need to be taken to support the person (e.g. referral to a practitioner, MDT member, link with a community member, etc.)

8.4 Step 3 - Monthly Review

Following on from the Annual Visioning Meeting and taking account of the minutes and actions identified, the *Monthly Roles based Action Plan* (Step 3) and the *Roles Based Progress Sheet Template (Step 4)* will be developed by the keyworker based on the roles that were identified at the visioning meeting. Each identified action will lead to a role for the person and create an action plan for the staff team as to how support the person in achieving the role.

The Roles Based Action Plan will define clear and detailed actions outlining how to progress valued role development. Identifying which of the 9 outcomes will be met and enabling the evidencing of intentional supports.

Being in valued roles that are related to the person's interests or talents reinforces the similarity between people, rather than emphasising what is different. It follows then that it is helpful to assist the person to find roles that are truly authentic for them and which build on the gifts they bring to the world.

The PIC and staff team ensure to schedule a monthly review for each person supported using the *Monthly Roles based Action Plan*:

- Use one Roles based Action Plan template for each of the identified goals for a person supported (e.g. Role as a consumer, Role as a patient, etc.).

- Review recording of actions and progress of same. Ensure there is clear evidence if goals are achieved.

- Record any changes or barriers that were identified while supporting the person in achieving their roles and goals and discuss possible strategies or changes.

- The *Monthly Roles based Action Plans* shall be providing all necessary information to prepare the annual review for the person supported.

- The monthly review meeting is also an opportunity to reflect with the person on all relevant aspects of live. Therefore use all documentation for the person supported in the monthly review (e.g. medical data sheet, etc.), if necessary.

8.5 Step 4 - Weekly Process

Written examples and notes are an important part of the person's personal plan to evidence progress and development. The *Roles Based Progress Sheet Template* is to be used to evidence weekly (or even daily) activities for the person supported in relation to each action area/role.

The *Roles Based Progress Sheet Template* is used to document:

- The action area/role the person is supported in.

- Engagement/Interaction and communication involved with the activity/role.

- Reflection on how to improve the experience for the person supported.

The *Weekly Roles Based Progress Sheet Template* is important documentation to ensure the person's outcomes and achievements can be reviewed and recognised at the monthly and annual review.

9. Summary

Individualised holistic assessment and personal planning is an ongoing process within the person's every day and not a once off annual or monthly carried out review of documentation. The person supported has to be involved in all stages of assessment and planning and their voice prioritised and respected.

To support a person in self-directed living the team needs to find out about the person, their abilities, skills and needs to ensure the person's views and wishes are respected and supports planned in an individualised way.

The Personal Plan Pathway is guiding the support team to be innovative in finding ways to help the person supported to express their views and wishes and live a life as they choose. As a result of ongoing person centred planning the person supported will hold socially valued roles and have meaningful experiences.

10. Audit

Personal Plans shall be audited on a regular basis to ensure adherence to the policy. A Personal Plan audit tool is available on SPC Q drive.

References

- Health Act 2007 (Care and Support of Residents in designated Centres for Persons with Disabilities), Regulations 2013
- National Standards for Children & Adult with Disabilities
- The NDA paper on outcomes for disability services – http://nda.ie/Publications/DisabilitySupports/NDA-paper-on-outcomes-for-disability-services.html
- National Framework for Person-Centred Planning in Services for Persons with a Disability, HSE, March 2018.
- Guidance for the assessment of centres for persons with Disability. HIQA, 2019.
- An Overview of Social Role Valorisation. Wolfensberger, 1999.

GUIDELINES TO DEVELOP THE PERSONAL PLAN

Use these guidelines to support the person through their personal planning process in annual and monthly reviews (visioning and roles based planning)

Assets and skills examples

Personal characteristics of a person

- Great smile
- Ability to get along with many different people
- Positive attitude
- Sense of humour
- Great communicator-uses different type of communication skills- vocalisations, body movements – refer to communication passport
- Can make a cup of tea
- Can dress themselves with little assistance
- Can open car door and put seat belt on
- Can put headphones on
- Can swipe through the IPAD and look at pictures of things they got up to that day

Interests example

How the person likes to spend their day

- Likes and dislikes
- Indoors/outdoors
- Walking/cycling
- Volunteering
- Being a club member- walking group, library
- Art
- Gaming
- Travelling
- Pets
- Music
- Travel
- Baking/cooking
- Reading

Conditions for success examples

What in the person's life has to be in place for their day to be a success?

- Link in with relevant documentation on the person file i.e. communication passport, behaviour support plan, support plans etc. to ensure that we are supporting this person in having a meaningful day
- Routine and rituals that the person does in their day/week that is important to them and would miss if didn't get to do them
- Adaptations that need to be considered for their home i.e. furniture at certain levels, OT guidelines followed
- Visual supports accessible at all times
- Enjoys having energetic people in their company
- A low arousal, quiet environment is important for the person to enjoy there day. May become upset/vocal in a loud busy environment
- Enjoys their own personal space
- Routine is very important e.g. has routine when dressing and during intimate care.
- The person doesn't like to wait any longer than they have to. People supporting him/her must ensure that they have i.e. car keys ready, files ready, bags packed etc. before communicating that they are ready to go to ensure anxiety levels aren't risen unnecessarily
- When in the persons company, ensure to speak with them directly – they do not like when people speak over them
- Likes to know that familiar people are around – likes to have soft noise in background, likes to know someone is around and listening to familiar voices
- Ensure that all physio programmes, OT assessments, swallow care plans and other support plans are adhered to and support this person in having a good day. These play a big factor in how the persons day will go and knowing plans in advance can allow the day to go smoothly
- Take pictures when out and about because this person enjoys sitting at home in the evenings with a cup of tea and look through their day visually. They also like to send these pictures to family members and enjoy seeing/hearing their response

Outcome 1 – LIVING IN THE COMMUNITY

Aligning with HIQA Residential standard
2.2 ***HOMELY SETTING***

QUESTIONS THAT MIGHT HELP TO GUIDE THE CONVERSATION

Your Home

- What do you like about it?
- What is your favourite place in the house?
- Are there people that you like living with?
- Are there people that you do not like living with? Why?
- Do you call this house your home?
- Are they things about this house that you do not like?
- If you could move to a house that you choose, would you, why?

What does it look like?

- If you were to think about a home of your own what would this look like?
- Is it different to the house you now live in?
- Where would it be?
- Who would you like to live with?
- What would your room look like?
- What would be near to the house?
- Do you think this would be better that the house you live in now? Why?
- Do you live near your family?
- What was the house that you grew up in like?

Your Privacy and Comfort?

- Do you have privacy and comfort in the house you live in now?
- Do you have and use your own key?
- When people visit are you supported to welcome them? (Make them tea, Chat with them in privacy)
- If not who do you think could help you with this?
- Are there any modifications that you need to make the house more comfortable/practical?
- Do you have a tenancy agreement? Do you know what this is and have you read it?

Your Role?

- Do you take part in household tasks like laundry, preparing your own meals, washing up, hoovering, gardening etc with the support you need?
- Do you share these tasks with the other people who live in your house?
- Do you have a good relationship with anyone in the house?
- What parts of managing the house do you enjoy the most?
- Do you know your neighbours?
- Do you attend any local events/ groups near your home?
- What would increase the chances that you could/ would invite people into your home?




Outcome 2 – CHOICE AND CONTROL

Aligning with HIQA Residential standard
1.3 CHOICE AND CONTROL IN DAILY LIFE** and **1.6 MAKES DECISIONS

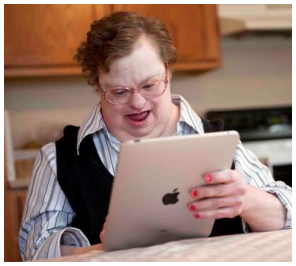
THINGS TO THINK ABOUT

My Day

- What is your favourite to thing to do each day?
- What part of your day do you not enjoy?
- Do you have the choice to change things that you do not like or enjoy doing during the day?
- Do you make your own decisions around where you go, what you do, when you go with whom?
- What supports do you need to make these decisions?
- What decisions do others make on your behalf?

My Rights

- What is your understanding about your rights?
- In what way do you advocate for yourself?
- If you are not yet able to advocate for yourself who advocates for you on your behalf?
- What supports are in place help you increase your confidence to advocate for yourself in time?
- Do you vote?
- Do you have your own money? How much control do you have over this?
- Do you know where your money comes from, how much you have and do you unrestricted access to it? If the answer is no, why? And who can support you with this?



Communication

- Are you present at all meetings about you? If not why not? Who can support you with this?
- Does communicating using pictures, IPAD etc., help you?
- Are any assessments needed around facilitating communication?
- Are you included in the decision making in your life? Do you have a lead role?
- Do you have access to your own phone or unrestricted access to a phone in your home?
- When looking at your vision for your life, what can you be supported with daily to achieve your goals?
- Who would be the best person that you feel could support you to self-direct your own life? Who will take responsibility to make sure this happens?

Outcome 3 – Social & Civic PARTICIPATION

Aligning with HIQA Residential standard
1.4 ***PERSONAL RELATIONSHIPS AND LINKS WITH COMMUNITY***

Things to think about

Being a member of my community

- Are you lonely?
- What do you enjoy doing at the week end or in the evening?
- What are you drawn to without encouragement or motivation?
- Is there anything you always wanted to take up as a hobby?
- What are all the places where people go to take part in groups with the same interests? Which one of these most excites you? Have you ever been to this specific one? If not would you like to?
- What groups were you part of before that you enjoyed or did not like?
- What groups are your friends and family part of? Do you like these groups or classes? Would you like to become a member of any group?
- What unique gifts and talents do you have that your community are missing out on seeing?
- Is your faith/culture important to you? How do you show this? What support might you need to support this interest?
- Would you like to get to know more people in your neighbourhood or your local community?
- Would you be worried about anything if you were to start a new group?
- How do you think you could be helped with this? What would staff need to do? (for eg Are you confident when chatting with others? What might help this? Do you need support around your mobility? What are your transport needs?)
- What can you do? What do you know? Who do you know? And what do others say about you? that is engaging, inspiring, likeable and impressive to others, let your keyworker help you with this.
- Who would be the best person that you feel could support you to take part in your community? Who will take responsibility to make sure this happens?

Outcome 4 – Personal Relationships

Aligning with HIQA Residential standard
1.4 ***PERSONAL RELATIONSHIPS AND LINKS WITH COMMUNITY***

Things to think about

Who

- Who are the people that you spend the most time with?
- Who are these people that are not your family members, are not from your service, or are not paid staff?
- Who do you think advocates for you the best, the most?
- Are there any people from your past that you would like to renew your friendship with? If so can you still get in touch with them? If not can your keyworker support you with creative ways around this?
- Do you a boyfriend or girlfriend? Would you like one? What help do you think you would need with this?
- Can your friends or family help you with any area in your life that you need support in? Is this happening? If not why not?
- Who would be the best person that you feel could support you to have more meaningful relationships in your own life? Who will take responsibility to make sure this happens?

What

- What other people do you see on a regular basis?
- What are the most important relationships at present in your life?
- What roles do you play in your family? (Sister, brother, uncle, aunt, son, daughter etc)What kind of relationships do you have with your family? Do you see them often? Would you like to see them more? How can you be supported to fulfil your role in your family?
- What barriers are present that could prevent you from building up your relationships?
- What specific supports need to be in place to address each possible barrier?
- What interests does this person have, that others in the community have that could be used as a basis to build up connections?
- What other ideas do people about what could help strengthen this persons existing relationships and help them make more friends in their community? Can we identify outlets where it is possible to build up further relationships?

Outcome 5 – Education and Personal Development

Aligning with HIQA Residential standard
4.4 ***EDUCATION, TRAINING AND EMPLOYMENT OPPORTUNITIES***

Revisit

Revisit the Visioning Meeting minutes what new things could I be interested in if I was introduced to them?

Learning

What new things could I learn if I was thought?

Routine

What is my current routine and how could this support be to develop more?

Motivation

What am I motivated by without encouragement? How can this be developed? What supports will I need?

Engagement

When new things have been introduced that I have paid particular attention to?

What have I stayed engaged with it, the time spent engaged, the environment and what worked best for me?

Experiences

How can I be supported to be at my best? What have new experiences thought those who support me?

Is there any area of life I always wanted to experience?

What support is needed in finding new experiences?

Outcome 6 – Employment and valued social roles

Aligning with HIQA Residential standard
4.4 ***EDUCATION, TRAINING AND EMPLOYMENT OPPORTUNITIES***

Things to think about

Making a contribution in my community

- What do you currently enjoy doing?
- What do you not enjoy doing?
- What are you good at doing? Specific answers needed.
- Do you have role in your community, employee, club or committee member?
- How can more valued roles be identified and met?
- What sort of work or work experience have you done in the past?
- Which one did you enjoy the most? Why? What was the working environment/team/hours like?
- If you haven't ever tried a job or volunteering what would you be interested in trying? (
- What work roles best match with your interests and are positive and possible to achieve?
- What type of training/courses do you need to teach you what you need to know to have this type of job or would advance your opportunities?
- If you are already in employment do you attend the social events, know your colleagues, have tea break in the canteen with others, socialise with them outside of work?
- Have you interest in seeking membership of a club or organisation?
- What things do you do for other people?
- Who would be the best person that you feel could support you to progress these roles in your own life? Who will take responsibility to make sure this happens?
- What are the most significant barriers to you becoming more valued have having a better future in the community? E.g. communication ability, work and training qualifications, social skills, image/appearance, financial barriers, transport, medical considerations etc.? How will you be supported with this?

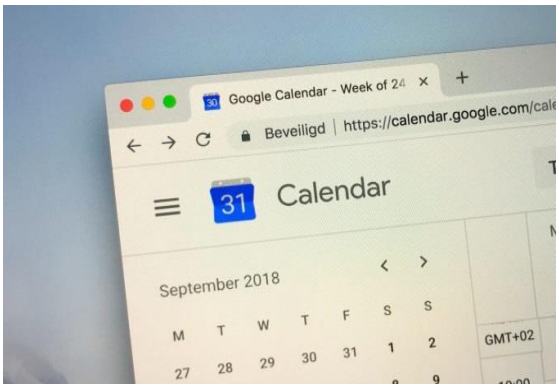
Outcome 7 – Quality of Life

Aligning with HIQA Residential standard
2.1 ***PERSONAL PLAN RE QUALITY OF LIFE***

Things to think about

Personal wellbeing and purpose – enjoying a good quality of life

- What is your current daily schedule?
- Which of these daily activities are beneficial to your future and why?
- Which of these activities will not make a big difference to the person future and/or reinforce negative stereotypes of people with disabilities.
- Which of these activities are easy to take part in but are currently being supported at the wrong times of day?
- What activities do you think should be stopped, reduced or moved to a different time of day so that support can be focused more on pursuing things that will have a more positive impact on the person's life?
- What other ideas to people who support you have about how your schedule could be altered to ensure support is used to accomplish the most good possible in the limited time available?
- Are you in good health? Is your health acting as a barrier to getting what you want in your life? What supports do you need with this?
- What have been the most difficult experiences in your life? Why? What supports do you get to help you with this?
- What have been your most positive experience? Why? What can happen to help you have other experience like this one?
- How could your life be better?
- Who would be the best person that you feel could support you enjoy a greater quality of life and wellbeing in your own life? Who will take responsibility to make sure this happens?
- What are the most significant barriers to this person becoming more valued have having a better future in the community? E.g. communication ability, work and training qualifications, social skills, image/appearance, financial barriers, transport, medical considerations etc?



Outcome 8 – Health and Well Being

Aligning with HIQA Residential standard
4.1 PROMOTION OF HEALTH, 3.2 SUPPORT TO POSITIVE BEHAVIOUR AND EMOTIONAL WELLBEING

Things to think about

Are you

- Are you in pain, uncomfortable, uneasy at any point during your day or week?
- Are you on any medication?

Do you

- Do you have your own GP, Dentist, Optician etc?
- Do you attend and advocate for yourself at these appointments? Do you receive the support your require with relation to this?
- Do you have everyday habits and routines that maximise your body and wellbeing? What do others in the community do to maximise their wellbeing?
- Do you have a sense of hopefulness and optimism about your future?
- Do you have helpful ways to manage stress and conflict when is arises?
- Do you need a medical review?
- Do you need adaptations made in your home or in any area of your life?
- Do you need any input from clinicians such as OT, Speech and language, psychologist, etc.?

Supports

- What supports do you need to help you to have greater personal insight? Are you aware of your own circumstances and the impact of your own decisions? What supports do you need with this?
- Have you any physical or mental health needs?
- Is support needed around pursuing a healthy lifestyle?
- Who would be the best person that you feel could support you to as healthy as you can be? Who will take responsibility to make sure this happens?

Outcome 9 – Safe and Secure

Aligning with HIQA Residential standard
3.1 FREE FROM ABUSE OR NEGLECT, 3.3 NO EXCESS RESTRAINT

- Do you feel safe in your home, work, community?
- Are your choices restricted in any way?
- Are any adult privileges denied to you?
- What are your greatest vulnerabilities?
- What are you or your families biggest fears for you?In addressing each of these fears are effective safeguards in place?
- Do you have enough relationships that can serve as a safeguard or are you isolated?
- Are there any relationships that you feel vulnerable in?
- What competencies/skills can you increase to help you to reduce any vulnerabilities?
- Do you engage in any behaviour that could be seen to put you at risk? Why? Do you have helpful ways to manage these behaviours and manage stress and conflict when is arises?
- Are you free abuse?
- To you feel respected and listened to?
- Who would be the best person that you feel safe and secure in your own life? Who will take responsibility to make sure this happens?

My Profile

What people admire about me

What is important to me

What's important for me.

Date for Review: _____

Person Completing the Profile: _____

The Biography of

This biography is the life story of _____ as written by _____on _____ 2019. The biography offers a glimpse of the person's life at this time. The biography is an attempt to uncover the inner person and is woven from the many accounts which already exist about _____, along with new information discovered in recent months as to the vision for _____ life.

SPC
Supporting People in Communities
St Patrick's Centre

Approved by:

Date:

Reviewed by:

Date:

1. Introduction

- Name, Age, where they are from, Personal Background
- Siblings, Parents – Brief Insight into family life and background
- Family relationship and how they will be supported to fulfil roles (ie. Daughter, son, brother, sister, aunt, uncle)
- What kind of environment is best suited for the person (to be included in conditions for success)
- Nice things people say about the person
- What interaction styles and communication aids are needed to support the person

2. Housing

2.1 Description

- Description of the house (facilities available in house etc) and location of same
- How is the house specific to the person and their wants and desires – how much involvement did the individual have in choosing bedroom, colours (to be included in advocacy and decision-making supports)
- What does the new community provide for the person?

2.2 Adaptations

- Include anything that has been put into the house specifically for the individual and why?

2.3 Contribution

3. Service

3.1 Home Living Supports

- Short paragraph introducing the current weekly routines and supports needed (no time table)
- Identified areas for staff to explore with the person from discovery or interests they may have

- Possible future schedule of what the week could look like including highlighted supports required to do so.
- Refer specifically to staff requirements at certain times of day, as needed.

3.2 Role Maintenance and Development

3.2.1 Community

- Description of skills, interests and activities the person is involved in now and what supports are needed to enhance that involvement into valued roles.
- Identify how this could look different when interacting with the community and what supports are needed to achieve that. Highlight any roles that are important for any reason.

3.2.2 Education/Lifelong Learning

- Discuss current and future learning opportunities/technology and what support could look like to develop these areas.

3.2.3 Employment

- Discuss any information in relation to current or future employment options for the person and what supports would be needed to develop this area with the person

3.2.4 Conditions for Success

- Identify and expand on any conditions for success the person has and how they could be supported linking with roles discussed earlier in section.

4. Supports to Maximise Independence

4.1 Advocacy and Decision-Making Supports

- How does __ make a choice?

- Has there been any change to how that choice is made?
- Does __ choose only in certain situations?
- How is ___supported to choose?
- How has ___ been supported with choice in the move?
- How did ___ react to the news of the move?
- What practices were used to communicate the move with the person and what has been observed?
- Does the person avail of advocacy supports at present? If so, who and why?

4.2 Support to Manage Individual's Money

- How they are supported now including any vulnerabilities and safeguards
- If they have had an assessment about managing their monies
- Any training (if appropriate) they may need around money management

4.3 Social and Communication Supports

- Discuss how the person interacts/communicates independently in social situations, including any vulnerabilities and safeguards
- Discuss what supports are currently in place to support the person's social communications/interactions
- Discuss how these supports could be developed when living in the community

4.4 Medical Supports

- Discuss the current medical needs of the person and how any supports they currently receive
- Highlight how these medical needs may be supported differently in their new home
- Identify any potential scope for developing more independence in supporting these needs (training etc.)

4.5 Health and Safety Supports

- Support Plans (listed, as required)

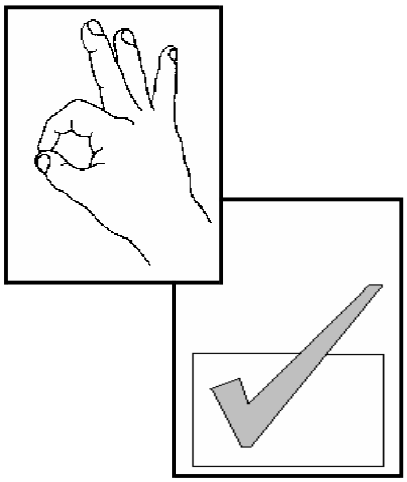
- Risk Assessments (listed, as required)
- Highlight any potential positive impact living in the community could have on risk assessments and any vulnerabilities and safeguards

4.6 Staffing Supports

- Highlight specifics of staff skills mix and profile, individually and as part of the home
- Highlight staff training requirements
- Operation and Management of Service

This Biography was compiled by using information from the following sources:

- Occupational Therapy Report, completed by Fiona Cullen, dated
- Care Staff and Keyworker for _____property. Dated: –
- My Communication Dictionary, completed by Sinéad Kellaghan, Speech & Language Therapist. Dated:
- Objects of reference and object based choice-making support guidelines completed by Sinéad Kellaghan, Speech & Language Therapist. Dated:
- Visioning Meeting minutes completed by _____. Dated:



The 'OK'

Health Check

For assessing and planning the Health Care Needs of People with Learning Disabilities

Resident Assessment Sheets

Name [(1)] **……**

Address **……**

……

Date **……**

Resident's Age[2]	**Gender[3]**

Has the Resident been diagnosed as having a particular clinical syndrome or congenital condition?[4]

Date of Previous Health Check[5] .....

Date of This Health Check[6] .....

Name of Assessor[7] .....

Date of most recent full medical examination[8] .....

Body Measurements **Difference +/-**

10. Weight last time:	11. Weight now:	12.
13. Height last time:	14. Height now:	15.
16. Waist last time:	17. Waist now:	18.

Body Mass	Yes	No	Don't Know
19. Do you consider the Resident to be overweight?			
20. Do you consider the Resident to be underweight?			

Please comment on the above as appropriate.

Current Medication[21] Dosage

22. List the known potential side effects of the above medication for which staff should be alerted to observe.

23. Date of last review of medication .....

24. Doctor who conducted the review .....

Pain	Yes	No	Don't Know
25. When the Resident experiences pain or discomfort, is he/she able to express it? Please give detail below.			
26. Does the Resident appear to suffer any particular pain or discomfort, frequently, occasionally or periodically?			

Please give additional details of the above items.

Circulation and Breathing	Pulse	Resp.	BP
27. Pulse, breathing and blood pressure at rest.			
	Yes	No	Don't Know
28. Does the Resident show any signs of œdema?			
29. Does the Resident ever show signs of cyanosis?			
30. Do the Resident's fingers show any signs of cardio-pulmonary disorder?			
31. Does the Resident suffer difficulty breathing or have a troublesome cough?			
32. Is the Resident known to have any congenital or chronic circulatory or respiratory disorder?			

33. Does the Resident have varicose veins?			

Comment on the above.

Details of any investigations .....

.....

Urinary System	Yes	No	Don't Know
34. Is the Resident incontinent by day or night?			
35. Has the pattern of incontinence changed recently?			
36. Does the Resident appear to have any problem passing urine?			
37. Does the Resident's urine appear abnormally coloured or smell offensive?			

Please give details of any of the above.

Date of the last routine urine analysis .....

Epilepsy	Yes	No	Don't Know
38. Does the Resident have any form of epilepsy?			
39. Is an accurate record of seizures maintained?			
40. According to those records, has there been any change in the frequency or pattern of seizures recently?			
41. Does the Resident receive anti-convulsant medication?			
42. If yes, does this medication require regular blood testing?			
43. Are all care staff fully aware of the various potential side effects of the Resident's anti-convulsant medication?			

Please give details for any of the above and provide dates as appropriate, state any factors that are known to exacerbate this Resident's epilepsy.

Date of last anti-convulsant medication review .....

Date of last anti-convulsant blood level tests .....

Digestion and Elimination	Yes	No	Don't Know
44. Is the Resident's diet obviously deficient in any way? Give details below.			
45. Does the Resident receive a 'special' diet for any reason? Give details below.			
46. Does this Resident drink adequate fluids?			
47. Does the Resident frequently suffer constipation or loose motions?			
48. Does the Resident pass abnormally coloured motions? Give details below.			
49. Does the Resident appear to suffer frequent discomfort that might originate in the digestive system or bowel?			
50. Does the Resident have any known chronic digestive condition?			
51. Does the Resident appear to experience any difficulty or reluctance to eat, or have any peculiar eating habits?			

Please give details of the above, including any investigations.

Date of last review of special diet by Doctor or Dietician .....

Skin	Yes	No	Don't Know
52. Does the Resident have any rash, irritation or itching?			
53. Does the Resident have any 'moles' or other marks that were not evident at the last assessment, or which have			
54. Do the Resident's pressure areas become inflamed?			
55. Does the Resident have any damaged or broken skin?			
56. Does the Resident have any chronic or long standing skin condition?			
57. Does the Resident suffer offensive body odour or other personal hygiene problem?			

Provide further details of the above including any investigations.

In your own words, describe the Resident's complexion.

Physique and Mobility	Yes	No	Don't Know
58. Is the Resident permanently physically handicapped? If 'yes' please give details below of the extent and nature			
59. Is the Resident's gross motor activity and dexterity impaired?			
60. Does the Resident have difficulty coordinating movement and/or hand-eye coordination?			
61. Does the Resident have a persistently poor posture? Comment on stooping and spinal curvatures.			
62. Does the Resident have contracture problems?			
63. Is there any evidence of tremors, twitches or other uncontrolled movements?			
64. Does the Resident suffer any myoclonic spasms?			
65. Does there appear to be any particular loss of movement or pain on movement? Comment below.			
66. Does the Resident have any muscle wasting?			
67. Does the Resident have any mobility or positioning aids? If 'yes' please comment on their use and condition			

Physiotherapy	Yes	No	Don't Know
68. Does the Resident receive the regular services of a physiotherapist?			

Comment on the above 'Physique and mobility' items and provide further details as appropriate.

State if attention is needed to any aids used by, or which might be useful to this Resident.

Date of last physiotherapy review .....

Name of Physiotherapist .....

Feet	Yes	No	Don't Know
69. Is there an obvious problem in relation to the shape of the feet?			
70. Is there any evidence of skin problems on the feet or between the toes, any signs of itching or discomfort?			
71. Are the toe nails thick, mis-shapen or abnormal?			
72. Does the Resident appear to have any pain in the feet?			
73. Is the Resident known to have a chronic foot condition?			
74. Is there any evidence of circulation problems to the feet?			
75. Is a chiropodist involved in the Resident's footcare?			

Comment on the above.

Date of last chiropodist appointment .....

Name of chiropodist .....

Oral Hygiene	Yes	No	Don't Know
76. Does the Resident have regular dental checks?			
77. Does the Resident have any teeth? Comment below.			
78. Is there any obvious problem with teeth or gums?			
79. Does the Resident appear to have any difficulty chewing?			
80. Does the Resident have persistently offensive breath?			
81. Does the Resident dribble excessively?			
82. Does the Resident have any chronic mouth condition?			
83. Does the Resident have frequent mouth sores or ulcers?			
84. Does the Resident appear to have painful or sensitive teeth?			
85. Does the Resident have dentures?			
86. If 'yes', does the Resident wear them?			

Comment on the above.

Date of last dental examination .....

Name of Dentist .....

Eyes and Vision	Yes	No	Don't Know
87. Does the Resident have any obvious eye/vision defect?			
88. Does the Resident have any obvious opacity of the eyes?			
89. Is there any behaviour which might suggest the Resident has discomfort or other problem of the eyes?			
90. Is their any behaviour which suggests problems of vision?			
91. Does the Resident appear suffer discomfort in respect of the eyelids?			
92. Does the Resident wear spectacles? If 'yes', comment on			
93. Has the Resident had their eyes and vision checked?			

Give details of any of above eye and vision items.

Date eyes and vision last checked .....

Name of ophthalmic practitioner .....

Ears and Hearing	Yes	No	Don't Know
94. Does the Resident have any obvious ear problem?			
95. Does the Resident's behaviour suggest a hearing problem?			
96. Does the Resident have a history of ear problems?			
97. Does the Resident have any impacted or excess ear wax?			
98. Have the Resident's ears and hearing been checked?			
99. Does the Resident use a hearing aid? If 'yes' comment on its use and condition.			
100. Does the Resident appear to have any balance problems?			

Comment on the above.

Date of last ears/hearing examination .....

Sexual Health - Female	Yes	No	Don't Know
101. Has the Resident had a breast examination? Give details.			
102. Has the Resident had a cervical smear? Give details.			
103. Does the Resident menstruate regularly?			
104. Does the Resident appear to experience any physical or psychological problems with her menstrual cycle?			
105. Does the Resident appear to have any frequent or periodic itching or discomfort of the anus, perineum or genitals?			

Comment on the above and any sexual activity that is likely to benefit from health promotion.

Details of examinations .....

.....

Sexual Health - Male	Yes	No	Don't Know
106. Has the Resident had a testicle/genital examination? Give details.			
107. Does the Resident frequently dribble after passing urine?			
108. Does the Resident appear to have any frequent or periodic itching or discomfort of the anus or genitals?			

Comment on the above and any sexual activity that is likely to benefit from health promotion.

Details of examinations .....

.....

Sleep	Yes	No	Don't Know
109. Does the Resident have a disturbed sleep pattern?			
110. Does the Resident often stay awake much of the night?			
111. Does the Resident often sleep much of the day?			
112. Does the Resident use night sedation to assist sleep?			

Comment on the above.

Mental Health	Yes	No	Don't Know
113. Does the Resident appear to experience frequent emotional distress?			
114. Does the Resident display apparently irrational mood swings?			
115. Does the Resident appear to experience altered perceptions?			
116. Does the Resident appear to have any irrational fears or anxieties?			
117. Does the Resident indulge in any obsessional behaviours?			
118. Does the Resident suffer from any psychosomatic disorders, or any physical condition that does not appear to have a cause, despite investigation?			
119. Does the Resident appear to suffer frequent or periodic headaches?			

Comment on the above.

Date of most recent psychiatric review .....

Name of Psychiatrist .....

Lifestyle Risks	Yes	No	Don't Know
120. Does the Resident take sufficient regular exercise?			
121. Does the Resident indulge in any behaviours likely to threaten health?			
122. Does the Resident have any habits that are likely to pose a threat to health? (Smoking etc)			
123. Does the Resident indulge in self injurious behaviours?			

Comment on the above.

Stressors Detail any specific stressors the Resident may currently be experiencing.

Other Health Issues

Comment on any issues not detailed elsewhere, or elaborate on any issues as necessary.

Summary

Briefly summarise the items which require further action or investigation.

Action Plan Briefly detail immediate, high priority actions, and interventions that are necessary.

Referrals and investigations required

Signed ..... Assessor

Signed ..... Team Leader

Date:…….

Fairfield Publications

P.O. Box 310, Preston Central, PR1 9GH, England.

www.fairfieldpublications.co.uk

Medical Data Sheet	Person Supported	House Name	Year

Please enter date and ✓ the box if action is required. Actions to be assigned on page 2

	January		February		March		April		May		June		July		August		September		October		November		December	
Mandatory Requirements	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**
Full Check Up/GP - Review																								
Dental Check - Yearly																								
Optician – 1-2 Yearly																								
Hearing Check/ as needed																								
3 Monthly Medication Review																								
Flu Vaccine / Yearly																								
Cholesterol – Yearly																								
Vitamin D, Calcium																								
Bone Health																								
Full Bloods – Yearly/as requested																								
Weight Check – monthly/as required																								

Please enter date and ✓the box if action is required. Actions to be assigned at the bottom of this page																								
	January		**February**		**March**		**April**		**May**		**June**		**July**		**August**		**September**		**October**		**November**		**December**	
Individual Requirements	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**	**Date**	**Action**
Psychiatric Clinic-6months/as directed																								
Dietician/as needed																								
Breast Check/as needed																								
Cervical Check/as needed																								
Chiropody/as needed																								
Bowel Screen/as needed																								
Testicular examination																								
Nutrition Checklist / Yearly																								
Neurologist																								
Diabetic Clinic-Yearly																								

Action	**Person Responsible**	**Complete by**

Action	**Person Responsible**	**Complete by**

Annual Visioning Meeting Minutes Template

Person Supported	
Date	
Facilitator	
Present	
Apologies	

Item Discussed	**Interests:** *For example hobbies, things the person enjoys doing*

Please tick the relevant box to record evidence of 9 outcomes

1. Living in the community		☐	2. Choice and Control		☐
3. Social and Civic Participation		☐	4. Personal Relationships		☐
5. Educations and Personal development		☐	6. Employment and valued social role		☐
7. Quality of Life and well being		☐	8. Health		☐
9. Safety and Security		☐	**Has evidence been recorded on the IPAD?**	**Yes** ☐	**NO** ☐

Interests

Identified Roles and Actions

Item Discussed	**Assets:** *For example personality, skills, qualities, attributes*

Please tick the relevant box to track discovery of information					
1. Living in the community		☐	2. Choice and Control		☐
3. Social and Civic Participation		☐	4. Personal Relationships		☐
5. Educations and Personal development		☐	6. Employment and valued social role		☐
7. Quality of Life and well being		☐	8. Health		☐
9. Safety and Security		☐	**Has evidence been recorded on the IPAD?**	**Yes** ☐	**NO** ☐

Assets

Identified Roles and Actions

Item Discussed	**Conditions for success:** *what has to be in place to support the person to have a successful day*

Please tick the relevant box to track discovery of information					
1. Living in the community		☐	2. Choice and Control		☐
3. Social and Civic Participation		☐	4. Personal Relationships		☐
5. Educations and Personal development		☐	6. Employment and valued social role		☐
7. Quality of Life and well being		☐	8. Health		☐
9. Safety and Security		☐	**Has evidence been recorded on the IPAD?**	**Yes** ☐	**No** ☐

Conditions for Success

Identified Roles and Actions

Item Discussed	**What does this person supported day look like:** *How I like to spend my day*

Please tick the relevant box to track discovery of information

1. Living in the community		☐	2. Choice and Control		☐
3. Social and Civic Participation		☐	4. Personal Relationships		☐
5. Educations and Personal development		☐	6. Employment and valued social role		☐
7. Quality of Life and well being		☐	8. Health		☐
9. Safety and Security		☐	**Has evidence been recorded on the IPAD?**	**Yes** ☐	**No** ☐

Meaningful day

What does this person day look like now?	**What does a person of the same age living in Kilkenny look like**

How can we support this person to have a more meaningful day?

Identified Roles and Actions

Item Discussed	**What does this person supported home look like:** *Compared to a person of similar age living in KK*

Please tick the relevant box to track discovery of information

1. Living in the community		☐	2. Choice and Control		☐
3. Social and Civic Participation		☐	4. Personal Relationships		☐
5. Educations and Personal development		☐	6. Employment and valued social role		☐
7. Quality of Life and well being		☐	8. Health		☐
9. Safety and Security		☐	**Has evidence been recorded on the IPAD?**	**Yes** ☐	**No** ☐

Home

What does this persons home look like now?	**What does a person of the same age living in Kilkenny home look like**

How can we support this person to make their house a home?

Identified Roles and Actions

Item Discussed	**What does this persons relationships look like now?** *Compared to a person of similar age living in KK*

Please tick the relevant box to track discovery of information

1. Living in the community		☐	2. Choice and Control		☐
3. Social and Civic Participation		☐	4. Personal Relationships		☐
5. Educations and Personal development		☐	6. Employment and valued social role		☐
7. Quality of Life and well being		☐	8. Health		☐
9. Safety and Security		☐	**Has evidence been recorded on the IPAD?**	**Yes** ☐	**No** ☐

Relationships

What does this person day look like now?	**What does a person of the same age living in Kilkenny look like**

How can we support this person to strengthen their current relationships and create new lasting ones?

Identified Roles and Actions

Item Discussed	What supports does the person need in relation to their Health & Wellbeing?				
Please tick the relevant box to track discovery of information					
1. Living in the community		☐	2. Choice and Control		☐
3. Social and Civic Participation		☐	4. Personal Relationships		☐
5. Educations and Personal development		☐	6. Employment and valued social role		☐
7. Quality of Life and well being		☐	8. Health		☐
9. Safety and Security		☐	**Has evidence been recorded on the IPAD?**	**Yes** ☐	**No** ☐

Health and Wellbeing

Identified Roles and Actions

Actions and Roles identified through Visioning and Assessment	Person Responsible	Completion date

Keyworker/Staff Member		**Date**	
Team Leader/PIC		**Date**	

Monthly Roles Based Action Plan Template

Name		**What outcomes will be met?**					
Home Name		1. Living in the community		☐	2. Choice and Control		☐
Date of monthly review		3. Social and Civic Participation		☐	4. Personal Relationships		☐
Key Worker		5. Educations and Personal development		☐	6. Employment and valued social role		☐
What roles are you supporting/developing/exploring?		7. Quality of Life and well being		☐	8. Health		☐
		9. Safety and Security		☐	**Has evidence been recorded on the IPAD?**	**Yes** ☐	**NO** ☐

Please give details of progress/actions/steps taken to meet the role/goal	**Person Responsible**	**Complete by**
What has worked well?		

What have been the barriers to implementing this plan?	**What actions have been taken to address the barriers?**
What has been learning from the experience to date?	
What is further required to support the implementation of this plan and does this action/role require further exploration and embedding?	

Key Worker Signature		**Date**	

Staff Signature		**Date**	
Manager Signature		**Date**	
Review Date			

Roles Based Progress Sheet Template

Name		**Progress Update Due**	
Key Worker		**Keyworker Signature**	
PIC/Team Leader		**PIC/Team Leader Signature**	

Action Area/Role

Actions and steps required to meet the role/goal

Date and Signature of Direct Support Staff	Participation of Person supported	Future Planning for increased chances of success
	Give example of Engagement, interaction and communication, Image enhancement, Evidence progress with pictures & videos on IPADs	*What would make this experience better and why? What future planning would be needed next time?*

Regulations 2013 (Health Act 2007) and National Standards for Residential Services for Children and Adults with Disabilities	
Regulations related to Capacity and Capability	
Regulation 3	**Statement of purpose**
Standard 5.3	The residential service has a publicly available statement of purpose that accurately and clearly describes the services provided.
Regulation 4	**Written policies and procedures**
Regulation 14	**Person in charge**
Regulation 15	**Staffing**
Standard 7.1	Safe and effective recruitment practices are in place to recruit staff.
Regulation 16	**Training and staff development**
Standard 7.2 Standard 7.3 Standard 7.4	Staff have the required competencies to manage and deliver child-centred, effective and safe services to children. Staff have the required competencies to manage and deliver person-centred, effective and safe services to adults living in the residential service. Staff are supported and supervised to carry out their duties to protect and promote the care and welfare of children. Staff are supported and supervised to carry out their duties to protect and promote the care and welfare of adults living in the residential service. Training is provided to staff to improve outcomes for adults living in the residential service.
Regulation 19	**Directory of residents**
Regulation 21	**Records**
Standard 8.2	Information governance arrangements ensure secure record-keeping and file-management systems are in place to deliver a child and adult person-centred, safe and effective service.
Regulation 22	**Insurance**
Regulation 23	**Governance and Management**
Standard 5.1 Standard 5.2 Standard 6.7	The residential service performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect each child and adult, and promote their welfare. The residential service has effective leadership, governance and management arrangements in place with clear lines of accountability. The use of available resources is planned and managed to provide child-centred effective residential services and supports to children. The use of available resources is planned and managed to provide person-centred effective and safe residential services and supports to adults living in the residential service.

Regulation 24	**Admissions and contract for the provision of services**
Standard 2.3	Each child's and adult's access to services is determined on the basis of fair and transparent criteria.
Regulation 30	**Volunteers**
Regulation 31	**Notification of incidents**
Regulation 32	**Notifications of periods when person in charge is absent**
Regulation 33	**Notifications of procedures and arrangements for periods when person in charge is absent**
Regulation 34	**Complaints procedure**
Standard 1.7	Each child's and adult's complaints and concerns are listened to and acted upon in a timely, supportive and effective manner.
Regulations related to Capacity and Capability	
Regulation 5	**Individualised assessment and personal plan**
Standard 2.1	Each person has a personal plan which details their needs and outlines the supports required to maximise their personal development and quality of life, in accordance with their wishes. Each child has a personal plan which details their needs and outlines the supports required to maximise their personal development and quality of life.
Regulation 6	**Healthcare**
Standard 4.1 Standard 4.2	The health and development of each child and adult is promoted. Each child and adult receives a health assessment and is given appropriate support to meet any identified need.
Regulation 7	**Positive behaviour support**
Standard 3.2 Standard 3.3	Each child and adult experiences care that supports positive behaviour and emotional wellbeing. Children and adults living in the residential service are not subjected to a restrictive procedure unless there is evidence that it has been assessed as being required due to a serious risk to their safety and welfare.
Regulation 8	**Protection**
Standard 3.1	Each child and adult is protected from abuse and neglect and their safety and welfare is promoted.
Regulation 9	**Resident's Rights**
Standard 1.1 Standard 1.2 Standard 1.3 Standard 1.6	The rights and diversity of each child and adult are respected and promoted. The privacy and dignity of each child and adult are respected. Each child exercises choice and experiences care and support in everyday life. Each adult exercises choice and control in their daily life in accordance with their preferences. Each child participates in decision making, has access to an advocate, and consent is obtained in accordance with legislation and current best practice guidelines.

	Each adult makes decisions and, has access to an advocate and consent is obtained in accordance with legislation and current best practice guidelines.
Regulation 10	**Communication**
Standard 1.5	Each child has access to information, provided in an accessible format that takes account of their communication needs. Each adult has access to information, provided in a format appropriate to their communication needs.
Regulation 11	**Visits**
Regulation 12	**Personal Possessions**
Regulation 13	**General welfare and development**
Standard 1.4 Standard 4.4 Standard 8.1	Each child develops and maintains relationships and links with family and the community. Each adult develops and maintains personal relationships and links with the community in accordance with their wishes. Educational opportunities are provided to each child to maximise their individual strengths and abilities. Educational, training and employment opportunities are made available to each adult that promotes their strengths, abilities and individual preferences. Information is used to plan and deliver child and adult person-centred, safe and effective residential services and support
Regulation 17	**Premises**
Standard 2.2	The residential service is homely and accessible and promotes the privacy, dignity and safety of each child. The residential service is homely and accessible and promotes the privacy, dignity and welfare of each adult.
Regulation 18	**Food and nutrition**
Regulation 20	**Information for residents**
Regulation 25	**Temporary absence, transition and discharge of residents**
Standard 2.4	Children are actively supported in the transition from childhood to adulthood and are sufficiently prepared for and involved in the transfer to adult services or independent living. Adults are supported throughout the transition from children's services to adults' services.
Regulation 26	**Risk management procedures**
Standard 3.4	Adverse events and incidents are managed and reviewed in a timely manner and outcomes inform practice at all levels.
Regulation 27	**Protection against infection**
Regulation 28	**Fire precautions**
Regulation 29	**Medicines and pharmaceutical services**
Standard 4.3	Each child's and adult's health and wellbeing is supported by the residential service's policies and procedures for medication management.