COMMUNITY LIVING DURHAM NORTH

PERSONAL SUPPORT PLANS

Policy No: B-4 (Service Delivery)

Effective Date: September 28, 2009
Last Revision: September 27, 2012
Last Review: July 26, 2019

Rationale:

To ensure that supports are of the highest quality and are consistent with the goals and aspirations of the particular person; also to ensure that every person receiving support is given the opportunity to direct and modify the services he or she receives.

Policy Statement:

Every person who receives support from Community Living Durham North will have a single, over-arching Personal Support Plan – the document referred to in Regulation 299/10 as the Individual Support Plan.

The person will be supported to participate as fully as possible in the development and review of his Personal Support Plan. His family and/or chosen significant others will also be integral to the process. The plan will have multiple components or functions.

The first part of the plan (Support Information) will describe or identify each person's specific needs, e.g. health alerts, and provide direction to staff and volunteers around how to effectively meet these needs. It is essentially about Health and Safety or personal risk management.

If the person has behavioural challenges, his or her Personal Support Plan will include a behavioural plan - a set of intervention strategies based on positive behavioural supports.

The Personal Support Plan will also include a more person-directed component that articulates and prioritizes hopes and dreams (My Life/My Plan), while fashioning a Goal Plan document that sets forth specific goals, actions that need to be taken in order to achieve the goals, and assigns responsibility for each action to particular people.

Finally, these different planning elements will be pulled together into a signed, quasi-contractual document called the Support Plan Agreement. Variations in support levels provided to people will be based on their varying levels of need, and upon the assistance they need to achieve articulated goals. There will be no distinction in the supports provided to people based on nepotism or biases arising out of differences in race, ethnicity, gender or sexual orientation.

Internal References:
B-18 Rights Review Committee
B-16 Supporting People who have Challenging Behaviours
B-25 Positive Behavioural Support

Approved by: Colin Kemp for the Board of Directors Date: June 8, 2017

COMMUNITY LIVING DURHAM NORTH

PERSONAL SUPPORT PLANS

Procedure No: B-4-1	Effective Date: June 30, 2011
Support Information	Last Revision: August 15, 2016
	Last Review: July 26, 2019

- This portion of the Personal Support Plan is actually geared to staff, in that it is intended to help them support the individual safely and effectively on a day to day basis.

- The Support Information form (*B-10*) must be completed and in place when the person begins to receive support. It will draw upon the Application form, the needs assessment used by the Application Entity (or DSO), and any other relevant clinical assessments. It will also rely on input from the person and his family and/or natural supports.

- The first section of the Support Information document contains important personal information such as history, communication style, important relationships, etc. It is written in the first person; i.e. "All About Me," and "How I Communicate." It will subsequently be added to and amended as the assigned support team develops a better understanding of the person.

- The second section provides support staff with crucial information about how to support the person properly. It includes "How to Keep me Safe," "My Health," "Managing my Money," etc.

- In addition to these routine supports, it is critical to include, and to highlight, supports necessary to alleviate risk. For example, if a person has epilepsy, the Support Information should tell staff what special precautions, if any, are required around bathing. If he/she is prone to elope, or does not have road safety skills, this should be clearly indicated, along with the strategies in place to support the person.

Procedure No: B-4-2	Effective Date: June 30, 2011
Behaviour Support Plan	Last Revision: March 15, 2012
	Last Review: July 26, 2019

- A Behavior Support Plan must be in place if the person has behavioural patterns that put himself, others, or the community at risk. This element of the Personal Support Plan is dealt with in detail by Policy B-25, *Positive Behaviourial Supports*.

Procedure No: B-4-3	Effective Date: June 30, 2011
The Planning Tool – My Life, My Plan	Last Revision: July 26, 2019
	Last Review: July 26, 2019

- "My Life, My Plan" is a planning tool used to compile information about how the person wishes to be supported, and it assists in the initial development of goals that he or she wishes to pursue. It cannot be in place as the person begins to receive service, but it will be developed within six months.

- It is developed at a meeting which the Team Leader facilitates with the support, if requested, of a designated Person Directed Planner. This meeting also includes the individual, significant others that he wishes to invite, and the support team. The group will compile information about the person using tools or prompts like "Great Things about the Person," "What's Important To…," "Good Day/Bad Day," and "Things to Figure Out."

- "My Life, My Plan" is a one-off document used in the further development of the person's Support Information document.

- If the person does not have the capacity to articulate his preferences, needs, etc., those in the group who know him best will guide the process.

Procedure No: B-4-4	Effective Date: June 30, 2011
Personal Outcomes	Last Revision: July 26, 2019
	Last Review: July 26, 2019

- As an aid to planning, CLDN uses *Personal Outcomes Measures* which is owned by the Council on Quality Leadership. It is a planning tool; it sets forth values and principles to which CLDN subscribes and which are intended to guide the planning process. It also serves as an organizational quality assessment tool, in that it provides a way to quantify the agency's performance in helping people to achieve their desired goals.

- Our Philosophy and Goal Development training module is loosely based on the planning tool known as Personal Outcomes Measures. It is provided to all direct support staff to help them understand how to help people to formulate meaningful goals. Some people who excel at goal development have been recruited onto a small team of Person Directed Planners. Members of this group are available as a resource to staff teams and can assist them to acquire a better understanding of the values and principles underlying the Personal Outcome Measures. They can also demonstrate how to "think outside the box" and help supported people to formulate meaningful goals.

Procedure No: B-4-5	Effective Date: June 30, 2011
Goal Facilitation	Last Revision: June 15, 2017
	Last Review: July 26, 2019

- The next step, informed by the person-centred planning process and the "My Life, My Plan" document, is the development of short and long term goals. Goals can help make positive change, form a new habit or change an existing habit, improve or develop a skill, talent or ability, or realize a dream. Goals are well defined targets that give clarity, direction, motivation and focus to someone's life. Team Leaders will assist each person to develop meaningful goals and will assign goal facilitators to be responsible for implementing particular action steps.

- The documentation of a person's goals in the AIMS Database will identify the expected outcomes, name the goal facilitators, and specify the time frame allotted to them for each piece of work.

- Goals are intended to capture the person's dreams and ambitions as they evolve. All staff are responsible for documenting steps taken towards goal attainment as well as indications that a person's goals may be shifting. Goal facilitators will update team members regularly and, minimally, document in the AIMS database that a regular review occurs every June and December. However, the Respite program is an exception; given the number of participants, goals will be reviewed once annually and documented in AIMS no later than December.

- AIMS Goal documents will be shared and reviewed with the person and with those acting on the person's behalf during the planning meeting and a copy will be placed in the person's Profile Binder.

Procedure No: B-4-6	Effective Date: June 30, 2011
The Support Plan Agreement	Last Revision: Aug. 15, 2016
	Last Review: July 26, 2019

- Finally, the Support Plan Agreement will draw together the different kinds of supports provided to the person into a single, quasi-contractual document that is signed off by both parties.

- Typically, the signing of the Support Plan Agreement will occur at the person's regularly scheduled annual planning meeting. It is the responsibility of the Team Leader to call and organize this annual meeting.

- The Agreement will identify the specific funded services and supports that will be provided. Group homes provide 24 hour support almost by definition, but for people

using Community Supports, the Agreement will name an agreed upon number of hours per week, and will identify the days of the week when that support will be available.

- The Agreement will identify other community resources that may be required, or accessed, including medical, vocational, recreational, cultural, religious and social resources. It will also review/update our information regarding decision making and consents.

- The Support Plan Agreement is scanned onto the agency server and the original is kept in the person's profile binder.

Procedure No: B-4-7	Effective Date:	June 30, 2011
Required Documentation, Consents and Reviews	Last Revision:	January 4, 2016
	Last Review:	July 26, 2019

- The Support Information portion of the Personal Support Plan will be in place upon admission.

- The Behavioural Support Plan component, if required, can only be in place as quickly as possible. Its development requires careful thought and the involvement of an external behaviour analyst and/or health professional might also be necessary.

- The person-centered planning process, the creation of the "My Life, My Plan" document, and the determination of goals will begin within six months of admission.

- The Support Plan Agreement is developed upon intake and reviewed, and signed, annually thereafter, typically at the person's regularly scheduled annual planning meeting.

- Once in place, all aspects of the Personal Support Plan will be reviewed at least annually, at an annual planning meeting, attended by the person and his family, or significant others. The plan will be dated; review dates will be scheduled.

- The above time frames are minimums; the Personal Support Plan is a living and working document that must be revisited, revised and updated on a continual basis. That said, for quality assurance reasons, all interim adjustments must be approved by the Program Manager.

- As the plan is developed, and at each annual planning meeting, staff will discuss with the person, or with those acting for him, the circumstances, if any, when he would permit the information in the plan to be shared with persons other than CLDN staff, and specifically with whom outside of the agency.

- Every Personal Support Plan will identify the persons, including staff, who were involved in its development.

- All staff working in a particular program must read and sign-off on each of the Personal Support Plans in that location.

- The Personal Support Plan and progress made in respect of the plan will serve as a basis for supervision of all support team members. Regular audits of progress achieved will be performed by the appropriate Program Director.

Approved by:	Glenn Taylor CEO	Date:	August 2, 2019