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NSW GOVERNMENT | Family & Community Services

Lifestyle Planning Guidelines

Summary: The Lifestyle Planning Guidelines consider the stages involved in preparing a Lifestyle Plan with the person. The Guidelines introduce Person Centred Thinking tools and refer throughout to the tools that can be used for different planning activities that retain the person at the centre.

Family & Community Services
Ageing, Disability & Home Care

Lifestyle Planning Guidelines

Document name	Lifestyle Planning Guidelines
Policy	Lifestyle Planning Policy
Version number	1.1
Approval date	March 2011
Policy manual	Lifestyle Policy and Practice Manual
Approved by	Chief Executive, ADHC
Summary	The Lifestyle Planning Guidelines consider the stages involved in preparing a Lifestyle Plan with the person. The Guidelines introduce Person Centred Thinking tools and refer throughout to the tools that can be used for different planning activities that retain the person at the centre.
Replaces document	Individual Planning Policy and Procedures, 2005 and Attachments 1 – 9
Authoring unit	Contemporary Residential Options Directorate
Applies to	People who are being supported in ADHC operated accommodation support services.
Review date	2015

Version control

The first and final version of a document is version 1.0.

The subsequent final version of the first revision of a document becomes version 1.1.

Each subsequent revision of the final document increases by 0.1, for example version 1.2, version 1.3 etc.

Revision history

Version	Amendment date	Amendment notes
V1.0		Replaces Individual Planning Policy and Procedures, amended May 2012
V1.1	February 2013	Formatted for Lifestyle Planning Policy and Practice Manual

Table of contents

1 Guidelines

1.1 Introduction

The *Lifestyle Planning Guidelines* (the Guidelines) refer to the development of a Lifestyle Plan and consider the preparation this requires. Planning is done with the person with disability and others who are important in the person's life.

To support planning activities, a set of Person Centred Thinking Tools is provided with the Guidelines to assist at all stages of planning. Each tool includes a description of its purpose, a template for recording information, and an example of a completed tool.

Individual tools have different purposes and can be used for:

- gathering information from the person and others about her or his wishes and preferences, dreams, aspirations and support needs
- learning about the person's strengths
- helping the person to make decisions
- working with others to solve problems
- running a successful planning meeting
- deciding on goals with the person and others, and determining how they will be achieved
- reviewing decisions.

The decisions and actions from the planning meeting form the basis of the Lifestyle Plan.

Note

26 Person Centred Thinking Tools and 4 additional resources accompany these Guidelines. You will not need to use them all. Follow the tips in the right hand margin of the Guidelines, from Section 1.5 onwards, to select a tool that you think will be most useful for the planning activity you are doing.

1.2 Summary of planning activities

The final Lifestyle Plan belongs to the person and is in a format the person understands.

The Guidelines offer flexibility in the way planning is done with the person, and allow planners to explore the different planning approaches that can be used.

Person Centred Thinking tools that accompany the Guidelines help support workers to implement the person centred approach being taken in ADHC. Training and coaching in their use is fundamental to implementing the Guidelines as they are intended.

While the Guidelines' flexibility allows planners to explore options and be creative, some basic outcomes are expected from the planning process as described below:

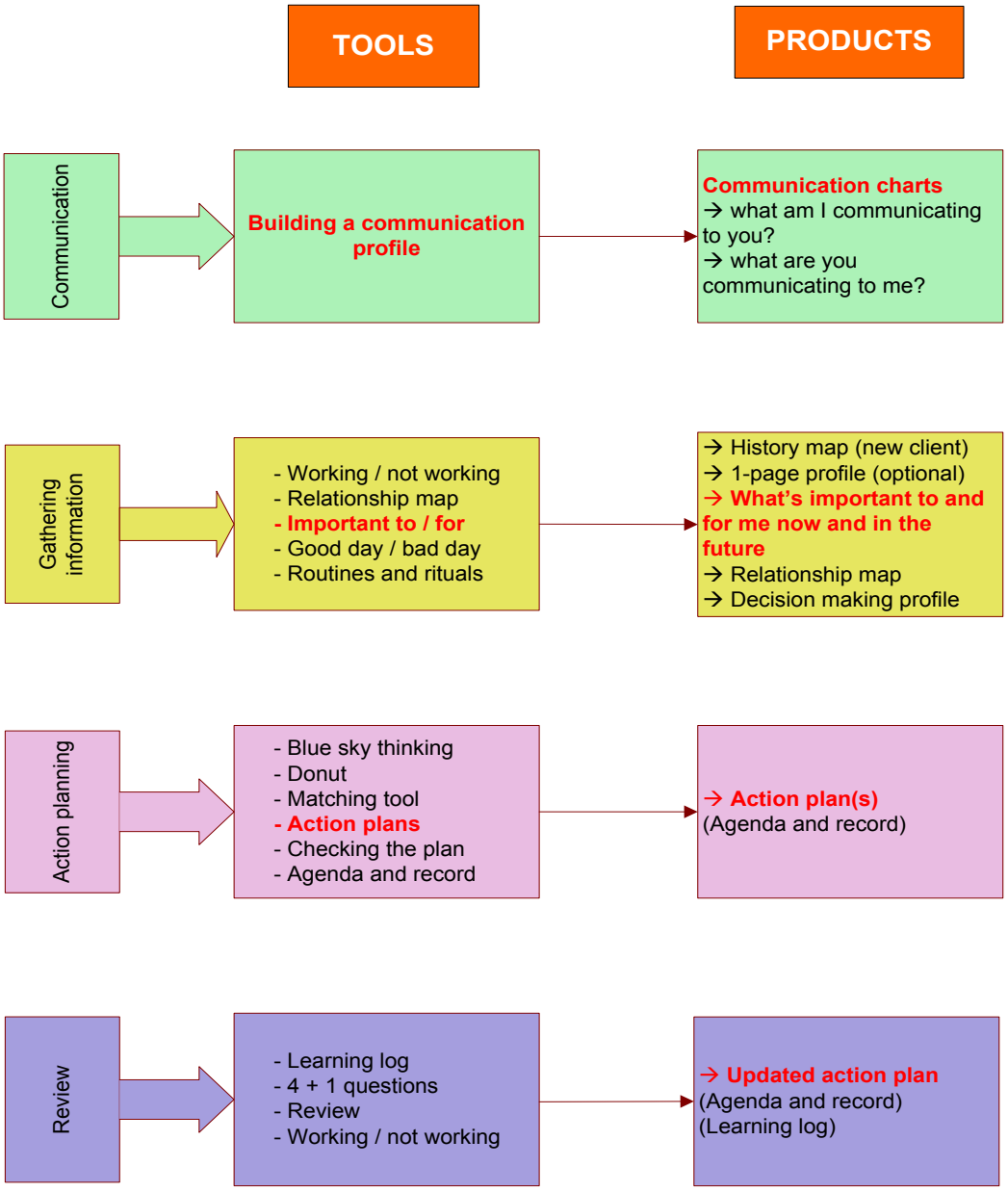
A **Communication Profile** is developed to understand the gestures, signs, sounds or other methods the person uses to communicate, and must be completed before planning starts.

Communication Charts show how the person communicates with others (expressive) and how the person receives information from others (receptive). Communication Charts help people who use behaviour as a means of communication to be better understood by others.

Important to / Important for is a basic Person Centred Thinking Tool. It is essential to maintaining the balance between what is important to the person to get the most out of life, and what others see as important for the person to stay healthy and safe.

The **Action Plan** is a record of the planning meeting, and contains the 'Who' the 'What' and the 'When' from the meeting.

The following chart shows where these four Tools fit into the planning process:


TOOLS
PRODUCTS
Communication
Building a communication profile
Communication charts
→ what am I communicating to you?
→ what are you communicating to me?
Gathering information
- Working / not working
- Relationship map
- Important to / for
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- Routines and rituals
→ History map (new client)
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→ What's important to and for me now and in the future
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→ Action plan(s)
(Agenda and record)
Review
- Learning log
- 4 + 1 questions
- Review
- Working / not working
→ Updated action plan
(Agenda and record)
(Learning log)

1.3 Why do we plan?

The reason we plan is to maximise the person's quality of life and to support the person to decide what is required to make that happen. With the person's consent, planning includes the family and other important people in the person's life.

We use planning to learn which things matter to the person from day to day, and the support needed to make them happen. Planning is based on the person's abilities, interests, dreams and aspirations, and on what the person wants and needs into the future.

1.4 How do we know what the person wants and needs?

It is important to know what the person wants and needs to be happy and healthy. The important things are sometimes described as those that are **important to** and those that are **important for**[1] the person.

Broadly, things that are **important to** the person are those that he or she tells us about. At times we observe behaviour which can also be the person telling us what is important.

IMPORTANT TO

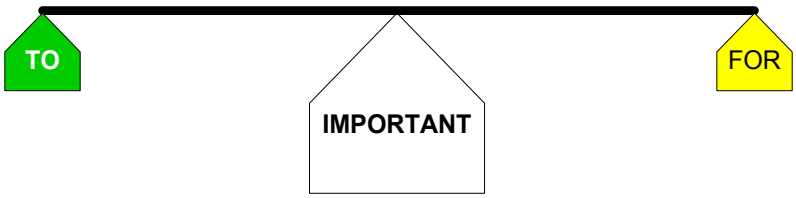
Some things may be important now, for example, always being able to follow preferred routines or be with favourite people, or in the future, for example, realising dreams and aspirations.

Things that are **important for** the person can be receiving support to be part of the community, and to make decisions and have choice. They can also be things that the person and others see as being important, such as keeping the person healthy and safe.

IMPORTANT FOR

It is possible for the same thing to be **important to** and **for** the person, but for different reasons. For example, it may be **important to** the person to do regular exercise because he or she gets to walk the dog or meet friends in the park. Others may see walking as **important for** the person because it is good exercise and helps the person maintain a healthy weight.

[1] Essential Lifestyle Planning, The Learning Community for person centred practices.



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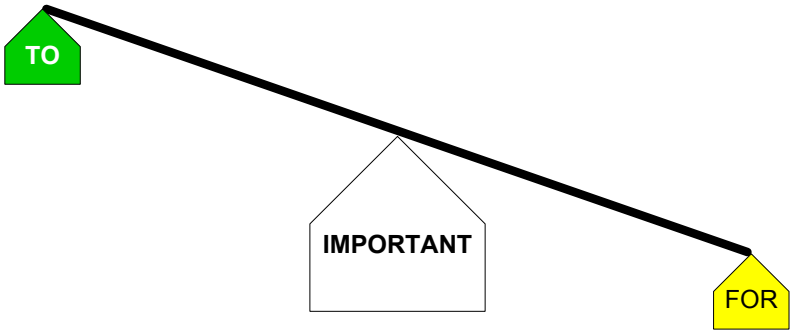
The aim is to maintain a balance between what is important TO and important FOR the person

NOT



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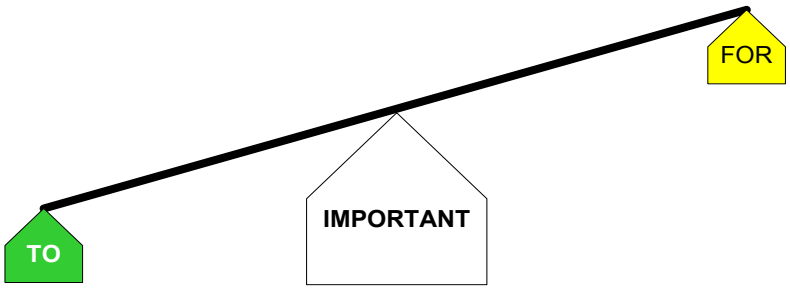
OR



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The aim of lifestyle planning is to create a balance between what is **important to** and **important for** the person, thereby providing opportunities for the person to get the most out of life while remaining healthy and safe.

1.5 Developing the Lifestyle Plan

Use the tips below to help you select a tool

1.5.1 Developing a new Lifestyle Plan

A person entering an ADHC accommodation support service for the first time may have a transition plan or a one-page profile that a case manager has prepared. The plan or profile contains information about what is **important to** and **for** the person and will help support workers to support the person in adjusting to a new environment.

Important TO and FOR

Working / not working

After entry to the accommodation support service, the person, family or guardian, and support workers, review and update the transition plan or one-page profile in the context of the new environment. The new Lifestyle Plan should consider any other plans that the person has already.

1 page profile

4 + 1 questions

A person who does not have a plan, and is entering an accommodation support service for the first time, will have a Lifestyle Plan developed in accordance with these Guidelines and within three months of entry to the service.

Important TO and FOR

1.5.2 Reviewing an existing Individual Plan

A person currently residing in an accommodation support service will have a new Lifestyle Plan developed in accordance with these Guidelines when the next annual Individual Plan review is due.

4 + 1 questions

1.5.3 Person centred approaches to planning

While the Guidelines do not specify a planning method they describe a person-centred approach to developing the person's Lifestyle Plan. To assist with this approach a range of Person-Centred Thinking tools are provided for use with the Guidelines.

A number of different methods have been designed for person-centred planning. Many require training and support to implement them as they are intended (see Other Resources).

All are based on the five principles of person-centred planning:

- The person is at the centre of planning
- Family and people important to the person are partners in planning
- The focus of planning is on developing the person's abilities
- Planning is based on positive action
- Planning is a process of listening and learning

Family information brochure

Support workers are encouraged to explore the range of person-centred approaches to planning and choose a method, or combination of methods that are best suited to the person.

Use the tips below to help you select a tool

1.5.4 Communication

Through communication we build relationships with other people, and we let others know how we feel and think. Being able to communicate gives us a say in our lives.

A person-centred approach requires planners to use the person's own way of communicating to understand her or his abilities, interests, dreams and aspirations.

Before this is possible, how the person receives and interprets messages (receptive communication), and how the person sends messages (expressive language) must be established.

Communication methods of people who don't use language to communicate are varied, and include signing or pointing to images, symbols, photographs or objects. Gestures, body or facial movements, behaviour and sounds also express needs or wishes (see Other Resources).

Be aware that a person who uses language to communicate may not understand everything that others say, and her or his receptive communication ability should be determined.

The *Lifestyle Planning Guidelines* require that a Communication Profile is developed before planning starts.

Communication profile

The Communication Profile will guide the preparation of tools that the person can use to communicate with others, for example a collection of meaningful objects for making choices, a chat book, video or Communication Chart. A Communication Chart could show pictures of the person using expressive gestures, or describe the person's actions and behaviours at particular times.

Communication chart

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 supporting the person.

It is important to remember that some people with disability may not have had many life experiences and that the interests or aspirations they communicate are based on what they know and their life experience.

There are a number of communication resources available for learning about the capacity of people to communicate and the range of communication styles used by people with impaired language skills (see Other Resources).

The Inclusive Communication and Behaviour Support[2] (ICABS) program is one such tool that has been implemented in ADHC. It teaches people to understand communication and its link with behaviour, and to develop tools for effective communication with people with disability.

The communication profile and associated resources are living documents and are updated as the person's communication style is better understood or changes over time, and at least once a year.

Communication documents encourage a shared understanding between the person and other people in his or her life, and should be used by anyone who does not know the person well and needs to relay information to or seek information from the person.

The environment is another important factor in communication. When meeting with the person, whether it is one-on-one or in a larger group, it is important to choose a space that encourages the person to communicate. Choose pleasant, quiet and comfortable surroundings, with sufficient space for the meeting. If the person has a favourite place in the house or unit, use it for the meeting.

All people respond to the way others address them and people with disability are no different. It is essential to recognise the person and not refer to her or him in the third person, and to be respectful and show loyalty as a primary supporter. Bringing related or unrelated conflicts and tensions to the meeting can inhibit the person who may think she or he has done something to cause the tensions.

Keep the person at the centre and make the conversation relevant to the person, who will quickly become disengaged if he or she does not feel included. Communicate at a level the person understands, this not only maintains engagement but also demonstrates respect for the person.

Avoid using jargon and technical language as this can also alienate families and others who are not familiar with the service system.

Use the tips below to help you select a tool

4 + 1 questions

Communication charts

Meeting checklist

[2] Department of Human Services, Victoria©

1.5.5 Getting to know the person

Use the tips below to help you select a tool

Support workers who gather information for lifestyle planning must be aware of the privacy requirements around collecting and sharing personal information about another person (See Other Resources).

The person is the primary source of information. The person's family, friends in the community or previous service providers who know the person well, are other important sources of information. They can help to paint a picture of the life the person leads now.

Information about the person can be collected in various ways. For example:

1. Take time to listen and observe and use the Person Centred Thinking tools provided with the Guidelines to learn what is important to the person and how she or he wants to be supported.
2. Use images that will indicate what interests and excites the person. This can be fun way of working with the person, and will work better with some people than other methods.
3. If the person already has a Communication Profile use it to learn about her or his life. This will engage the person and should turn information gathering into an enjoyable conversation.
4. Advise the person that you are gathering information for the Lifestyle Plan and arrange to get together and talk. If the person agrees, the family or others who know the person well can join in.
5. Pay attention and ask others about what helps or hinders when the person is having a bad day.
6. If the family or others are providing additional information about the person make a phone call to talk about the things that are **important to** the person and what has worked before in their experience. It might help families or others to use some of the tools included with the Guidelines.

Important TO and FOR

Learning log

Communication profile

4 + 1 questions

Good day / bad day

Relationship map

Meeting checklist

Consideration should be given to other priorities in the person's life by having the meeting at a time that suits the rhythm of the person's day.

It will help if the person looks forward to meetings as pleasant experiences. Try and make the information gathering process fun and interesting to the person because more discussions and meetings will be needed during development of the Lifestyle Plan.

Some aspects of the person's life are important to know early in the planning process. Routines are one of these and tell us a lot about what matters to the person who does not use words to communicate. Routines allow the person to know what she or he will be doing next,

give structure to daily activities and provide opportunities for the person to make choices.

Use the tips below to help you select a tool

1.5.6 What makes a good day?

Identify the person's preferred daily routines and determine whether and how their disruption might affect the person. Take time to determine what parts of a routine really matter to the person, and work at helping her or him to construct an ideal morning, evening, bathing or other routine.

Routines and rituals

Important TO and FOR

1.5.7 What makes a good week

Learn about a typical week for the person. If the person has regular commitments you need to know what they are to be able to support the person to meet them.

Good day / bad day

1.5.8 Learning about the person's strengths

Find out what things the person does well and start recording them in the Lifestyle Plan. This may require an assessment of the person's skills or getting the information from people who have known the person for some time.

Learn about the person's strengths and the positive things that other people know and like about the person, for example, being a good listener or having a great sense of humour.

Person Centred Thinking tools can be used to record the person's likes and dislikes, what makes a good or bad day for the person, what is working or not working, and any previous activities or goals that did not work for the person.

Once the person's strengths are known, planning can proceed on the basis of those strengths. Using the person's existing strengths is likely to increase her or his ability to engage in an activity. When the person is successful in these pursuits, she or he may be more inclined to try new experiences.

Use the tips below to help you select a tool

Gifts and strengths

Reputations

Good day / bad day

Working / not working

Learning log

1.5.9 Supporting the person to make decisions

Use the tips below to help you select a tool

The person must be enabled to make decisions and choices about her or his present and future life. Provide the person with the support and encouragement required to identify the activities and interests needed to realise her or his dreams.

Decision making profile

If the person has a Communication Profile use it to provide support for decision making and to help the person understand the choices she or he makes.

Support can be given by talking through the dreams and aspirations the person has identified. Explain what they could mean in her or his life, who else might be involved in making them happen and what things the person might have to do to achieve them.

Decision making agreement

Remind the person that pursuing these dreams will result in some changes in her or his life and, if possible, explain what the changes will mean to the person and others.

Ask the family and others to support the person in understanding what the decision will mean. When a person is assisted by family or others to make a decision, the assistance is based on what is best for the person and on quality of life. It must lead to the person achieving her or his dreams and aspirations, building on skills and abilities and increasing community involvement, while remaining healthy and safe (See Other Resources).

Relationship map

If the person does not have a family or other naturally occurring support group, effort is required to identify other people in the person's life who are willing and able to support the person to realise her or his dreams.

1.5.10 Engaging others in lifestyle planning

Use the tips below to help you select a tool

The person needs to have more relationships in life than those with paid carers. Having different relationships helps create opportunities for the person to get the most out of life, in the same way as having a balance between the things that are **important to** and **for** the person.

The family and close friends are often the main source of personal relationships for people, and they can have a central role in lifestyle planning. Some families and friends will not be able to take a role or want to have that level of involvement. Ask them how much they want to be involved in the person's life, and how they prefer to receive information about the person's activities.

Relationship map

If the family and friends want to participate in planning, confirm that the person is agreeable to their involvement before asking for their input.

Spend time with families and friends and talk through the reasons for planning, and for developing the person's capacity to engage in meaningful activities. Explore with families and friends the potential benefits to the person from increased engagement with the community and from making decisions in her or his life.

Family information brochure

1.5.11 Including other partners in problem solving

Use the tips below to help you select a tool

Planning will sometimes uncover obstacles that are hard to overcome, and no one person is expected to resolve every issue.

Support the person to build a network of partners who can help resolve some of the obstacles, and increase the person's opportunities for leading a meaningful and fun life. Identifying potential partners, especially those who have similar interests to the person, can be one of the planning activities. Remember to go outside the disability system when looking for partners to be involved in planning and problem solving with the person.

Blue sky thinking

Relationship map

Obstacles and barriers exist for various reasons. They may relate to the person's ability to follow a chosen life course, to the availability of resources to support the person's aspirations, or to the person's unstable or frail health. Having different support partners can help the person to overcome these obstacles, increase community engagement and integration, and to develop social networks.

Matching tool

CHECKPOINT 1

By now you should have:

- reviewed transition plans
- assessed the person's communication methods and needs
- started gathering information about the person's abilities, interests and strengths
- discussed choices and decision making with the person
- identified partners for support
- chosen a planning method

1.6 Pre-planning

Use the tips below to help you select a tool

1.6.1 Dreams and aspirations

IMPORTANT TO

In the pursuit of things that are **important to** us, we need goals we can reach to keep us working towards realising our dreams. The same applies to people with disability.

Personal goals contribute to the quality of life enjoyed by

In the context of these Guidelines, a goal is an event or achievement that occurs at a point in time. It is a step on the path to the dream, and when a goal is achieved it is recorded.

Action plan

The person and the support group may identify one or more goals during the planning process. Some goals will require a number of activities for their completion. Goals, and the activities that relate to them, are recorded in the person's Action Plan and are regularly monitored and reviewed.

Important TO

Goals and activities are **important to** the person. For example, a person wants to write regular updates and email them to family members who live too far away to visit. Before this is possible the person needs to learn how to use a computer. The dream (writing updates), the goal (becoming computer literate) and the activities required to reach the goal (having computing lessons) are all **important to** the person. They are recorded in the Action Plan along with who is responsible for the action and a completion date. The Action Plan is regularly monitored and reviewed.

Hopes and dreams

Similarly, receiving support to make informed choices in life, being given the opportunity for personal growth and development that leads to increased community participation, and being able to take responsibility for her or his own life are **important to** a person for achieving a higher goal. Developing new skills are **important to** the person who wants to live more independently.

Hopes and fears

There are no time constraints on reaching a dream; it can take as much or as little time as required.

Action plan

No dreams should be excluded from consideration because they all say something about what the person wants. A dream might be unattainable because of the cost (being on a disability pension and owning a house at Palm Beach), because special skills are required (being an airline pilot) or because of physical limitations (doing the Bridge Climb in a wheelchair).

Presence to contribution

However it is possible to think about some aspect of the examples provided as potential goals. For example, spending a night or weekend in a house by the beach, having a behind-the-scenes visit to the airport and sitting in the cockpit of a plane or crossing the Harbour Bridge footway and seeing the view from there.

Use the tips below to help you select a tool

History map

Learning log

Because the person had a life prior to entering the accommodation support service she or he has a history and life experiences. It is possible that she or he already has some dreams and goals. If these were not identified during earlier information gathering, now is the time to learn about those dreams.

If the person has not identified any dreams, start to explore interests and previous life experiences with the person. Think about the sort of things that other people of a similar age or the same culture might enjoy doing. This can be a starting point. Also look at what the person enjoys doing now that you could support and help build on. Having magazines or pictures handy could suggest some ideas. If the person has recently reached a goal consider how that achievement might be used to reach the next goal.

1.6.2 Health and safety

Use the tips below to help you select a tool

An equally critical aspect of pre-planning activity is the review of management and support plans which are **important for** keeping the person healthy and safe. To ensure a balance is maintained these are considered with reference to what is **important to** the person.

IMPORTANT FOR

ADHC has a number of policies for managing the health and related needs of people with disability. In line with the requirements of these polices, consult with the person, family and others to develop or review plans for the management of health and related needs.

The number of management or support plans a person has will vary depending on how much support the person needs. The following areas of support commonly require a management or support plan and there may be others:

Important FOR

- Health Care
- Nutrition
- Epilepsy
- Behaviour

If the person has other support needs that require a management plan, these are developed or reviewed during pre-planning, in accordance with the person's needs and the relevant policy (See Other Resources).

Good day / bad day

In addition to supporting the person to remain healthy and safe, many areas of the person's daily life include **important for** things. Examples include, having privacy and personal space, living with compatible companions and being comfortable. Many of these can be identified using Person-Centred Thinking tools such as Good Day / Bad Day and What's Working / Not Working.

Working / not working

Discussions about management or support plans must not take over the Lifestyle Plan meeting which is about the person's abilities, interests, dreams and aspirations.

Management or support plans inform the Lifestyle Plan meeting and can have an impact on its final outcomes. Support workers and other people, and families who choose to, will be present for discussions about management and support plans.

Decision making agreement

The person is supported to participate in the **important for** discussions if she or he has the capacity and interest to be involved. If the person is unlikely to stay interested keep the meeting short. If the person does not want to attend the meeting hold it before the Lifestyle Plan meeting without the person being present. The Lifestyle Plan meeting can then follow on with the person and others who are part of the person's support network.

REMEMBER:

The person is central to planning

1.7 Organising the meeting

Start planning the meeting. Make it a happy occasion and something for the person to look forward to with pleasure. Help the person decide where the meeting will be held, what refreshments to serve and who will be at the meeting.

Some guidance will be required to ensure that people at the meeting are a mix of those the person wants to be there, others who are important in the person's life and those who need to attend, for example, professionals.

Family and friends have priorities beside the person's planning needs, and meetings should fit in with their commitments too. Give families and friends enough notice to organise their attendance at the meeting. If travel to the meeting is not an option, consider holding it near or at the family home, or by telephone.

Before the meeting, contact families and friends by phone to check that they understand the purpose of the meeting, and to answer their questions before the meeting day. Show respect for the person's family and friends by listening to them and addressing any concerns they raise outside the planning process so they are free to focus on the meeting.

It is important to remember that the person has a history as we all do, and there may be some people who the person does not want at the meeting. If they are significant people, such as a family member or guardian, and their signatures or consent are required for any planning activities, these should be obtained without causing undue distress to the person.

Some people have no family or close friends, and ensuring they are well supported requires identification of others who are important in their lives and seeking their involvement in the Lifestyle Plan meeting.

If the person declines to participate in the planning process the person's support group focuses on how to create opportunities for the person to pursue known interests and enjoy a good quality of life. People who know the person well and those who are important in the person's life will explore ways of engaging the person's interest in thinking about and eventually working towards a dream.

If there are likely to be conflicting views about any of the goals or other content in the Lifestyle Plan, try and address them before the Lifestyle Plan meeting. Providing information or education about planning and its purpose may be an easy solution if the issue is due to a lack of understanding about the planning process. However, if there is conflict about fundamental differences in philosophy, someone with suitable experience may be needed to help reach a resolution.

Use the tips below to help you select a tool

Decision making agreement

Relationship map

Meeting invitation

Meeting checklist

Family information brochure

Relationship map

Matching tool

Presence to contribution

4 + 1 questions

Working / not working

Family information brochure

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 Plan meeting, as well as, or instead of the family. The person may want to invite a partner, boyfriend or girlfriend, who will be part of the planning activities.

In order to maintain the person at the centre of the planning process consideration should be given, prior to the meeting, to the person's capacity for participating in the meeting. Depending on the person's ability and interest, discuss how she or he might be supported to lead the meeting. Explore what the person could do, for example, hand out the agenda, introduce the meeting attendees or facilitate all or part of the meeting.

Use the tips below to help you select a tool

Relationship map

Meeting invitation

Presence to contribution

Decision making agreement

CHECKPOINT 2

By now you should have:

- completed the Communication Profile
- identified and documented **important to** information
- identified and documented **important for** information
- started planning the meeting with the person
- decided on meeting date, time and place
- invited others to the meeting
- made necessary arrangements for the meeting

1.8 The Lifestyle Plan meeting

1.8.1 Running the meeting

A meeting facilitator is selected prior to the meeting, and the right choice will depend on the complexity of the planning discussions. If it is known there are issues that will impact on the planning process, ensure that the mix of people at the meeting includes some with the knowledge and skills to address the issues. This should not stop the person from leading the meeting in whatever role she or he has chosen.

Provide a written agenda for the meeting. If possible send the agenda to the people who are attending before the meeting date. Having an agenda helps to avoid discussion that diverts the meeting away from the person and the purpose of the meeting.

The following items will have to be discussed and resolved with the person and support people. They form the basis of planning discussions and the meeting agenda.

1	**Goal/s** - decide what is being planned for
2	**Activities** - record all the steps needed to reach each goal
3	**Resources** - record everything needed for each goal including the people
4	**Risks** - identify the things that could go wrong for each goal
5	**Manage risks** - work out how to avoid things going wrong
6	**Barriers** - look at anything that might stop the person from reaching the goal
7	**Overcome barriers** - work out how to ensure the person can reach the goal
8	**Review** - make a timetable that includes all the activities and resources for each goal

Use the tips below to help you select a tool

Decision making agreement

Meeting checklist

Meeting agenda

4 + 1 questions

Action plan

Donut

Blue sky thinking

1.8.2 Decisions made at the meeting

If the person comes to the Lifestyle Plan meeting with some goals in mind, the person and support people should use the meeting to decide about who and what support is needed for the person to achieve the goals, and how it will be provided.

If the person has not identified any goals before the Lifestyle Plan meeting, the person and support people will focus on exploring her or his interests, dreams and aspirations. A second meeting may be required to decide on how to support the person to reach the goals. If the person and others cannot attend a further meeting, support people can be contacted by phone or email.

Take advantage of people who share interests with the person for their capacity to help the person identify some goals, and provide support to achieve them. The amount and type of support that people contribute will vary depending on the goal, and on their capacity to provide the level of support the person requires.

All the goals the person identifies are recorded. Depending on the number and their complexity they may need to be given different priorities in accordance with the person's ability and the availability of resources. Priority is discussed and decided with the person and support people at the Lifestyle Plan meeting.

Use the tips below to help you select a tool

Decision making agreement

Relationship map

Hopes and dreams

Hopes and fears

Action plan

Decision making agreement

1.8.3 Material and personal resources

Use the tips below to help you select a tool

Decision making agreement

Action plan

Blue sky thinking

Presence to contribution

Once goals and related activities are known, the person and support group can identify the material and personal supports that will be needed.

When looking for creative ways of supporting the person to achieve a dream, do not be confined to the disability system. Mainstream services and community resources are all possible sources of support. Access to community resources is a preferred long-term option because it has the benefit of increasing the person's participation and ongoing involvement with the community.

During the Lifestyle Plan meeting a goal-related activity is identified that requires the person to travel to a computing class once a week. There is only one support worker in the house at the time the class is on, and the person cannot afford to catch a taxi every week. The computing course runs for twelve weeks.

Someone in the person's support group happens to be the local swimming coach who teaches the person and some of his housemates to swim. The coach lives quite near the person's home and on the evening of the class he is free to give the person a lift. The coach is happy to make this offer because he likes the person and will not find twelve weeks too long a commitment.

Blue sky thinking

The disability service's capacity to support the person's goals may relate to the availability of support workers (rostering issues) or the service's budget. Service staff must discuss these with the person and support group with the purpose of finding a solution.

Action plan

If the person's own finances are seen as barriers to reaching a goal, the person's financial capacity must be discussed with the family or the person's financial manager. If the family does not manage the person's finances, the financial manager should be present at the meeting, or at least have provided an indication of the person's financial capacity.

Working / not working

The following resources are examples of some supports a person could need:

Blue sky thinking

- environmental – modifications to the house or other venue that are related to the person's goal
- personal resources – personal confidence, someone to share interests, or financial capacity for some goal-related activities
- transport – access to public or private means of travel
- time – support workers or other support people who are available for regular activities
- internal – requirements for extra support to achieve goals

- external – general support e.g. a companion card for a supporter who is accompanying the person to an event

Use the tips below to help you select a tool

When considering goals that the person or others identify, the capacity of others to support the person must be identified at the meeting or as soon as possible after the meeting.

Decision making agreement

The informal and naturally occurring support people, such as the immediate family and friends, are often the most likely options. However, there will be other people in the person's support group, for example:

Relationship map

- extended family
- acquaintances
- co-workers
- neighbours
- members of a club
- church
- social groups
- health and other professionals.

The Relationship Map is a useful tool in this situation.

1.8.4 Process and timeframes

At the Lifestyle Plan meeting, the actual activities required to achieve goal/s should be nominated and recorded in the Action Plan. If possible, the level of involvement of support people, and the type and number of resources needed for each step are identified during the meeting and recorded in the Action Plan.

People who agree to take a role in supporting the person to reach a goal, and who are not present at the Lifestyle Plan meeting, are contacted as soon as possible after the meeting to confirm their participation. Their agreement to support the person and the level of support they will provide is recorded in the Action Plan.

Agree on milestones when setting goals so that timeframes for achieving goals are known to the person and support group, and a review schedule can be developed during the meeting.

Use the tips below to help you select a tool

Action plan

Relationship map

Decision making agreement

CHECKPOINT 3

By now you should have:

- identified or confirmed goals
- identified activities for goals
- recorded decisions
- identified material and personal resources required
- identified process and timeframes for each goal
- contacted support people

1.9 Monitoring and review

1.9.1 Monitoring

Use the tips below to help you select a tool

When the Action Plan is completed it includes a series of activities that the person and support group have agreed are necessary for helping the person to reach a goal, and ultimately the dream.

Action plan

The support worker who has primary responsibility for supporting the person or who has a monitoring role in the unit, monitors activities with the person to make sure they are still relevant to the goal/s. The Person-Centred Thinking tool 'What's working / What's not working' is a simple and useful way of gathering information from the person and support group for monitoring goal related activities.

Working / not working

Monitoring is a continuous process and ideally is part of the daily routines of the household. Goal related activities could be put on display so that everyone can see and understand them, for example, as images on a wall calendar. They can then be discussed at mealtimes or when the relevant people are present, and decisions made about who will do what and when it will be done. Individual households should decide on a monitoring process that best suits its people, and their abilities and routines.

4 + 1 questions

Learning log

Monitoring this way means that everyone in the house is aware of goals and related activities that need attention, and if the responsible person is not able to undertake an activity when it requires action, someone else can do it.

Relationship map

If the activities are progressing as planned, make a record in the Action Plan as each activity is completed. If an activity is not being done as planned for any reason:

Action plan

- remind the person who has taken primary responsible for the activity (the person, a family member, someone from the support group or a support worker) that it is due, or
- determine if there is a problem and how it can be resolved.

Working / not working

If a problem arises that relates to the service system, support workers should raise this with a line manager. The matter should also be discussed with the person and support group to try and identify an alternative approach, without compromising the person's right to reach a chosen goal.

Decision making agreemen

If the problem relates to any other issue, try and resolve it with the person and support group. If this is not possible, problem-solve together to identify an alternative approach. Any changes or amendments to activities are recorded in the Action Plan.

Blue sky thinking

1.9.2 Review

Use the tips below to help you select a tool

Review the Action Plan regularly to ensure that goal related activities are being achieved according to the agreed timetable. The regularity of reviewing goal related activities is decided during the Lifestyle Plan meeting and recorded in the Action Plan.

Action plan

See Other Resources ('Review the plan resources') for additional tools that can be used during this phase of planning.

A formal review of goals is conducted with the person and support group once a year. Quarterly reviews are undertaken to ensure the person and support group are updated on goal related activities, and that problems have been identified and addressed. It is not necessary to arrange a formal meeting with all members of the person's support group for quarterly reviews.

Working / not working

However, those who have a role in supporting the person to reach a particular goal should be involved in the review, even if it is by telephone. Their involvement can range from, receiving a written or verbal update on progress over the previous three months if everything is going as planned, to problem-solving with other members of the support group when issues arise.

4 + 1 questions

Outcomes of reviews are discussed at team or house meetings, thereby providing all members of the person's paid support team with regular updates on progress. It is also an opportunity for support workers to take advantage of the experience of their peers.

All review activities are documented in the Action Plan, and new information is recorded in the Learning Log.

Learning log

CHECKPOINT 4

By now you should have:

- recorded outcomes of monitoring goal activities
- reviewed activities
- identified barriers to progressing activities
- resolved barriers or identified changes
- sought agreement with the person and others to make changes where necessary

2 Policy and Practice Unit contact details

You can get advice and support about this Policy from the Policy and Practice Unit, Contemporary Residential Options Directorate.

Policy and Practice, Service Improvement

Contemporary Residential Options Directorate

ADHC

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