PROCEDURE
2.0 – INDIVIDUAL SUPPORT NEEDS, VALUES & PLANNING

(Supersedes Individual needs Policy)

Number	***Procedure***	***Related National Disability Insurance Scheme Quality Practice Standard***
14.01 (A)	*Annual Planning Reviews*	*1,2,3*
14.01 (B)	*Annual Support Planning Checklist*	
14.01 (C)	*Development of individual plans NDIS*	
14.01 (D)	*Reviewing Support Plan Goal Outcomes*	
14.01 (E)	*Distribution, recording and storage of individual plans*	
14.01 (F)	*Monitoring of individual plans*	
14.01 (G)	*Obtaining signatures*	
14.01 (H)	*Client choosing not to have an individual plan*	
14.1 (I)	*Conveying/communicating a Service User's Individual Needs/Information, Support plans and changes to Individual Needs/Information and Support Plan to Continuing and New Support Staff*	
14.01 (J)	*Development of individual plans Skilling Queenslander for Work (SQW)*	

Purpose

This procedure explains how Better Together employees must develop, record, monitor, review, distribute and store individual support plans
An individuals Plans should;

- builds on their natural supports such as friendships, neighbours and community groups,
- maximise an capacity and minimise deterioration/ dependency
- clarify their choices about a pathway towards the life they want to live
- identify opportunities to belong and make a contribution that is welcomed
- develop their talents and skills
- build on opportunities for a valued role in the community
- feel confident that their future is safe and secure
- access the supports and services they require to achieve their goals.

Better Together foundation is underpinned by the frameworks and principals of Social Role Valorisation and Person-Centred Planning.

Definitions:

Social Role Valorisation: is a powerful set of ideas useful in addressing the marginalization of people in society by supporting them to have access to the same good things in life enjoyed by typical people.
Person Centered Planning is planning from an individual's perspective on his or her life. The individual around whom planning is conducted and his or her wishes are taken as the single most important point of reference for the entire planning venture

Procedures

14 (A) Annual Planning Reviews

Rational
Better Togethers compliance requires annual reviews of service users support plans under the NDIS quality practice standards. Reviewing previous outcomes promotes positive refection on previous achievements and provides opportunity to make sure a service users needs are being listened to and met.
Detailed Procedure:

An individual plan will be formally reviewed or updated in the following situations:

- Before the review date stipulated on the plan occurs
- (If a service users receives additional support Better Together services than the original individual plan states.
- If all goals have been achieved.
- If the service user would like to change their goals.
- If any early review has been requested due to a change in the service users circumstances

Organising the annual planning meeting:

- Contact Service User and arrange an annual support planning meeting that is at a time and place that is suitable for them.
- Invite them to include any individual who they would like to be a part of that planning process. Support them in inviting them should they need.
- Use the Annual Support Planning Meeting Checklist and procedure to prepare and check all of the correct information is collected, signed and given at the meeting.

14 (B) Annual Support Planning Meeting Checklist

Before the meeting

- Call service user and arrange a meeting time, place and location suitable for them to have their annual review meeting. Have a conversation about their new service agreement and how many hours of support they are looking at having with Better Together over the next 12 months. Find out if they need any support or alternate communication tools, interpreters/translators for the meeting
- Support them to invite who they wish to this planning review meeting.

- Give them a list of the information they will need to bring to their annual planning meeting
- If a service users requires in home supports an in home safety checklist and emergency evacuation plan needs to be undertaken before the meeting

Documentation service user needs to bring to the meeting

- Current medication sheet from their chemist
- Medication Authority from the Doctor where necessary
- New NDIS Plan/goals

Documentation Staff Planner needs to bring to the meeting

- Service user handbook (link to website)
- List of website policy and procedures
- Feedback form
- How we can do things Better Brochure
- Copy of approved chemical list
- Diversity poster
- Service Users Rights and Responsibilities booklet

Support Planning:

- Complete the visioning workbook
- Review previous years support plan (*see procedure… reviewing goal outcomes)*
- Create new Support Plan. *(See procedure… development of individual support plan NDIS)*

Updating Service User Documentation:

- Go through the first 3 Tabs in the Participant's Flow Logic (Basic Details, NDIS, Details) and verify details are up to date (phone numbers, emails, address, emergency contacts, etc)
- Ensure completion of health and safety TAB forms: individual risk assessment
- Ensure individual emergency and disaster management form
- Make sure medication details are present in the system (Participant > Details > 3.1 Current Medications)
- Under details click into the entry under "9.1 Service User Entry Checklist" and scroll to the bottom. Make sure the signature section is complete.
- Do they have a current NDIS plan in the system? If not ask if they are okay with you taking photos of the goal section of the plan (we don't need to know the financial details, just the goals).

Informative Spiels: (Please read the following to the Service User and tick when complete)

Complaints: "Better Together values feedback and wants to know how to improve our service. We never want you to feel like you cannot speak up about your concerns. Ask them the question. "who could you complain to if you needed to?" walk them through the "*How you can do something better brochure*'.

Advocate: when updating the section about who is their advocate, remind them that if ever they want or need an advocate Better Together can support them in accessing one. Hand them the are you an advocate sheet.
Respecting diversity, values and beliefs: Better Together values diversity, you should feel free to express who you are and what you value, if ever you feel like your values or beliefs are not being respected please tell us. Hand them a *diversity poster*
Confidentiality: "Better Together takes your privacy seriously and will never share information about you with anyone other than the parties that you nominate in the form" Show (if at the office) or tell the person where their personal information is kept ensuring their privacy and confidentiality is maintained and explained that their information can be amended whenever they like.
Website Information : all of Better Together Policies and Procedures can be found on the Better Together Website. Along with copies of the suggestions form and the complaints form

Signing documentation:

- If the Service User has a new Service Agreement ask them to sign it and provide them a signed copy
- Media release form
- Support plan
- Information permission form (Double check with the Participant they are still happy for us to correspond with these parties. Check if there are any new parties they would like to give us permission to speak with)

14 (C) Development of individual plan NDIS

Rationale

Service user of Better Together who have National Disability Insurance Scheme plans will come to Better Together with existing plans these goals identified in their NDIS plan will form the basis for their Better Together individual support plan.
An *NDIS Support Plan* is a written set of goals and strategies for an individual, which serves as an action plan for that person and their lifestyle coach/s. Individual support planning underpins the support provided to the person. The plan allows each individual and significant others to*:*

- monitor the type of support, information and service they receive, hence becoming more independent and self-determining;
- see the progress they are making towards their goals;
- gain confidence in making other choices and decisions

Better Together planning approach is based on Person Centered Planning and using a Social Role Valorisation based framework. Better Together will provide information which will assist an individual to make decisions around what social, economic and civic roles they wish to participate in.

Detailed Procedure

The support planning process is not a prescriptive process having a comfortable relaxing environment where everyone involved feels safe and confident to support the individual to get the information needed to develop their individual plan. However there are a few steps and considerations that should be looked at and talked through during the planning meeting.

A Planning staff members will;

- Make an arrangement to meet with the person who will receive support and/or their family, carer and/or advocate at a time and location convenient to them and spend time with them developing an individual support plan for the type of support they will receive and for what duration.
- If the person receiving support is under the care of the Adult Guardian an invitation will be sent in order to include them in support plan review meetings.
- ascertain, and try to understand, through discussion with the person (and key people the person has asked to provide information), the person's needs, wishes, interests, expectations, life experiences and how this person would benefit most from support of Better Together.
- With permission being sought initially from the person (as much as possible), Inclusion of everyone who has a positive role in the person's life can be invited to be present during support plan review meetings. This information will form the foundation of the person's individual support agreement.
- Every planning session will start with looking at the progress that was made towards the goals that were identified in the pervious years support plan (see procedure 14.(D) reviewing support plan goals)
- Work through the Visioning Workbook step by step, this workbook are some of the minutes of your meeting – upload workbook to service users file in flow logic under/correspondence/meetings and complete a meeting form for each planning meeting.
- Provide information which will assist an individual to make decisions around what social, economic and civic roles they wish to participate in. This information will be provided in an accessible form, taking into account a persons age, gender, social network, cultural and religious background.
- fully document the Individual Support Plan, signed by both service user or delegated person and provide a copy to the individual and if required by law or requested by person, the individuals family/carer/advocate;
- commit the organisation to delivering services in accordance with the agreed Individual Support Plan;
- After 12 months (or time indicated in plan), arrange to meet with the person with a disability, their family, carer and/or advocate, to review the individual support plan and negotiate a new individual support plan. Review of plan can happen earlier to suit changing needs of the person. If the person/family/advocate are happy to not change the plan it can continue as is with new time frames

14 (D) Reviewing Support Plan Outcomes

Rational
Reviewing goal outcomes is a chance for a service user to celebrate accomplishments they have achieved over the past 12 months or longer. Looking at the progress of previous goals supports all stakeholders to analyse how successful or unsuccessful the strategies have been in supporting the individual to achieve their goals. This process can also be used as a starting point for the following years new goals or continuation of goals.

Detailed Procedure

The Planning worker will;

- Use the *visioning workbook* to work through the first page of where is your life now.
- Take a stock take of what is happening in their life now, and talking through the previous years identified goals.
- Reflect with the Service User and invited stakeholders how they felt they have progressed towards the goals.
- Discuss what strategies worked best for them
- Talk about any issues of barriers that may have prevented them from being able to achieve their identified goals

14.01(E) Distribution, recording and storage of individual plans

Rationale

Access, and storage of a service user plan is essential for maintaining confidentiality and for positive outcomes in service delivery.

Detailed Procedure

The Planner will:

- ensure that the service user, family and support staff in the planning meeting have access to a copy of the signed individual plan, preferably via email. The service user may require their individual plan in an alternative format which must be provided.
- stored electronically an individual's file in Better Togethers information technology system (Flow Logic) where permissions for access is only granted to relevant employees within the organisation.
- Type up minutes from the meeting into the service user individual file in Flow Logic
- Scan and save copies of annual visioning workbooks into their individual file

14.01(F) Monitoring of individual plans

Rationale

Monitoring processes need to check that strategies are working, and that the person is satisfied with the service they are receiving. Monitoring also enables the worker to evaluate their role in the process

Detailed Procedure

As part of the Safety Management System, and as a method of monitoring staff performance, Better Together requires Lifestyle coaches to:

- complete, at the end of their support time with the person, File Notes *(see Policy 10.0-) Monitoring Staff Performance*) that report on key strategies and success factors against the individual support plan including;
    - Ongoing Development of Valued Roles and Community Involvement
        - What support goal does todays activity relate to:
        - How has the lifestyle coach assisted in achieving the service users goal
        - How did the lifestyle coach promote positive behaviour and / or discourage negative behaviour? (if applicable):
    - Developing and Supporting Relationships
        - Has the service user met anyone new today? If so give details - name & environment and role of lifestyle coach:
        - Has the service user connected with anyone they have an existing relationship with - Name, location, activity:
        - If they havent connected with anyone this week, why:
    - Decision Making and Choice
        - What decisions did the service user make today:
        - Did the service user request the Lifestyle coach to assist with the decision making process? If so how:
    - Incidents
    - Communications & Comments
        - Communications: provide details of any phone calls, texts or conversations you had with another Lifestyle Coach with regards to this shift:
        - Other comments
- Lifestyle coaches will undertake a risk assessment and fill out a HIRAC form for any new activities a service user will undertake during their supports.
- Lifestyle coaches will review already undertaken HIRAC assessments if it is the first time they are supporting a service user in an activity.
- Report an incident that occurred during the support shift where a person associated with Better Together was injured, put at risk or distressed;
- report any other health or safety concerns they had during the support time (*see Policy 11.0 Safety and Risk Management).*
- All Better Together employees working with the Service User must be aware of then individual plan and ensure strategies are implemented to assist the client to achieve their goals.

- Lifestyle Coaches workers must complete individual case notes after each shift within the last 15 minutes of every shift in order to track the client's progress against their goals
- Every File note refer to the service users support goals identified in their support plan in their file notes
- If new goals is identified by any employee, they will send the office an email identifying the new goal and strategies they service users would like to undertake.
    - Admin staff will;
        - write a new attachment support plan into flow logic
        - Contact a lifestyle coach working with the service users to sign the new amended support plan
- Better Togethers file note has a section that refers to the communication of issues, concerns or changes. Records of this are saved here.

14.01(G) Obtaining signatures

Rationale

The role of a signature is to verify the agreement or decision of a particular individual. Signatures express compliance for our quality assurance and commitment for our stakeholder

Detailed Procedure

It is a requirement that a service user signed and date their individual support plan:

- once the planning process is finished and both parties are in agreement about the contents of the plan and
- once the review of the plan has been completed and the level of goal

An alternative person to clients aged 18 years and over with reduced decision making capacity may be required to sign the plan as a nominee. This would usually fall to a family member or other person supporting or caring for the client, unless the client has an appointed guardian. A parent or person with parental responsibility to make decisions for individuals aged under 18 years would be expected to sign the individual plan for that child

14.01(H) Client choosing not to have an individual plan

Rationale

Service user have a choice as to whether or not they would like a individual plan

Detailed Procedure

Should a service user choose to opt out of having an individual plan the staff member undertaking the planning meeting will:

- fill out in the support planning document in Flow Logic that the service user has opted out of having an individual's support plan.
- Explain to the service user and also write into the support plan that should the service user choose not to have an individuals plan, they may reverse this decision at any time
- Have the service user sign the individual plan confirming their decision
- All plan and choices must still be reviewed every 12 months

14.0 (I) Conveying/communicating a Service User's Individual Needs/Information, Support plans and changes to Individual Needs/Information and Support Plan to Continuing and New Support Staff

Rationale

After an initial introduction, Better Together uses a Buddy Shift system to familiarise new support staff with service users and their support needs. This system allows a new Lifestyle Coach to obtain the practical skills required to assist the individual. Buddy Shifts are conducted by a Lifestyle Coach who is experienced in completing the tasks required and has the appropriate skill level to train a less experienced worker where the support regularly occurs. All Buddy Shift training will be documented and signed by the Lifestyle Coach and the trainee (*see Policy 10.0-Staff Induction*).

Detailed Procedure

Buddy Shift training will include the following where applicable:

- going thorough all Service Users Tabs in our Customer Management system (flow Logic)
- meeting the individual, if not already acquainted;
- support environment orientation;
- instruction regarding identified support tasks;
- assistance with the individual's communication and/or tools or aids;
- practical instruction regarding the individual's health/medication requirements;
- tips regarding the individual's routine, likes, dislikes and interests;
- identified fire, safety and emergency procedures.

14.0 (J) Development of individual plans Skilling Queenslander for Work (SQW)

Rationale

Participants in this program are eligible due to their long term unemployed status and many experiencing multiple barriers to employment, undertaking an individual plan to have a

foundation discussion about the person to learn who they are and their vulnerabilities is the starting point to supporting them in overcoming their barriers. This process outlines how this is undertaken in our SQW program.

Detailed Procedure

Related Better Together Policies and Procedures

Policy 2.0 Individual Needs
Policy 3.0 Decision-Making and Choice
Policy 6.0 Valued Statues
Policy 14.0 Protection of Legal and Human Rights and Freedom from Abuse and Neglect
Policy 11.0 Safety & Risk Management
Policy 11.01Safe Work Practices and Service Delivery