PRINCIPLES OF CAREGIVING DEVELOPMENTAL DISABILITIES MODULE

CHAPTER 4: SUPPORT PLANNING

CONTENT:

- A. Goal Planning
- B. Individual Support Plans
- C. Support Plan Basics
- D. Roles and Responsibilities of Team Members

Competencies:

- 1. Explain the purpose of the Individual Support Plan (ISP) or other Division of Developmental Disabilities planning documents.
- 2. Identify two ways a DCW is involved in the team approach in plan development.
- 3. Name three parts of the planning documents that help inform the DCW about the person receiving support.

Key Terms:

Back-up plan Risk assessment

Individual Support Plan (ISP) Short term goal

Long Term goal Team assessment

A. GOAL PLANNING

Long-term goals

A long-term goal is anything that you want to accomplish in your life. Make it specific, i.e. buy a house, get a degree, lose 25 pounds, etc.

My long-term goal:
Short-term goals A short-term goal is a milestone, or major "chunk" of the long term goal that you will need to accomplish in order to achieve your long-term goal, i.e. have a credit score of 600, or identify the part of town you want to live in.
My short-term goals:
First steps First steps are the things that you can do today, or in the very near future, to reach your milestones (short-term goals), and eventually your long-term goal, i.e. open a bank account or get a gym membership.
My First Steps:
Barriers Barriers are anything that may slow you down, or prevent you from reaching your Goals i.e. poor health, lack of budgeting skills
My barriers:

B. INDIVIDUAL SUPPORT PLANS

The Support Plan describes the person's goals and plans and what works for the person. This can include:

- Likes and dislikes.
- Abilities and special needs of the person in areas like daily living skills.
- Medical issues, communication and movement issues.
- Social and family supports.
- Medication assistance needs, potential health and safety risks.
- Services and supports a person will receive.

The purpose of support planning is to ensure that everyone is working together to achieve the goals identified by the individual being supported. The planning document becomes the roadmap for how services and supports are delivered.

The Support Planning Team:

The support plan is developed during a team meeting that includes, most importantly, the person being supported. The team will also include all the people that are important to the person and may include:

- Person being supported.
- Parent or guardian.
- Support coordinator (case manager).
- Direct care workers.
- Friends, family, advocates, neighbors and others as invited by the individual and their family.

During this meeting, one or more long-term goals will be identified that are important to the person and his or her family. Services, supports, team agreements and assignments, specific outcomes and other action items will then be identified based on this long-term goal.

All Support Plans:

- Are individualized.
- Are developed with the person and, when appropriate, his/her family.
- Documents the individual's strengths, needs, and resources.

C. SUPPORT PLAN BASICS

Preferences and Vision of the Future

The <u>vision of the future</u> section identifies the person's 3-5 year goals, such as relationships, community involvement, work, education, where the person wants to live. This is based on the person's goals and should be in the person's own words.

The <u>preferences</u> section should give the Direct Care Worker information about what motivates the individual, activities the individual enjoys, and what to avoid.

Team Assessment Summary

The <u>team assessment summary</u> provides the Direct Care Worker with an overview of the individual's strengths and support needs in areas of health, learning, communication, social skills, self-care, family, etc.

Support Information, includes medication, adaptive equipment, and behavioral health needs. Information in this section changes rapidly, so be sure to check for updates.

Risk Assessment

The <u>risk assessment</u> identifies areas of health and safety the Direct Care Worker needs to be aware of. Some examples include history of seizures, self-abuse, dietary needs, choking, etc.

Back-up Plan

The <u>back-up plan</u> will list names and contact numbers if a Direct Care Worker is unable to provide a contracted support, and timeframes for filling the need.

The areas listed above are some examples. Attendant care tasks, accomplishments, team agreements, and all other plan documentation will also support the Direct Care Worker.

- Each individual receiving services through DES/DDD has an individualized plan, Individual Support Plan (ISP), or an Individualized Family Service Plan (IFSP), used for children 0-3 years of age and their families. They may also have a Person Centered Plan (PCP).
- The support plan provides important information you need to do your job.
- The support plan documents the person's likes, dislikes, individualized needs, and goals.
- The support plan is reviewed through quarterly and annual team meetings, and ongoing monitoring by the Support Coordinator.

D. ROLES AND RESPONSIBILITIES OF TEAM MEMBERS

Individual

The individual receiving support is central in the development of the plan. The person is there to talk about choices, hopes, dreams, and any potential barriers. Regardless of any potential participation barriers, including age, cognitive development, and communication ability, this meeting is for the person. The plan is belongs to the individual. Teams may need to be creative to accommodate the person's needs and preferences.

People important to the individual including:

Family

Depending on the needs of the individual, the family may play a very large role in the planning process. In fact, if the plan is an IFSP, the planning process focuses on the family, not just in the individual. For other plans, family involvement will vary from person to person. If family members are legally responsible, they must be a part of the planning team. If the person is an adult and legally responsible for himself or herself, it's the person's choice who they wish to invite. Participants in the support planning process could include:

- Family members
- Significant Others/Spouse
- Friends
- Other Advocates

Other Team Members

Other team members contribute in any way that reflects the best interests of the person being supported. This could include sharing assessment information, advocating, making recommendations and determining the specific supports and services that will help the person achieve their goals.

Direct Care Workers

Direct Care Workers support people with developmental disabilities to work toward their goals and help to meet their daily needs. The support plan is the person's map directing you to where the person wants to go and the steps needed to get there.

Before the meeting:

- Get to know the person and develop a respectful relationship.
- Help the person think about what he/she wants to express at the meeting.
- If need be, think of ways to help the person participate in the meeting.
- Prepare to discuss progress, challenges, and changes since the last team meeting.

During the meeting:

- Be professional.
- Be a positive, active participant.
- Speak up and share what you have learned about the person.
- Support the person's participation.
- Focus on the person's desires, capabilities and talents.
- Be an advocate.

After the meeting

- Implement the supports outlined in the plan.
- Carry out the actions you are responsible for.
- Communicate with other team members.
- Complete required documentation.