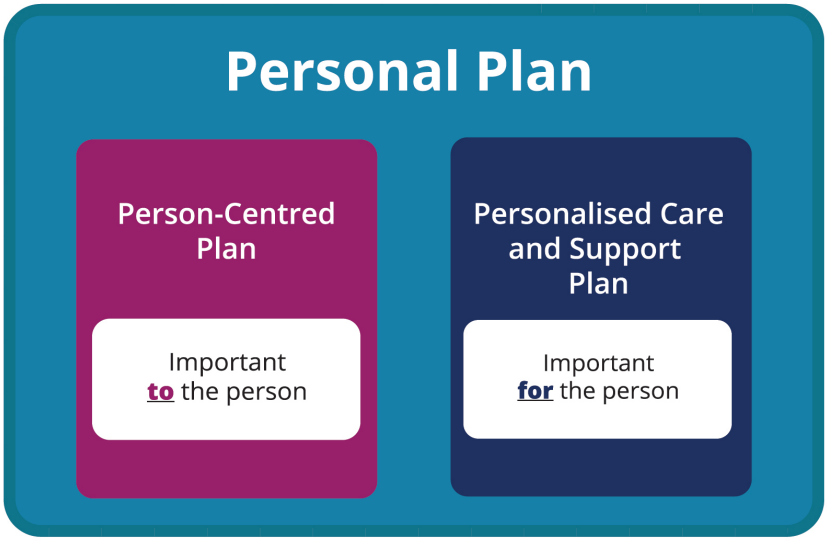
A Guide to Understanding the Difference between the Person-Centred Plan and Personalised Care and Support Plans



New Directions

Contents

1. Introduction

The National Framework for Person-Centred Planning in Services for Persons with a Disability refers to:

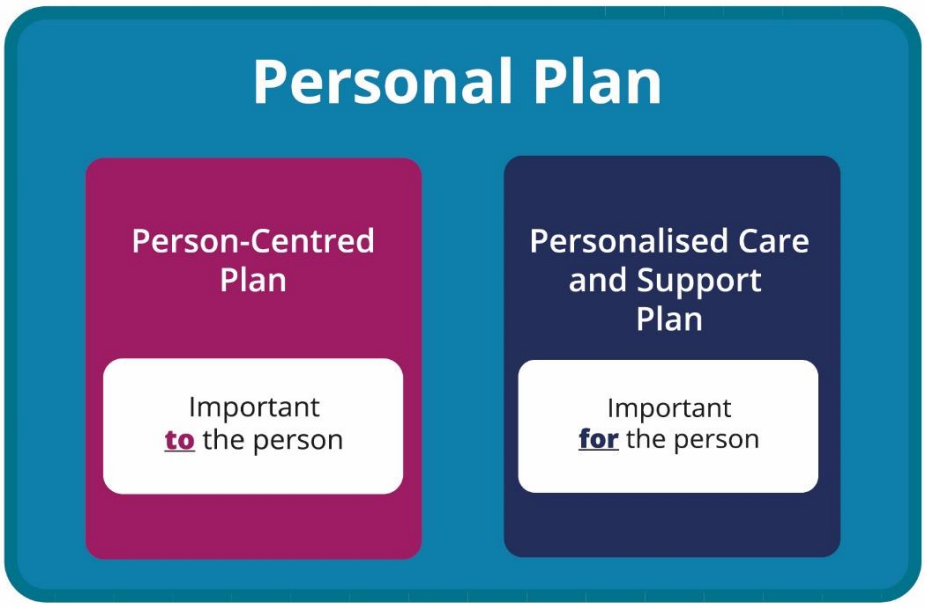
- Personal Plans
- Person-Centred Plans
- Personalised Care and Support Plans.

The Framework states that all organisations should have a Person-Centred Planning policy. The policy must ensure that the Person-Centred Plan is separate to Personalised Care and Support Plans. It is crucial that staff understand the difference between the Person-Centred Plan (**what is important to the person**) and Personalised Care and Support Plans (**what is important for the person**).

This guide sets out to provide clarification and additional detail on the different plans, and to explain how Personalised Care and Support Plans can support Person-Centred Planning. Further guidance on the development of the Person-Centred Plan can be found in the Framework document.

2. What is a Personal Plan?

The standards and regulations for residential services for persons with disabilities in Ireland require each person to have a personal plan. The personal plan is an overarching plan which can contain a number of different types of plans, depending on the person's individual needs. The image below illustrates that a personal plan comprises the 'Person-Centred Plan' and 'Personalised Care and Support Plans'.



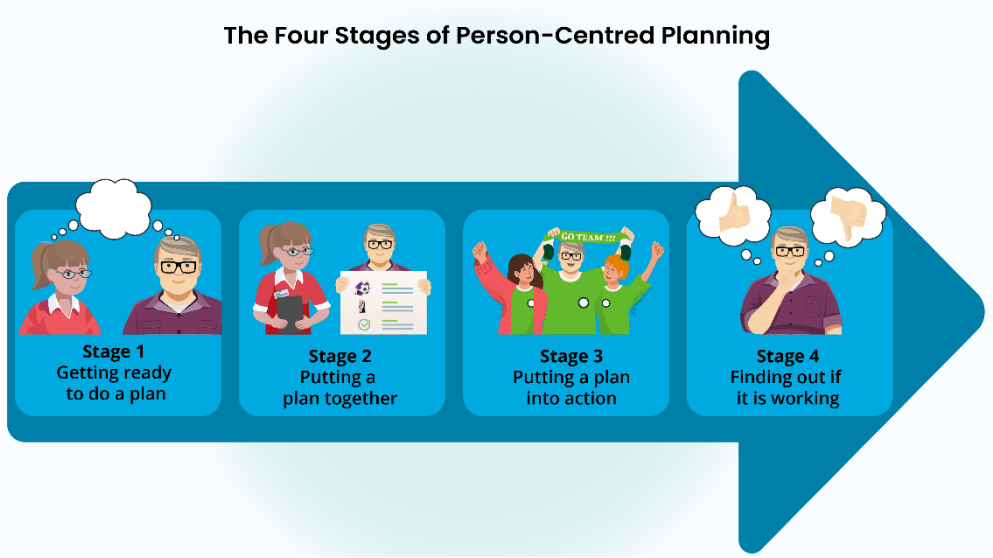
3. What is the Person-Centred Plan?

Person-Centred Planning (PCP) supports and enables a person to make informed choices about how they want to live their life, now and in the future. It supports the person to identify their dreams, wishes and goals, and what is required to make those possible. A Person-Centred Plan reflects what is important **to** the person. Person-Centred Planning requires the supports available to be responsive to the person and to focus on the outcomes they want to achieve.

The best measure of success for Person-Centred Planning is whether the individual at the centre of the planning process has experienced a real change for the better in his or her life, as a result of their Person-Centred Plan being implemented.

The Framework organises the Person-Centred Planning process into four main stages:

- Stage 1 - Getting ready to do a person-centred plan
- Stage 2 - Putting a person-centred plan together
- Stage 3 - Putting a person-centred plan into action
- Stage 4 - Finding out if person-centred planning is working.



Please refer to the Framework document for guidance on each stage of the Person-Centred Planning process.

4. What are the core beliefs and foundations of Person-Centred Planning?

Beliefs

- Individuality
- Equality
- Respect
- Dignity
- Empowerment
- Choice
- Inclusion and active citizenship
- Independence.

Foundations

- The beliefs outlined above form part of the organisational culture. The culture is person-centred
- Person-Centred Planning is about achieving outcomes. Outcomes are good changes that give each person a better life
- Person-Centred Planning happens across the organisation
- Every Person-Centred Plan is different
- Individuals, staff teams and managers really listen to and respect the choices that each person makes
- The organisation is responsible and shows how they support each person to achieve their goals and outcomes
- There are high expectations and hopes for each person
- Individuals, staff teams and managers make sure that each person has the time, space, and chance to build meaningful relationships. They work in partnership with persons with a disability.

5. What is in the Person-Centred Plan?

The Person-Centred Plan reflects the hopes and dreams of the person who owns the plan. It describes a vision of a more positive future for the person.

A personal profile

Information is gathered with the person on a continuous basis. The Person-Centred Plan is developed when the person who owns the Person-Centred Plan has the supports they need to make choices and decisions, for example, communication or advocacy supports. It should only be developed when there is a clear understanding of the person's preferences and interests, for example, information on their strengths, likes and dislikes, hobbies, dreams, daily routines and activities, and opportunities. It is important to know what is and is not working well in the person's life, and what the person would like to change. The Person-Centred Plan can include a personal profile, such as an 'about me' book, poster, film, or a life story.

Every Person-Centred Plan should respect and reflect the identity and culture of the person who owns the plan.

Personal goals

The person supporting the individual to put the Person-Centred Plan together and the Circle of Support should assist the person to work out what they want in their lives, and to select and prioritise aspirations and goals.

Each Person-Centred Plan should contain a number of different goals. These goals should be SMART (Doran, 1981) - specific, measurable, attainable, relevant, time-anchored. Goals should not focus on achievable activities of daily living. Please see the guidance document 'A Guide to Goal Setting in Person-Centred Planning' for further information.

The action plan

The Person-Centred Plan must include an action plan. This should explore how each dream or goal can be achieved. The action plan includes the person's goals, the supports required, the names of those responsible for supporting them to achieve the goals, and timeframes. It identifies risks, barriers and challenges, and ways to overcome these.

The action plan should say how progress will be monitored and reviewed. Actions plans should be flexible and should be updated as progress is made or needs change.

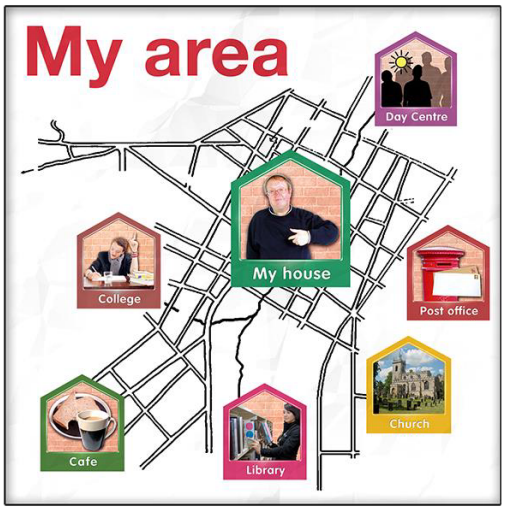
Resource or community map

The Person-Centred Plan may include a resource map or community map, and ideas on how to harness all available resources.

The person who owns the Person-Centred Plan can be supported to explore their community to identify places, activities, groups, or opportunities which would be of interest to them. It is important that goals and actions are not limited to or by service routines and activities.

A resource map can identify deficits in services and supports, and their potential impact. Actions should be taken to highlight these deficits to the relevant stakeholders.

This section of a Person-Centred Plan might also include information on funding options such as personalised budgets.



Evaluation and outcome measurement

The Person-Centred Plan should support outcome measurement. Organisations may use different tools and resources to measure outcomes. Person-Centred Plans should be able to influence all levels of the organisation. Outcome measurement is an important part of the overall evaluation of each individual plan and of the PCP process.

6. How do you develop a good quality Person-Centred Plan?

The National Framework for Person-Centred Planning in Services for Persons with a Disability provides detailed information on best practice in the development of the Person-Centred Plan.

In particular, organisational culture and the clarification of staff roles within the process, are especially important to good Person-Centred Planning.

The development of the Person-Centred Plan should be viewed as an ongoing process and not an annual event. The plan itself is not a goal or an outcome (Sanderson, 2003).

The person who owns the Person-Centred Plan is always at the centre

The person who owns the Person-Centred Plan is central to all elements of the PCP process. They should be encouraged to take the lead wherever possible and must be supported to make their voice heard.

Informal environments and relationships may be more conducive to Person-Centred Planning. The natural authority of the person who owns the Person-Centred Plan, and where appropriate their family, must be respected. A Circle of Support should be established – please see 'A Guide to Circles of Support' for more detailed information.

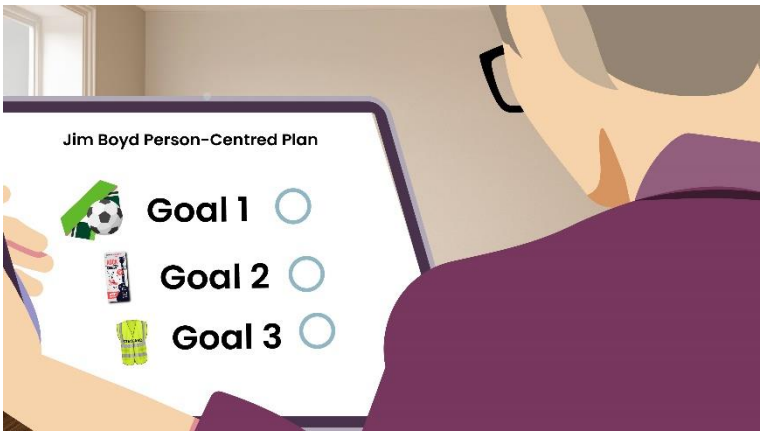
The PCP process should be empowering for the person who owns the Person-Centred Plan and their supporters. It should create opportunities for the person and their Circle of Support to share and learn new skills. The experience of success and real change is a key element in supporting persons with disabilities to understand the PCP process.

Every plan should look different

Every plan should be unique. One concern expressed in the literature on Person-Centred Planning is that the process can become too formal and there may be an over-reliance on standardised planning tools or organisational templates. These tools can be helpful but there is a danger that they can promote a 'one size fits all approach' and work against the principles of person-centredness. Organisational systems, templates and paperwork should not impose limitations on how a plan is developed or formatted.

'Formalised and systematised approaches may be very helpful in particular settings but the right philosophy, an open mind, an open heart and a blank sheet of paper is still the best way of doing person centred planning'.

Jack Pearpoint



Be creative

A good quality Person-Centred Plan will be accessible to the person who owns the Person-Centred Plan. Where possible, they should be fully involved in all aspects of its creation. An accessible plan promotes autonomy and independence, and may reduce the need for staff facilitation. Assistive technologies such as iPads, switches, multi-media software, apps and communication devices can be used to develop Person-Centred Plans.

A Person-Centred Plan could be produced as or could include:

- A road map
- A mind map
- A video presentation, film, or blog
- A drawing or painting
- A piece of art or craft
- A set of graphics
- A set of photographs or symbols
- An Easy to Read plan
- A written or picture diary or journal
- A written plan
- A memento box
- A scrapbook.

The person who owns the Person-Centred Plan needs to feel comfortable and confident with the format selected to communicate their dreams and wishes. The format should facilitate self-expression and engagement.

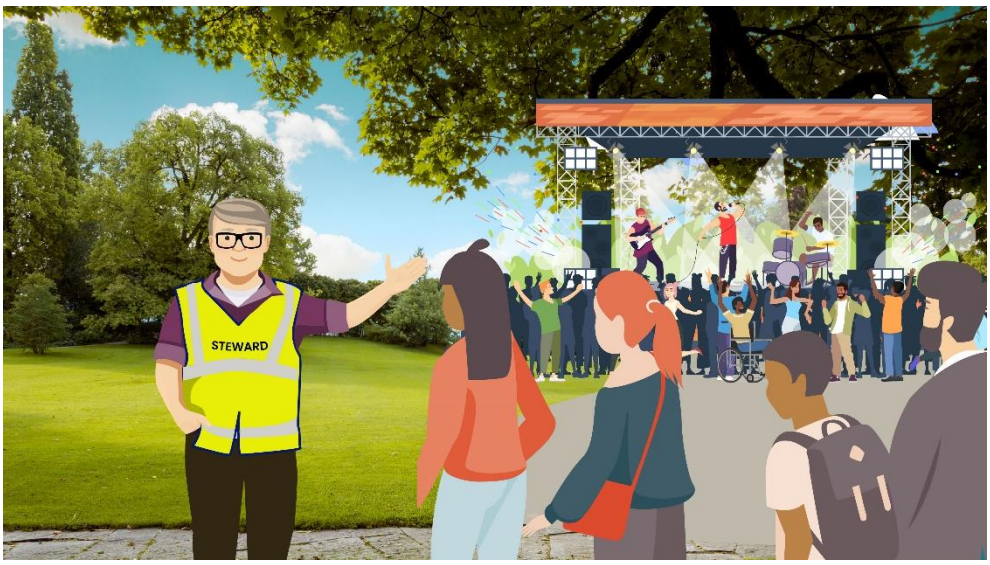
Positive risk-taking

Good quality Person-Centred Plans are innovative – they identify risks, barriers, and challenges, and potential solutions. A good plan establishes a balance between choice and safety. It supports the person who owns the Person-Centred Plan to become more independent and to acquire the skills they need to live the life they want to live.

Good quality Person-Centred Plans allow the person who owns the plan to experience the 'dignity of risk' – sometimes it is only by making mistakes or bad decisions that we learn and grow.

Active citizenship

Person-Centred Planning should promote active citizenship, community participation, and valued social roles. A good Person-Centred Plan focuses on the person's skills and talents, and not on their disability. It explores the different contributions that the person could make to their community and society.



7. What are Personalised Care and Support Plans?

Personalised care and support is an important part of a person-centred approach. Personalised Care and Support Plans consists of a range of different plans that respond to a person's everyday needs.

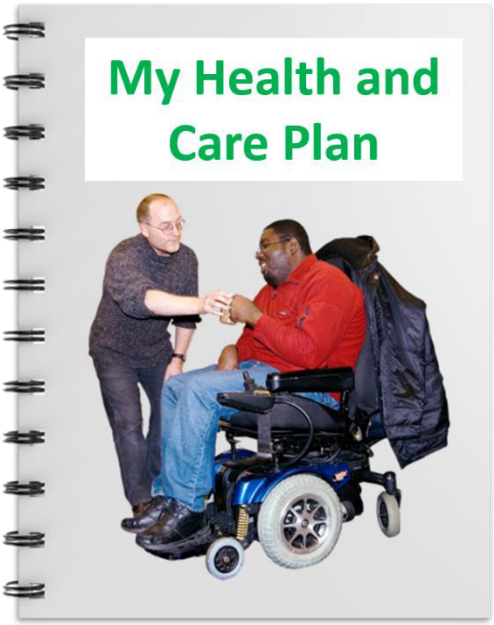
These are about what is important **for** the person, the support they need to stay healthy, safe, and well.

Personalised Care and Support Plans may be developed following an assessment of need. When complete, they should deliver holistic and integrated planning which covers all aspects of a person's health, wellbeing, and care.

The plans should support the person to learn what works best for their health and care, what supports they need, and how to fit this into their life.

8. What are the key principles of Personalised Care and Support Planning?

- Nothing about me without me
- Open and Honest
- Holistic approach
- Respectful
- Active listening
- Time and space for reflection
- Accessible information
- Timely advice and intervention
- Shared, realistic expectations
- Goals lead to actions
- Outcomes focused
- Flexible supports.



9. What is in Personalised Care and Support Plans?

Personalised Care and Support Plans could include items such as:

- Health action plan
- Wellbeing plan
- Intimate care plan
- Positive behaviour support plan
- Capacity assessment
- Advocacy support plan
- Communication passport and/or communication support plan
- Manual handling guidelines
- Hospital passport
- Medication management plan
- Clinical guidelines
- Dietary or dysphagia management plan
- Safeguarding plan
- Safety or positive risk-taking plan
- Crisis or contingency plan
- Advance decisions or end of life plan
- Respite plan
- In some cases, information, advice, or guidelines in relation to income or housing.

10. How do you develop good quality Personalised Care and Support Plans?

Wherever possible, Personalised Care and Support Plans are developed in partnership with the person who owns the plan. Persons with disabilities are recognised as experts by experience with a unique understanding of their own health and care needs. The research tells us that where a person is more 'active' in the management of their health and wellbeing, they are more likely choose preventative and healthy behaviours and have better outcomes. 'Active participation' can also encourage communities to work to improve health and wellbeing and reduce health inequalities (NHS, 2015).

Personalised Care and Support Plans are a collaboration between the person, their family/carers (if the person wants this), and the professionals/services supporting them.

The person with a disability should be central to the decision-making wherever possible. The process of developing Personalised Care and Support Plans should be accessible and tailored to the individual.

Personalised Care and Support Plans should capture conversations, decisions, and outcomes in a way that makes sense to the person (NHS, 2015). It should build on a person's skills and strengths and support them to identify things they might need/want to change about their health and wellbeing.

As with all planning, goals should be set, an action plan developed, and progress reviewed at regular intervals.

There is no set template for what Personalised Care and Support Plans should look like. It is important that all health and care records meet the relevant standards and follow privacy laws. The person who owns the plan should have a copy in a format which they understand. The person should decide who can access the information in their plan. It may be appropriate for certain professionals to access specific elements of the plan only, for example, intimate care guidelines would only need to be seen by those providing this type of care to the person or those supporting key aspects of this care such as manual handling.

Some individuals may not be able to engage with the process of developing Personalised Care and Support Plans. If a plan is developed on behalf of an individual:

- Their point of view must be considered and should be central to the process
- All forms of communication should be responded to and valued
- Consent should not be overlooked – for assessment, treatment, sharing information, etc.
- Information should be gathered in creative and dynamic ways
- Information should be sought from others that know the person well
- Those developing the plan should be open to possibilities and should reflect on and review decisions regularly.

What are the benefits of Personalised Care and Support Plans?

Good quality Personalised Care and Support Plans should assist the person to:

- Have a healthy lifestyle and look after their wellbeing
- Identify and understand their health and care needs
- Access information about their health and care needs, and understand when to seek help
- Understand the supports available to them and recognise good quality supports
- Have a continuity of care
- Manage their own health and care where possible
- Understand the choices they have in relation to their health and wellbeing. Make their own choices and decisions, or engage with supported decision-making structures
- Be independent
- Learn new skills
- Interact with health care providers, use community services where possible, and move between services when necessary
- Recognise an emergency and prevent a health crisis
- Fit their health and care needs in with the rest of their life.

11. Is the Person-Centred Plan different to Personalised Care and Support Plans?

Yes! The fundamental difference is the separation of what is important to the person and what is important for the person. Services can sometimes over-focus on what is important for a person, for example, supports in relation to their medical and clinical needs, or safety. Helen Sanderson Associates (2020) suggest we need to 'see the person first – what matters to them, not just what the matter is with them'.

Quality personal plans strike a balance between the two. Please see the graphic on page 28 for more detail.

A Person-Centred Plan focuses on dreams, wishes, goals and what is required to make those possible. It supports the person to plan and make choices for their life now and in the future. The focus is on what is important **to** the person; housing, education, employment, social relationships, leisure activities, holidays, outings, and life events. The process is responsive, and the individual may be supported by a Circle of Support rather than a group of professionals and paid staff. The goals in a Person-Centred Plan differ significantly from those in Personalised Care and Support Plans in that they do not concentrate on the health or care needs of the person.

Personalised Care and Support Plans focus on a person's medical, clinical, and care needs; the things that are important for them. Often, there is a need for involvement from professionals, specialists, and paid staff to develop this type of plan and to help the individual to set their goals.

12. What is the relationship between the Person-Centred Plan and Personalised Care and Support Plans?

Good Personalised Care and Support Plans are vital in order for a quality Person-Centred Plan to be developed and the goals achieved. Personalised Care and Support Plans inform and facilitate the development of the Person-Centred Plan, ensuring the person is in the best possible place to make important life choices and decisions.

Persons with disabilities have emphasised the importance of good wellbeing and health to the Person-Centred Planning process. It was noted that it can be hard to engage in Person-Centred Planning if you are struggling with your mental health or if you are feeling generally unwell.

Personalised Care and Support Plans can:

- establish many of the beliefs and foundations in the Framework - respect, dignity, choice, empowerment, listening, partnership
- encourage learning and development
- ensure the person has the best possible physical and mental health
- facilitate accessibility and establish the use of assistive technologies
- establish capacity, support choice-making, and enable the person to communicate their dreams and wishes
- identify advocacy supports and opportunities
- assist the person to identify meaningful activities
- identify aids, appliances, and other tools which can support independence
- encourage positive risk-taking
- support access to mainstream services and build community networks.

13. Examples of the impact of Personalised Care and Support Plans on Person-Centred Planning

Jack's story: Getting ready to do a Person-Centred Plan

Jack recently moved to a new day service. His keyworker, Mary, is keen to develop a Person-Centred Plan with Jack. However, Jack has limited verbal communication and Mary is finding it difficult to get to know Jack and to find out about his preferences and interests.

Mary is unsure how to support Jack to get ready to do a Person-Centred Plan. She looks at the standards of practice in the Framework and decides to begin by looking at the accessibility of the planning process and the use of assistive technologies.

Mary starts by organising a meeting with Jack and Michael, the keyworker from his residential house. Michael has known Jack for some time and has developed a good understanding of his likes and dislikes. Michael explains that an assessment of need is being completed for Jack. This has highlighted areas where Jack requires additional support and the staff team have identified that Personalised Care and Support Plans could help to address these needs.

Michael suggests that they could start to work on one personalised care and support plan, explaining that this could focus on Jack's communication and behaviour support needs.

Michael believes that these unmet needs are a barrier to the development of a quality Person-Centred Plan for Jack. He will seek the advice of Jack's family and the Multi-Disciplinary Team (MDT) to develop this personalised care and support

plan. There is also a specialist behaviour support team in the service and their guidance could be requested too.

Mary asks Michael about the differences between a Person-Centred Plan and Personalised Care and Support Plans. Michael explains that the Person-Centred Planning policy in the organisation recommends separating Personalised Care and Support Plans from the Person-Centred Plan. They agree to develop separate plans, both in picture format.

A communication support plan could explore the potential for Jack to use an alternative communication system and/or technology to maximise his skills. This could assist him to indicate his preferences more clearly.

Once this personalised care and support plan is in operation, a more robust Person-Centred Plan could be developed. Identifying and managing what is important for Jack will help those supporting him to ascertain what is most important to him.

Conor's story: The importance of wellbeing to Person-Centred Planning

Conor is a thirty-five-year old man with a mild intellectual disability. He has engaged in Person-Centred Planning for several years and has an established Circle of Support. Conor has achieved many of his personal goals in the past and feels he has a good quality of life. His current goals centre around a holiday and a new course at a local college. Conor was looking forward to these.

Last year, Conor's father passed away. This was a difficult time for Conor and his family, but he did not seek any specific supports, saying he was determined to carry on with work and life in general.

At the last two meetings, Conor's Circle of Support have noticed that he is quiet and disengaged. He appears uninterested in his goals and has not made any progress with these recently. A member of the Circle of Support decides to speak to Conor on his own and they arrange to meet for a coffee. Conor explains that he has been feeling low and has become anxious. He finds it hard to think about and plan for the future when the present feels so uncertain. He misses the support of his father and he is worried about his mother. Conor's mother is now his primary carer. His anxieties and worries have overshadowed other things in his life and his personal goals seem unimportant and even irrelevant now. In particular, Conor is reluctant to leave his mother to go on a holiday.

Conor agrees to speak with his keyworker in his day service. Together, they decide to review Conor's Personalised Care and Support Plans. At the next meeting of his Circle of Support, Conor suggests that they pause work on his goals for a short time while he focuses on his mental health and his care needs.

The members of the Circle of Support agree but they decide to continue to meet on a social basis whilst this is happening. Conor is happy with this ongoing support, but at this time he wants to focus on what is important for his health and wellbeing.

Conor and his keyworker develop his Personalised Care and Support Plans. They focus on a wellbeing plan. As part of this, they organise a number of bereavement counselling sessions for Conor. He also decides to try a mindfulness class in his day service. They speak to the social worker about the possibility of a short respite break. This is different to his original goal of a holiday, but respite may be a good interim step and Conor thinks it would give his mother a rest too.

Once Conor is feeling well, he will review his Person-Centred Plan with his Circle of Support. He can start to think again about the things that are important to him. His goals can be changed if necessary or the Circle of Support can assist him to identify small, manageable steps towards his bigger goals.

Angela's story: How Personalised Care and Support Plans can facilitate goals in a Person-Centred Plan

Angela is a young woman with a physical disability. One of the goals in her Person-Centred Plan is to get a job. Angela has been offered a position in a local company but transport to work and access to the office is difficult with her wheelchair.

Angela is concerned that she will have to turn down the job offer. She has a meeting with her Circle of Support. It is suggested that Angela could review her Personalised Care and Support Plans with her keyworker. Angela thinks it would be good to get some additional support from clinical services and from expert organisations.

It has been a few years since Angela was assessed by the Occupational Therapy service. These days, Angela is more active and is travelling about in her community more. She decides to request some advice on wheelchairs, and on aids and appliances that might support her at work. The occupational therapist meets with Angela and reviews her seating. They identify a more suitable wheelchair to meet Angela's current needs. They also talk about aids to help Angela transfer in and out of a car, and to complete office tasks. The occupational therapist updates the manual handling guidelines.

Angela speaks to an employment service about the accommodations that her employers could be expected to make and the funding options for these.

Her keyworker assists her to look at support options so she can travel to work safely and on time.

Angela asks to meet with the social worker to discuss any changes to her income when she takes up her new position.

Once Angela has accessed the right information and supports through her Personalised Care and Support Plans, and has addressed her concerns, she is ready to start in her new job, achieving one of the goals in her Person-Centred Plan.

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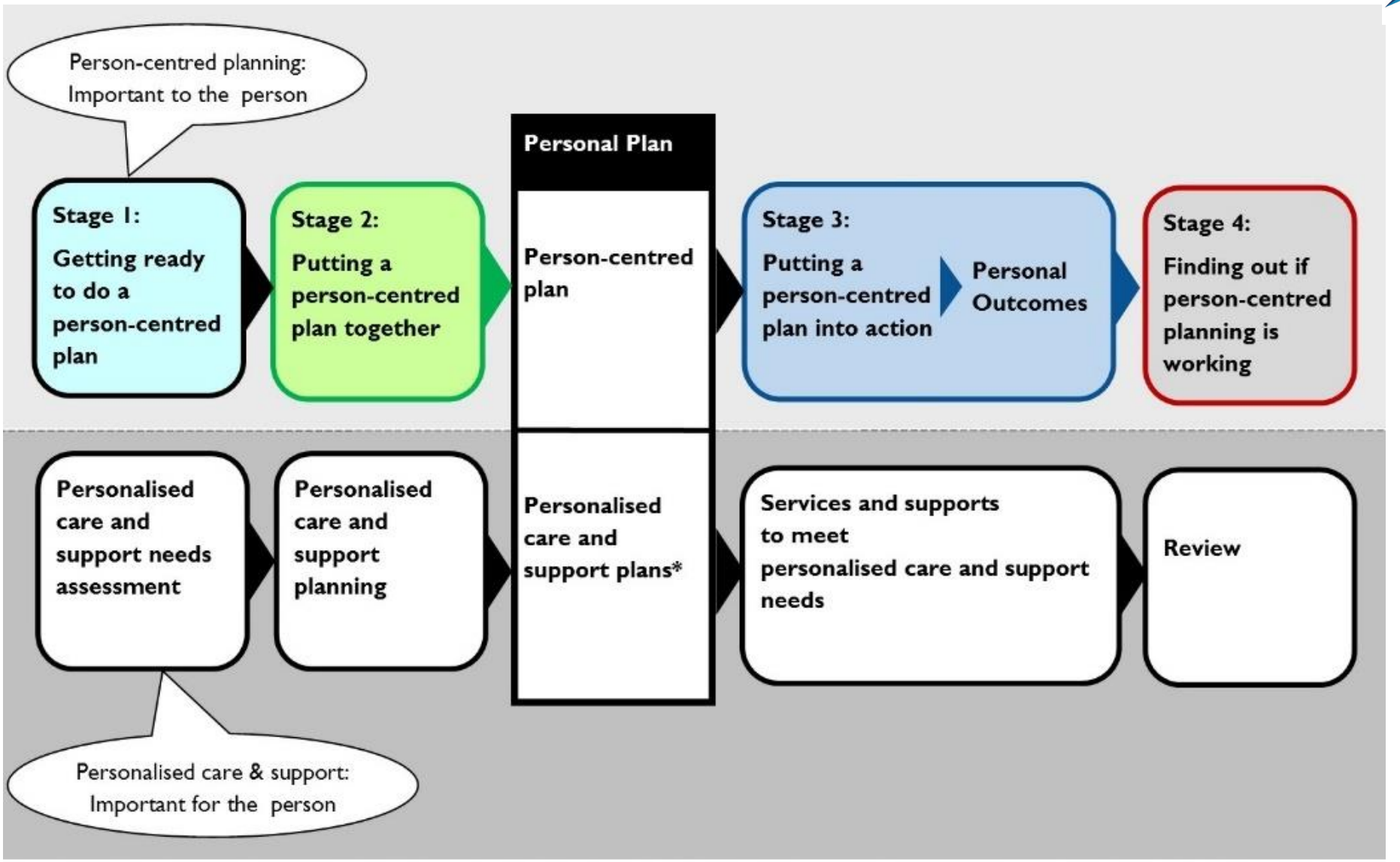

*Personalised care and support plans should be developed within 28 days of a person starting to use a HIQA-registered residential service. Person-centred planning may take considerably longer, depending on the individual.

Contact details:

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