Guidelines on
Person-Directed Planning
Guidelines on Person-Directed Planning within Saint John of God Community Services Limited

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5 Steps to Person-Directed Planning

1. Supporting a person to gather information
2. Supporting a person to create a vision for a desirable future
3. Supporting a person to plan for this future
4. Supporting a person to implement the Plan
5. Supporting a person to review the Plan
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Introduction

This *Guide to Person-Directed Planning* has been developed to assist staff in supporting Service users plan for a life of their choosing. The term Person Directed Planning is rooted in Person Centred Planning to emphasise the key role of the service user in directing all aspects of the planning process. This is underpinned by Our Saint John of God Values - Compassion, Respect, Justice, Excellence and Hospitality.
Person directed planning is a way of supporting someone to discover exactly what sort of life he/she wants – then supporting the person to plan ways of making this happen.

Person-directed planning puts the person in control of important decisions that affect his/her life.
Why Person Directed Planning -

Person-directed planning is designed to maximise a person’s choice and control so that we, as staff, can support the person to achieve the following -

- **Self-determination:** The person has choice and control over his/her life. He/she will choose opportunities and experiences that enable him/her to learn, explore and develop in ways that he/she wants.

- **Inclusion:** The person will be physically and socially present in mainstream life through using the places and resources available to all citizens.

- **Valued Social Roles:** The person will have a range of valued social roles in the mainstream community, for example, employment, membership of community organisations (sporting clubs, community groups, groups involved in leisure pursuits), volunteering, being involved in a range of different relationships (from family, friendships to more intimate relationships). The community is rich in possibilities where a person may contribute to a wider community.
• **Contribution and Participation:** The person will be supported to build on his/her unique skills and capacity to maximise his/her participation in community.

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**Steps in the Person-Directed Planning Process**

There are five steps to the Person Directed Planning process -

1. **Supporting a person to gather information:** The person-directed planning process supports the person to gather key information about him/herself to understand what he/she wants for the future and, in terms of supports, what works and does not work for him/her.

2. **Supporting a person to create a vision for a desirable future:** The person, with staff support, will use the information gathered to outline a picture of how he/she would like life to be for example -

   - Where he/she wants to live,
   - Where he/she wants to work.
   - How and where he/she wishes to use the time outside of work, time for leisure, to take advantage of learning opportunities
   - The relationships he/she wishes to maintain or develop.

3. **Supporting a person to plan for this future:** The person with staff support will share this vision of how he/she would like life to be. This will be done with others who agree to support him/her to work towards this life vision. These people, known as a **circle of support,**
will engage with the person to realise the person’s goals. They agree to work with the person to achieve goals that the person wishes and which support the person to move towards achieving the life of his/her choice. This is the plan.

4. **Supporting a person to implement the Plan:** Every contact has a purpose and every interaction of a staff member with a person supported should be in line with their plan.

5. **Supporting a person to review the Plan:** The person, after an agreed period of time, with his/her support people, will check that the plan is working as the person wishes. The person may then wish to set new goals, change goals or problem-solve about goals that have not yet been achieved. The goals must be reviewed at least every six months and the overall plan reviewed at least annually.
Implementation

Reviewing the plan
Step 1: Supporting a person to gather information

This step is all about supporting the person gathering facts about him/her to understand what he/she wants in life. Some of the things that must be considered are -

A. How the person communicates  
B. The person’s likes and interests  
C. Key people in the person’s life  
D. The person’s skills, talents and contribution  
E. Supports in building a good life  
F. The person’s well-being

Sometimes people use tools to help them in the gathering of information. You will find some examples of person-directed planning tools at the back of this guide and available on St John of God Intranet.

A. How the person communicates

Sometimes it is hard for some people to say what they want with words. But when people listen carefully, and take time to learn what he/she wants, this can support the person to self-direct decisions about life. The person may need help from family or friends to communicate what he/she wants. Sometimes, staff may need to depend on their knowledge of the person, intuition and their ability to understand behaviour in order to interpret what the person is saying. Everyone communicates in different ways and everyone needs a supportive environment in order to make good decisions.
B. The person’s likes and interests

It is important in all of our lives that we are involved in things that we like and in which we have an interest. And so, with the person, we will want to support him/her to identify those things that he/she likes doing and those things that he/she may wish to try.

C. Key People in the Person’s Life

Everyone has a need for relationships. It is good to know who can be counted on in good times and, even, in not so good times in our lives.

Thinking about key people in the person’s life is a good way to discover who the person might want to continue to spend time with, to get to know better and who may be potential new friends. These key people could include:

- Family
- Friends
- Neighbours
- Important people in the person’s past
- Key staff
- Acquaintances
- People the person would like to get to know better
- Potential new relationships

These people could also form the person’s, circle of support

D. The person’s gifts, talents and contribution

Everyone has specific skills and talents. These are important aspects of anyone’s life and the person may wish to use and build on these. And so, the information-gathering step will empower the person to identify these which include -

- The person’s personal qualities
- The person’s strengths and skills (things that the person is good at)
- Things others count on the person for
- Contributions that the person already makes
Everybody has a fundamental right to be involved in their mainstream community. The person may already be involved to a greater or lesser extent in the wider community. It is important, then, as part of the information-gathering, to include details of the places and the ways that the person is involved in the wider community. It is also important to detail ways that the person may be involved in the wider community in the future. Exploring social participation and knowing the person’s current involvement in the community is a good way to discover new possibilities. Some examples of the information here include:

- The person’s current involvement in and opportunities for education and learning
- The person’s current involvement in and opportunities for volunteering
- The person’s current involvement in and opportunities for employment
- The person’s current involvement in and opportunities for involvement in community clubs and organisations

**E. Supports in building a good life**

The person will also be enabled to gather information about what needs and supports he/she requires in building a good life in the community. It is important to remember that, when we are considering what a good life in the community may be, we are not limiting our thinking based on the person’s disability or his/her previous experience. We are considering what a good life might look like for a person without a disability of the same age and gender as the service-user. We then use this comparison to ask the person and those who may be supporting him/her to see the potential good life as
including a wide range of experiences similar to those of people without an intellectual disability.

The needs and supports will be unique to the person. Some examples of needs might be:

- What are the person’s passions in life
- What the person requires in terms of positive risk taking to ensure that he/she gets the opportunity to take part and enjoy the good things life has to offer.
- What the person may need to promote learning and personal development
- What the person requires in terms of key daily routines
- What the person requires in terms of health (personal well-being)
- What the person requires in terms of transportation
- What the person requires in terms of safety and security
- The nature and extent of specific staff support the person may require

**F. The Persons Wellbeing**

Wellbeing is about more than physical health. As well as being well physically, a person’s wellbeing is indicated by how contented and fulfilled he/she is about life and how well the person can cope with life’s challenges. We are supporting the person, then, to identify those things that foster fulfilment for him/her and those coping skills that enable him/her to deal with life’s stresses.

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**Step 2: Supporting the person in creating a vision of a desirable future**

The person, with your support and using the information gathered, will now create a picture of how he/she would like life to be. This involves a detailed
vision of what the person’s life would look like if she had everything she hoped for.

This vision must be part of all discussions throughout the Person Directed Planning process.

**Step 3: Supporting the person in planning for this future**

Planning for the future is **about the person**. A first part of the planning process is that the person shares his/her vision with others who agree to support him/her to work towards the achievement of this vision. (These others are referred to as the person’s **circle of support**, and more details about them may be read below). This vision of a desirable future is shared so that all willing to support the person know in which direction he/she wishes to move with life. At any given time, however, the person will have priorities they wish to focus on and wish to set goals about some parts of this future vision.

The key tasks of this stage are:

A. Identify Circle of Support  
B. Sharing a vision of how the person would like life to be  
C. Agreeing the priorities  
D. Setting goals and action-planning  
E. Recording the plan  
F. Planning to review
This is the person’s planning process. The person with your support will determine what the priorities are and how best he/she may be supported to achieve them and facilitate the action planning process.

A. Circle of Support

The person may wish to bring together a group of people who can support him/her achieve his/her desires and wishes. This is what we call the circle of support.

The Circle of Support, directed by the person, may include:

- family members
- key workers
- friends
- friends of family
- neighbours
- people from the community groups (running club, football club, choir)

The person may wish to meet the people from the circle of support individually, as a group, or whatever way works best for him/her. The person with your support may add new members to the circle of support or can change whom he/she wishes in the circle of support when he/she wants to.

B. Sharing a Vision of how the person would like his/her life to be.

It is good to have some guidelines or ground rules for this stage of the planning process. This part of the planning process usually involves a meeting(s) of some sort. Here are some points that you must consider:

- The person may choose to have the meeting(s) at a time outside of normal working hours in a variety of formal or informal settings.
- The person must be supported, if required, to invite those he/she wishes to be involved in the planning process. The person may need to know about
giving people enough notice so they are ready to attend as the process may involve a meeting.

- People must understand that the person may choose to use a variety of methods to communicate, i.e. Speech, Lamh, pictures, objects of reference, assistive technology.
- The person must be supported, if required, to set some ground rules for any planning meeting (such as, everybody should use respectful language, everybody should respect the confidential nature of the meeting, do not rush– take as much time as you need)

**C. Agreeing the Priorities**

While engaging with others (*circle of support*) in the planning process the person, with support, may want to prioritise parts of his/her future vision. You will support the person to ensure that these priorities are the specific focus of the action planning. These are the person’s choices; remember it is the person’s process or meeting.

**D. Setting goals and Action Planning**

Setting goals is a way to make the person’s future vision and desires become a reality. The goal setting/action planning process will determine what outcome the person wishes, who will support him/her achieve this outcome and within what time-frame. The person may need support to share relevant information already gathered about the best ways to support him/her to achieve positive outcomes.

**E. Recording the plan**

Recording the planning process is a means of keeping a record of what has been decided, that is, the outcomes desired by the person, who has agreed to provide support for these outcomes and when it is expected that the outcome will be achieved.
The record is captured in a way that makes sense for the person, for example, photos, video, audio.

This enables the person, at a later stage, to monitor successes and identify challenges which can then be reviewed to move towards the person’s vision and desires. Or, on the basis of experience and learning, this allows the person to change aspects of their future vision.

At the end of the action planning part of the Person-Directed Process, the person needs to be satisfied that all are ready to start working as agreed towards achieving his/her goals and implementing the plan.

F. Planning to Review

The person will agree a date, time and location to review how the work agreed as part of the planning process is going. This review will evaluate what has been achieved, what issues need to be addressed to succeed in agreed goals and whether the person has changed his/her mind about anything in the agreed plan.

The goals must be reviewed at least every six months and the overall plan reviewed at least annually.

Step 4. Supporting the person to Implement their Plan

The implementation stage of the person-directed planning process focuses on working towards the goals agreed by the person and the circle of support. Goals, in line with the person’s life vision, will have been set at the planning stage where specific activities have been agreed to happen within a certain time-frame and with goals supported by identified people.

It will be the responsibility of the person and his/her key worker to ensure that the actions agreed at the planning stage are carried out and that all those who have committed to carry out an action actually do so. The person and the key
worker will certainly be required to check with all relevant people to gather information about how they are progressing with the actions to which they have committed at the planning stage.

Implementation of the plan needs to happen on a daily basis. Every contact has a purpose and every interaction between a staff member and the person supported should be in line with his/her plan.

The key worker will meet more formally with the person monthly, or as needs arise sooner, to monitor the roll out of the person’s plan and to get feedback from the person. The aim of this meeting is to ensure that the agreed actions and the support work are going according to plan and to trouble shoot where there may be issues. The person supported by the key worker will need to document all of the actions taken to work towards and achieve the person’s goals and this should be done at these monthly monitoring meetings.

**Step 5. Supporting the person to review their plan**

The Person-Directed planning process is a **continual process** moving from visions and desires, setting goals, making a plan to taking action and monitoring the outcomes. Having a plan is not the desired end result. It is only the first step.

It is a good idea to have the circle of support come together at agreed times after planning meeting(s) or at least annually, to discuss the plan. A review of the process is very important and regular review meetings may provide encouragement and support effort. This is called monitoring and evaluation. The plan should also measure and record the involvement and the person’s participation in directing this process.

The focus of the review meeting(s) includes -

- Progress of the plan
• Ensuring that everyone is doing what they said they would do.
• What is working well.
• What is not working well
• How difficulties might be addressed and what else may be tried
• Is the plan still a good fit with what the person wants in life?

All review meeting(s) are recorded and captured in a way that makes sense to the person.
Useful Documents


References

HIQA Communicating in plain English Guidance for providers of health and social care services, 2015

Templates and tools for gathering information and helping in the implementation of Person Directed Planning process are available on the staff intranet.