

CENTRAL CARE POLICY INDIVIDUAL SUPPORT PLANS FOR DD CONSUMERS

SUBJECT:	INDIVIDUAL SUPPORT PLANS FOR DD CONSUMERS
ANNUAL REVIEW MONTH:	June
RESPONSIBLE FOR REVIEW:	Director of Central Care
LAST REVISION DATE:	August 2010

PURPOSE: To describe components of the Individual Support Plan.

ISP meeting participants shall be:

1. The person receiving services, unless clearly unable or unwilling to attend;
2. The guardian or representative of the person, as well as any other people significant to that person or invited by that person, unless inappropriate, unable or unwilling;
3. The Team Leader and/or House Manager;
4. Direct care staff who provide daily services and programming; including staff from day supports and residential providers;
5. Professional staff and any other person(s) who possess the knowledge, skills, and expertise necessary to accurately identify the needs of the person receiving services and to design programs which are responsive to those needs.

Indirect Support:

1. The Support Coordinator serves as coordinator of the Interdisciplinary Team and has the primary responsibility for organizing and conducting the annual and other ISP meetings.
2. The Support Coordinator will begin the conference proceedings by briefly stating the purpose of the meeting and acknowledging the person receiving services, family or guardians, and any other special participants.
3. The person receiving services and/or family will be encouraged to participate in all aspects of the meeting. Particular emphasis will be placed on eliciting the person's personal preference.
4. Each Service Provider, as appropriate will briefly review the person's progress in programs for which they are responsible.
5. The Support Coordinator will ensure the support intensity scale tool will be used for the identification of skills and lack of skills for each domain, and

how their function can be improved, either through teaching, environmental adaptations, or provision of adaptive, assistive, orthotic or prosthetic equipment.

Discharge Plan/Alternative Living Arrangements:

1. The ISP team will delineate what supports are necessary for that individual to reside in the community setting, or in an alternate setting requested by the person or the person's guardian or family.

Plan of Care Development:

1. Personal focus is created about the individual including important facts that are priorities for his/her plan of care;
2. What is presently working for the individual and what is not working;
3. The person's specific developmental strengths; what has changed in the past year, identify change of needs/supports;
4. The person's specific medical development and behavioral support needs are reviewed using SIS, HRST, psychological, social, health and risk assessments;
5. Review of person's current ISP/Service/Support facts.
6. Summary of proposed services/support for upcoming year with emphasis on the person's preferences and self-determination.

Personal Goal Action Plan Development:

The action plan will document:

1. Specific goals necessary to meet the individual person's needs as identified by the comprehensive assessment.
2. Specific plans necessary to meet the person's needs, as identified by the comprehensive assessment;
3. The plan components for dealing with those objectives;

Person oriented components will be:

1. Stated separately, in terms of a single outcome;
2. Assigned projected completion dates;

3. Expressed in behavioral terms that provide measurable indices of performance;
4. Organized to reflect a developmental progression appropriate to the person.

Action Plan:

The Action Plan will identify:

1. Brief narrative to describe issue addressed;
2. The goal and plan of how accomplished;
3. The categories of the goal;
4. The party responsible for the program (program monitor);
5. When and where each component will be carried out and documented. The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;
6. The person's challenging behavior if applicable and positive behavior support plan;
7. Relevant interactions to support the person toward independence;
8. Identification of the location where program strategy information (which must be accessible to any persons responsible for implementation) can be found.
9. For those persons who need and desire them, personal and household skills essential for independent living.
10. Opportunities for choice and self-management.

APPROVED:

George Harris, LCSW
Acting Director of Central Care

Date