POLICY

Policy Title:	Community Living disABILITY Services – Support Plan Policy	**Date Approved:**	June 24, 2019
Branch/Division:	Adult Disability Services Community Service Delivery	**Applicable to:**	Community Living disABILITY Services
Responsible Authority:	Department of Families	**Next Review:**	TBD
Policy Owner:	Executive Director, Adult Disability Services	**Date Reviewed:**	
		Date Revised:	

1.0 Policy Statement

Support plans are to be developed and maintained for all individuals receiving agency-delivered services and/or residing in a home share placement funded by Community Living disABILITY Services (CLDS). Service providers are to follow the established guidelines and standards when developing and maintaining a support plan, in order to ensure all plans have the information and/or protocols necessary to encourage and maintain the health and safety of an individual, mitigate risk and ensure assessed needs of an individual are being met.

2.0 Background

Legislative Framework

The Adults Living with an Intellectual Disability Act (ALIDA) is enabling legislation that recognizes the rights of individuals to make their own decisions and receive advice, support or assistance, where necessary, in a manner that respects their independence, privacy and dignity.

Part 2 – Support Services of the ALIDA provides the legislative authority for the department to provide or arrange for support services for adults living with an intellectual disability as defined by the ALIDA.

Sections 11(1), 11(2) and 12 of the ALIDA set out a series of requirements and principles which regulate individual planning processes once support services are arranged. Under the ALIDA, the Executive Director or delegated departmental staff:

- shall develop an Individual Plan for every adult living with an intellectual disability who receives support services from CLDS;
- shall take reasonable steps to ensure that each adult living with an intellectual disability and their substitute decision maker or committee (if any) has an opportunity to participate in the development of this plan;
- shall take reasonable steps to inform each adult living with an intellectual disability and their substitute decision maker or committee (if any), of all decisions respecting the individual's plan; and
- may review an Individual Plan and vary it.

Person-Centred Planning Principles

CLDS aims to have person-centred principles drive all individual planning processes. The person-centred planning process is based on the belief that the individual should have the opportunity to direct and lead a life which is personally satisfying, secure and productive. Person-centred planning is utilized to assist an individual to identify the services and supports required to meet their needs and goals and addresses what is important "to" the person by way of their preferences and "for" the individual to remain safe and healthy. The CLDS Person-Centred Planning Policy describes these principles at length.

Planning in CLDS

Person-centred planning philosophies drive all individual planning activities. A planning activity or event will occur, at minimum, annually. Based on the information gathered at the planning event, there are several types of plans that will require updating or development.

1. Person-Centred Plan (or Individual Plan)

   A Person-Centred Plan or Individual Plan, is a plan for an adult living with an intellectual disability regulated by Section 11 of the ALIDA. A Person-Centred Plan may take any format, from formal to informal, and identifies personal strengths, needs, current interests and aspirations, makes choices, sets goals and identifies actions to achieve these goals. Individuals are encouraged to make decisions about their plan independently, but a plan may be developed with the assistance of a support network. The plan may assist the individual to identify the services and supports required to meet their needs and goals.

   There are a number of planning methods that may be used to develop a Person-Centred Plan including, but not limited to, the CLDS Person-Centred Planning Tool, Circles of Support and Circle of Friends, Essential Life Planning, Group Action Planning (GAP), Making Action Plans (MAP) Personal Futures Planning, Planning Alternative Tomorrows with Hope (PATH) and Sorting Important To/For. When selecting a planning method, the individual's ability and means of communicating should be considered.

   For more information about a Person-Centred Plan, review the CLDS Person-Centred Planning Policy.

2. Support Plan

   A support plan is developed and maintained by a service provider and is required for every individual who receives agency-delivered support services from CLDS and/or resides in a home share placement. A support plan defines what is important to know and do in order to support an individual in leading a life which is personally satisfying, secure and productive. The information in a support plan identifies how supports need to be provided day-to-day and is crucial to ensure that assessed needs of an individual are met. Supports must reflect the assessed needs of the individual in order to maintain or enhance a good life and to ensure health and safety.

A support plan is developed and/or updated when:

- an individual is receiving or will be receiving agency-delivered service;
- an individual is or will be residing in a home share placement;
- an individual's support or care needs have changed; and/or
- there is a change or addition to service provider(s);
- If no changes are required due to the above situations, the support plan should be reviewed for accuracy on at least an annual basis.

3. Plans or Protocols that are Situation-Specific

   Situation-specific plans or protocols are only required when they are applicable to an individual's personal circumstances. These plans are completed by various members of an individual's support network (in collaboration with the CSW) dependent on the content of the plan and are updated as an individual's support or care needs change. Some examples of situation-specific plans are behaviour support plans, restrictive practices or restraint plans, health care plans/protocols, delegated nursing task plans and individualized support (home alone) plans. Service providers should always contact the CSW if a situation-specific plan or protocol is required.

3.0 Purpose

The purpose of this policy is to establish a set of guidelines and standards for service providers to follow when developing and maintaining a support plan, in order to ensure all plans have the information and/or protocols necessary to encourage and/or maintain the health and safety of an individual, mitigate risk and ensure assessed needs of an individual are being met.

4.0 Definitions

"CLDS" means the Community Living disABILITY Services Program of the Government of Manitoba.

"Individual Plan or a Person-Centred Plan" is a plan for an adult living with an intellectual disability under Section 11 of the ALIDA. A Person-Centred Plan may take any format, from formal to informal, and identifies an individual's personal strengths, needs, current interests and aspirations, makes choices, sets goals and identifies actions to achieve these goals.

"Individualized Support Plan" is a plan that outlines the level of independence and support required when an individual is requesting increased independence or remains at home without supervision in a licensed or approved facility.

"Person-Centred Planning" is a process directed by the individual served and their support network, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. Person-centred planning philosophies drive all individual planning activities for development of all types of plans an individual may require.

"Service Provider" is an agency or private operator responsible for the provision of services to the individual.

"Substitute Decision Maker" is a substitute decision maker for property and/or personal care appointed in accordance with the ALIDA.

"Support Network" is family, friends and/or community members who provide personal support, advocacy and/or help with monitoring services and who have reciprocal relationships with individuals.

"Support Plan" is a plan developed, utilized and maintained by a service provider, that identifies how supports are to be provided day-to-day. A support plan is used to maintain the health and safety of an individual, mitigate risk and ensures that assessed needs of an individual are being met.

5.0 Policy

This policy applies to all individuals in receipt of agency-delivered services funded by CLDS and/or who reside in a home share placement. If an individual is in receipt of Supported Independent Living services or the In the Company of Friends model, service providers may review the template to determine what areas are applicable in supporting an individual, while still aligning with departmental guidelines. All areas of support that an individual receives must be discussed in a support plan.

The format and content of a support plan (or care plan) may vary amongst service providers. This policy includes an example of a support plan template (My Support Plan) with a corresponding guide describing standards and best practices. This template should be considered the minimum standard. While service providers may already have or wish to develop their own template, all support plans must be complete with adequate information to meet department guidelines established in this policy and guide.

A support plan defines what is important to know and do in order to support an individual in leading a life which is personally satisfying, secure and productive. The information in a support plan identifies how supports need to be provided day-to-day and is crucial to ensure that assessed needs of an individual are met. Supports must reflect the assessed needs of the individual in order to maintain or enhance a good life and support health and safety.

6.0 Core Supporting Standards, Procedures and Guidelines

6.1 Standards

1. A support plan is developed for each individual in receipt of agency-delivered services and/or who reside in a home share placement funded by CLDS.

2. A support plan is developed by the service provider during intake and referral, prior to delivery of supports or placement. This ensures that a new service provider is aware of an individual's support needs and has a plan in place once service delivery begins. In the event of an emergency or crisis placement, a support plan is developed within two weeks.

3. Updates to existing support plans are made as support needs change. Service providers should review support plans on a regular basis to ensure that they remain current. Support

plans must indicate the date that a plan was updated or reviewed, as well as the name of the person who updated or reviewed the plan.

4. All planning activities are in keeping with the principles contained in the preamble of the ALIDA.

5. The service provider leads the development of the support plan, however, it is important that the Individual/SDM, their support team and the CSW, are actively involved in the plan's development, implementation and review. The extent of CSW involvement will vary from case to case.

6. When an individual receives both residential care and day services, the residential service provider leads the development and revision of a support plan. With consent from the individual, the residential service provider distributes the support plan to all other team members that provide care to the individual, as well as the CSW and SDM (if applicable and appropriate). As support plans may contain sensitive and personal information, it may be appropriate to consider whether the entire residential support plan is relevant for the day service provider or other members of the support team. In these situations, an abbreviated version of the support plan may be shared with the day service provider or other team members, which exclude those sensitive routines that may only be relevant for residential care. While the day service provider may choose to keep their own support plan format, relevant content between plans must be consistent.

7. A support plan contains the following components:

    a. What is important "to" the individual:

        i. Information regarding the individual's strengths, interests, routines and preferences

        ii. How a support person can assist in the way an individual prefers

        iii. Specifics about what works and does not work for an individual

    b. What is important "for" the individual to remain safe and healthy:

        i. Critical information required to support the individual's health

        ii. Critical information required to support the individual's personal care and finances

        iii. Critical information required to support the individual's independence and safety

8. While an individual's choice and dignity are always respected and preserved, there are rare instances where protocols for safety and supervision do not align with the individual's preferences, but are required to prevent serious harm. For example, someone may require direct supervision while bathing due to a health or physical condition, but the individual would prefer that staff not be present. Where this is the case, the risk of harm should be clearly identified as well as the safeguard required to mitigate this risk. The individual should be

included in the plan to the extent possible and every attempt should be made to explain to the individual why the safeguard is required.

9. If situations arise that increase risk or harm to an individual, development of a situation-specific plan or protocol may be required. Service providers will contact the CSW if a situation-specific plan or protocol needs to be developed. For example, delegated nursing task plans, restrictive practices or restraint plans or behavior support plans.

10. All information as part of a support plan is collected, used, disclosed and protected in accordance with the provisions of The Freedom of Information and Protection of Privacy Act (Manitoba), The Personal Health Information Act (Manitoba) and all other applicable legislation.

    a. A service provider shall only collect as much personal and health information about an individual as is reasonably necessary to provide the services required.

    b. Information shall only be used and shared with those employees who need to know the information to provide and monitor support.

    c. Disclosure of personal and health information to any person outside those responsible or accountable for support must have voluntary, informed consent of the individual the information is about.

    d. Where an individual will not provide consent, service providers should consult the CSW. The service provider and CSW should have an open conversation with the individual to understand the nature of the individual's concern. The service provider and CSW will explain what information needs to be shared and the rationale. Obtaining consent is considered best practice, however, information can be shared without consent of the individual to the extent necessary to provide safe and adequate care to the individual.

11. Service providers are responsible to ensure all staff working with an individual have received appropriate introduction to the support plan and adequate orientation to provide the supports as described. Service providers must have internal policies and procedures in place for orientation, training and review of support plans. *See example signature record*.

12. The CSW participates in discussions and planning meetings which address the provision of support services through CLDS.

6.2 Procedures

A support plan is developed and/or updated when:

- an individual is receiving or will be receiving an agency-delivered service funded by CLDS or is moving into a home share placement
- the existing plan does not meet the required departmental standards for support plans
- an individual's support or care needs have changed
- an individual is dissatisfied with the existing plan
- there is a change or addition to service provider(s)

Service providers are expected to:

- ensure all relevant information is addressed in the support plan, in line with departmental guidelines
- ensure any relevant situation-specific plans or protocols are included with a support plan
- update an individual's support plan should their support or care needs change and review the plan regularly to ensure it remains current
- distribute any new or updated support plans to the individual's CSW, any other service providers involved and any relevant members of the individual's support network
- ensure all staff working with an individual are aware of the support plan, know where to access the support plan, are provided an orientation to the plan and provided adequate training to provide the support as described in the plan
- monitor supervision of staff implementing the plan to ensure staff are appropriately trained

CSWs are expected to:

- ensure that service providers are aware that a support plan is to be developed prior to placement; in the event of an emergency or crisis placement, the CSW will ensure that the service provider develops a plan within two weeks of the placement
- act as a resource to the service provider(s) and support network by sharing information about support services and the process for accessing same
- if required, provide additional support to private home share providers with the development or revision of a support plan
- review new or updated support plans when received ensuring content aligns with departmental guidelines and maintain a copy on the individual's hardcopy file
- participate in problem resolution should conflicting ideas arise in development of a support plan; this may include situations where the individual does not agree with a safeguard that needs to be put in place to prevent serious harm (e.g., a requirement for direct supervision while bathing, but the individual would prefer to be alone during a bath)

6.3 Guidelines

A Guide to Completing My Support Plan

7.0 Policy Documents

Attachment 1: CLDS My Support Plan TEMPLATE
Attachment 2: A Guide to Completing My Support Plan

8.0 Resource Documents

CLDS Circular #2016-09 Person-Centred Planning Policy
CLDS Person-Centred Individual Planning Policy – C66 – April 22, 2016
CLDS Circular #2016-07 Person-Centred Planning Template
Attachment: Building Personal Supports Budgets for Adults with Intellectual/Developmental Disabilities Information Brief – March 9, 2016
Attachment: Person-Centred Thinking Training, Helen Sanderson Associates
Attachment: Person-Centred Planning Tool – March 29, 2016
Individualized Support in Residential Care Facilities – C166.8 – November 1, 1997