8. Person-Centred Planning

Definition

Person-centred planning refers to individuals and their personal networks (families, friends, allies) leading the planning process. As a well-known self-advocacy statement goes, "*nothing about us, without us*." Person-centred planning is at the heart of Spectrum's approach to serving individuals and families.

"Planning" vs. "A Plan"

Planning is the process of coming up with a plan. It is an on-going process of discovery, dialogue, and collaborative decision-making. There are many different ways that planning can occur. Some people like the formality of a meeting at the office, with an agenda. Others prefer a more intimate setting, like their own home or a coffee shop, and a smaller gathering of close family, friends and trusted supporters. Many people at Spectrum have chosen to do PATHs, which are a more visual and experiential approach to planning. We encourage people to use whatever method they're most comfortable with. For more information or suggestions on facilitating person-centred planning, please refer to the resources on Spectrum's website.

A *plan* is the course of action agreed upon through the planning process. Plans, too, come in all different shapes and sizes. Sometimes people come to Spectrum with a plan already established, which we work with them to implement. Other times we assist people to develop a plan.

Regardless of the methodology, the supervisor is responsible for documenting planning meetings and the nature and scope of the person's support plan on the appropriate templates, for quality assurance purposes.

Policy

(a) Each person receiving service from Spectrum will have a Service Plan that outlines the scope of services, long term goals, decision-making and accountability for the various aspects of the person's support. Individuals may also have a Support Plan (or equivalent, eg. IPP), which documents short term goals and specific support strategies. The Service Plan and Support Plan will be driven as much as possible by the person and those closest to him or her.

(b) The Service Plan will be completed upon start-up of services and will be reviewed annually (or more often if the person's needs or circumstances change significantly). The Support Plan will be developed in consultation with the person and the team and updated as needed to reflect the person's current priorities and supports.

(d) Individual goals may be added, discontinued or updated at any time; however this should only occur in consultation with the person and his or her network.

(e) Any changes to the person's goals, and strategies for implementing goals, will be approved by the supervisor and explained to team members prior to implementation.

(f) Documentation and recording procedures will be clearly specified in writing and all personnel will be expected to follow these procedures consistently.