

Report under Section 11(c) of the
*Community Services (Complaints
Reviews and Monitoring) Act 1993*

**Audit of individual planning in
funded disability accommodation
services**

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Why audit individual planning?

The NSW Ombudsman determined in early 2004 to initiate an audit of individual planning in funded disability accommodation services across NSW.¹ This decision followed information we received from complaints to the Ombudsman and reports from Official Community Visitors that raised concerns about the way services undertake individual planning, including the adequacy of plans, monitoring, and involvement of service users.

The focus of the audit was to examine individual planning for adults with disabilities living in the care of funded organisations, and to determine current levels of compliance with Disability Services Standard 2.0 *Individual Needs* and Minimum Practice Guideline 2.1 *Individual Planning and Review*. In addition, the services audited have provided information concerning the level of guidance provided, and monitoring undertaken, by the Department of Ageing, Disability and Home Care (DADHC) in relation to individual planning.

The importance of individual planning

Individual planning is the means by which disability services ensure that the services they provide meet the individual needs and goals, both current and future, of their service users. It is the means by which services coordinate their service provision, work out what action they will take to meet the needs and goals of service users, and allocate responsibilities to staff members.

The *NSW Disability Services Act 1993* (DSA) makes it a legal requirement for services to meet the individual needs and goals of service users. Services must meet the requirements of the DSA, and the associated Disability Services Standards, in order to uphold the funding agreements they have with DADHC.

Benchmarks

The DSA requires services to be designed and run so as ‘to meet the individual needs and goals of the persons with disabilities receiving services’², and ‘to meet the needs of persons with disabilities who experience an additional disadvantage as a result of their gender, ethnic origin or Aboriginality’.³ The Disability Services Standards refer specifically to Individual Needs in Standard 2.0, with Individual Planning and Review outlined in Practice Guideline 2.1. The *Standards in Action* document provides guidelines for services on how to meet the standards and practice requirements. We audited services against the minimum standards and minimum practice requirements.

The audit process

We selected ten services to obtain a mix of service sizes, and to cover both metropolitan and regional areas. In all, we audited sixty service user files. As part of our selection process, we excluded any services the subject of current action by the NSW Ombudsman, or where other activities within the service may have impacted on the audit. Selection was not based on service quality or performance.

¹ The audit was conducted under Section 11(c) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

² *NSW Disability Services Act 1993*, Schedule 1, 2(d)

³ *NSW Disability Services Act 1993*, Schedule 1, 2(e)

How we did it:

1. We reviewed each service's policy and procedures relating to Individual Needs and Individual Planning and Review.
2. We audited the files of six selected service users from each service, using an audit tool we developed based on the minimum standards and practice requirements. The file audit involved examination of the service's current individual plan for each service user, as well as the previous two individual plans, the individual plan minutes, any assessments done in relation to individual planning, and support notes.
3. We met with a representative of service management at the beginning and end of each audit in order to clarify any questions about the service's individual planning process, to discuss our findings, and to provide feedback to the service.

Summary of key findings

The audit considered seven broad areas that comprise individual planning in disability services, namely policy and procedures, presence of plans, assessment, development, content, implementation, and review.⁴ These areas reflect the standards.

1. Policy and procedures concerning individual needs and planning

We found that while all services have written policies around individual needs and planning, few services have clear and sufficiently detailed procedures to guide staff (such as what assessments should be undertaken, what the review process involves, or how monitoring of the plans is conducted).

Providing policies and procedures that are in formats appropriate to the needs of the people receiving a service is fundamental to their participation. When we considered whether services have made the policies and procedures available to service users in appropriate formats, we found that only six services had done so, even though all of the services involved in the audit have at least some service users who have cognitive impairments.

2. Presence of individual plans

In the main, we found that the majority of the service users whose files we audited have current plans in place to meet their goals. Most of the services develop plans with service users on a regular, at least annual, basis, although some services have elected to develop new plans every three to six months. In general, the services that develop new plans more frequently than annually have reported that it allows them to be more responsive to the changing needs of service users.

We found three services that had taken over twelve months to develop new plans with service users, with delays extending from three months to eight years. Significant delays in developing new plans⁵ raise questions about how those services identify and document the individual, ongoing, and changing needs of the service users, and how the services meet those needs.

⁴ The headings used in this report are the constructs of the NSW Ombudsman. *Standards in Action* makes no such separation. We have separated the standards into different areas for ease of reporting.

⁵ In this report, we have considered significant delays to be six months past the due date and over.

We also considered how services ensure that they meet the needs of service users who choose not to have an individual plan.⁶ Most services indicated that they have service users who choose not to participate from time to time, and outlined a variety of other methods they employ for meeting the needs of these service users (such as undertaking planning for the person outside of a formal meeting). The services we audited appear to appreciate that although service users may not wish to participate in a formal planning process, the agency still has an obligation to ensure their individual needs are identified and met, although few services refer to this in their policies or procedures.

3. Assessment

We found that services are using a wide variety of assessments to ascertain the needs, abilities, and strengths of service users, including Lifestyle and Environment Reviews, skills assessments, and health reports. In some cases these assessments are used to identify both the needs of the service user as well as potential goals. (Planning to meet both of these areas is discussed further in the ‘Content’ section).

While all ten services we audited undertake some form of assessment of service users, only four of those services use the assessments to inform the development of the individual plan. The reasons for services failing to use comprehensive assessments to inform development of individual plans appear to be linked to timing, guidelines, and monitoring:

- In some of the files we examined, we found that the assessments identified by services as being part of the planning process had been undertaken *after* the plan had been developed, allowing no opportunity for the plan to be informed by the findings.
- Not all services refer in their procedures to individual plans being developed following a comprehensive assessment of the service user’s needs. Few services’ procedures contain clear guidelines as to the timing of assessments, what assessments are required, and how assessments link to the development of the plan.
- Only three services have a clear process in place for monitoring individual plans to ensure that guidelines are accurately followed and that assessments feed into the development of the new plan.

We also looked at whether services reassess the needs and goals of service users following significant changes in their situation. We found that, although few services provide prompts in their procedures for this to happen, reassessments appear to be occurring in practice in some services (including developing transition plans for changes in service user accommodation, and organising a psychiatric review in response to changing mental health needs).

4. Developing individual plans

Explaining the planning process

The majority of the services we audited have a step in place to explain the individual planning process to service users before their planning meeting. This step varies from the Keyworker meeting individually with the service user, to discussing the process with the service user at the beginning of the meeting itself. A few services have developed resources to assist with explaining the planning process, including service user booklets and plain English leaflets.

⁶ Our audit of 60 services users included one person who chooses not to participate in a formal planning process.

Three-month timeframe

We found mixed results when we considered whether plans had been developed within three months for new service users. Of the eight service users who fell into this demographic, half had had their plans developed within three months of entering the service, while the other half had not had plans developed until six to 12 months had elapsed.

Involvement of the service user, their representatives, key staff, and others

All services involve the service user in their individual planning meetings, although we did find two plans in one service where this did not appear to be the case.⁷ Services are demonstrating good practice in holding planning meetings in locations that assist the participation of the service user, such as their home. The majority of services also involve representatives and key staff members in the individual planning meetings of service users. Most services take active steps to include representatives in the planning meetings, including holding meetings while representatives are visiting the service user, or organising a telephone link-up to representatives in distant locations.

Although we found it easy to determine if service users and their representatives are present at the individual plan meetings, it was difficult in the majority of services to find evidence that they also have input into the development of the plans. We found little information to identify whether the plan was informed by direct service user or representative input, or what their goal suggestions may have been. Where minutes were kept of the meeting it was much clearer who had input into the plan.

Few services have mechanisms in place to record the contributions of service users or their representatives, particularly where information is provided verbally. In addition, few services have methods for recording the contributions of those staff members who work with the service user but may not be involved in the planning meeting.

Nomination of participants

Only three services we audited have a mechanism in place to prompt or record consultation with the service user as to who they would like involved in the development of their plan. A number of services indicated that this is something that happens as a matter of course, but is not documented. It is worth noting that very few services include this step in their individual planning procedures.

5. Content of individual plans**Focus on outcomes**

Only half of the services we audited feature plans that are consistently outcomes-focused with achievements that can be measured. It was difficult to see from some goals what the outcome would be, or how staff members, service users, or their representatives would measure whether they had been achieved. The following examples found in the audit illustrate the difference between goals that are outcomes-focused with measurable achievements, and those that are not:

Example of an outcomes-focused goal with achievements that can be measured:

To move to the Central Coast to be near my family.

It is easy to identify from this goal that the intended outcome is that the service user will

⁷ The service has advised that this is most likely due to the service users choosing to leave the individual planning meeting partway through, and their presence not being documented as a result.

move to the Central Coast, and the achievement can be measured by whether or not the person has moved.

Example of a non-outcomes-focused goal with achievements that cannot readily be measured:

Always use real objects to enable Jenny⁸ to predict activities.

This is not a goal so much as an instruction for staff to follow. The intended outcome may be that Jenny will be able to predict activities, but it is not clear how Jenny, or anyone else, would be able to measure whether the 'goal' had been achieved.

Long-term goals

Some services distinguish between long-term goals (those that are broad and may take longer than 12 months to achieve) and short-term goals on the individual plan. When we considered how long-term goals had been used in plans, we found mixed results. Some plans included long-term goals, but they did not have strategies in place, and they did not appear to be linked to the review process. In these cases, we found little evidence of goal implementation, and it was difficult to see how the long-term goals may progress from one plan to the next. We found positive examples of the use of long-term goals where the long-term goals were translated into steps to be taken to progress the goal. For example:

Long-term goal: Simon will continue to broaden his social networks and relationships and facilitate friendships with ladies.

Short-term goal: Simon will invite a female friend of his choice on group outings and home for dinner.

Strategies:

1. Support Simon to choose a lady to invite.
2. Support Simon to make invitation for group outing.
3. Liaise with family / other service re arrangements.
4. Support Simon to make invitation for dinner at home.
5. Support Simon with food preparation and entertainment.

We found evidence that the short-term goal is being implemented, and hence progress is being made towards one aspect of Simon's long-term goal.

Needs and goals

We found that services have different methods of planning for service user needs and goals. Some services incorporate needs (including health care) into plans as 'goals'. Others keep needs and goals separate, and either plan for needs through alternative mechanisms (such as behaviour management plans), or include needs in a separate section of the individual plan. It was much easier to identify goals as being client-directed (that is, goals that capture what the service user has identified they want to achieve) in the services that distinguish between planning to meet needs, and planning to achieve goals.

We found a higher proportion of service goals (that is, goals that reflect routine service provision, or capture what the service believes the service user needs to achieve) in services that do not have alternative means of planning for the needs of service users. This varied from goals that capture routine service delivery, such as hygiene, to plans that include a number of service goals that had been pre-set into every plan, such as 'Budgeting'. In some cases,

⁸ The names of service users have been changed in this report to protect the privacy of individuals.

services appeared to be using individual plans as ‘work plans’ for staff, incorporating service goals.

Goals vs objectives

Standards in Action uses the words ‘goals’ and ‘objectives’ interchangeably, and does not define either term. We found that defining these terms is problematic for agencies, and practice is thereby inconsistent. In some plans, the objectives were broader than the goals, in others the staff members had left objectives out, and in yet others objectives were goals that had been broken down into more defined and specific statements.

Strategies

Eight services develop strategies, or steps to be taken, for goal achievement. However, half of these services do not develop strategies consistently, or list strategies that have insufficient detail to provide guidance to staff or service users.

Timeframes

Although most services include some form of timeframe in individual plans, this is interpreted in a variety of ways both across and within services, including ‘Start date’, ‘By when’, and ‘Action date’. Where we found plans that consistently recorded the timeframe as the date of expected goal achievement, this was due to a sole staff member being responsible for writing all individual plans in the service.

Responsibilities

The majority of services consider the issue of responsibility in the individual plans, although we saw significant variation in the way responsibilities are allocated, including naming specific individuals (including the service user), listing staff positions, listing locations (eg: a particular group home), or stating ‘All staff’. In some services, broad responsibilities such as ‘All Staff’ featured where the goals appeared to be ‘service goals’, or routine activities that are expected of all staff members.

Monitoring

Most of the services we audited do not have any clearly identifiable process in place for monitoring individual planning.⁹ Where services have developed systems for monitoring, it is not always clear how that monitoring would feed back into the planning process. For example, if the person responsible for monitoring the plans identifies a significant barrier to implementation, it is not always evident how that information would be used to inform the plan or to amend the process.

In the few services that have developed systems for monitoring, we found good practice where a number of different methods are used, such as supervision sessions and staff meetings (where plan development and implementation are included), random file audits, and monthly reports on plan implementation.

6. Implementing individual plans

All services demonstrated implementation of plans, although not all were consistent in this practice. While most services use progress notes to capture plan implementation, few tie progress notes to individual goals. The services that tie progress notes to goals or strategies provide a means of monitoring and reviewing progress towards achievement, and for identifying barriers to progress. That said, the services that do currently tie progress notes to goals are not always capitalising on this practice, either because the service has not developed a monitoring system, or is not following the system it has developed.

⁹ We considered monitoring of the process (development and implementation), as well as quality (content).

At times, it was difficult to identify in some services whether steps had been taken to implement goals. This was notably the case where goals were broad or complex, or where strategies had insufficient detail to indicate how staff would go about taking steps to achieve the goal. For example:

Goal:	Investigate and plan for retirement.
Strategy:	Investigate retirement options.

This is a broad goal with many potential components. The strategies in this case provide no further guidance for staff on where they should start, or what components of retirement they may need to consider. We found little evidence to suggest that any action had been taken in relation to this goal, although the service user's other goals were obviously being implemented.

We also looked at whether services seek expert advice and assistance when needed to help in meeting the identified goals. We found that all services use community resources to assist the service user to achieve their goals, and most services are tapping into expert advice and assistance, where this is available. Many services advised of the limited availability of expert services in regional areas.

7. Reviewing individual plans

While half of the services consistently identify the date of review on the individual plan, only one service consistently carries out reviews of plans in practice. In terms of frequency, we found that four services review plans more often than 12-monthly, but, again, only one service does so on a consistent basis. This service has a position dedicated to coordinating individual planning in the organisation, uses a matrix to identify outstanding and upcoming reviews, and has several monitoring methods in place.

We found that the lack of regular reviews of plans in services is linked to a lack of effective monitoring, scheduling, and difficulties services have in differentiating between review and plan development. In most of the services it was not clear what the review process involves, as there did not appear to be a clear distinction between reviewing the current plan and developing a new plan. It was also difficult in the majority of services to see how reviews (where conducted) link back to the planning process. That is, how reviews may trigger a reassessment of needs and goals, lead to the development of more detailed strategies, or result in changes to staff practice.

We also considered whether services actively encourage and support the involvement of the service users and their representatives in the individual plan review. Half of the services advised that their reviews of plans involve the service user as well as staff, but it was difficult to see this in practice. For the majority of the reviews we examined, it was not clear who had been involved in the review. Where we were able to identify who was involved, it was typically a sole staff member.

8. Guidance and monitoring

As part of the audit, we asked services what guidance had been provided, and monitoring undertaken, by DADHC in relation to individual planning. It is a legislative requirement that DADHC, on behalf of the Minister for Disability Services, monitors agencies to ensure they are delivering services in accordance with the DSA, including planning for and meeting the needs and goals of service users. Further, DADHC has stated that it is responsible for

providing guidance to services to assist them to meet their service delivery obligations.¹⁰ This includes guidance around individual planning.

Guidance

Services reported that, while *Standards in Action* does provide general advice about individual planning, it does not provide specific guidance on how the elements should fit together, what is meant by goals, objectives, or strategies, or what forms should look like. While some services have been able to obtain guidance and advice from other service providers in their region, others have had to research practice in similar services outside of NSW. Up to half of the services involved in the audit have called on consultancy services in order to obtain guidance in relation to individual planning, using part of the grant money that is allocated to them to provide direct services and support to service users.

All services reported that they have received no guidance from DADHC around individual planning. While some services reported that they have not sought guidance from DADHC, one service reported that on the one occasion it did seek advice, the Service Support and Development Officer (SSDO) referred the service back to *Standards in Action*. Our audit indicates that there is a need for guidance and service development around individual planning that is currently not being met by SSDOs.

All services involved in the audit were eager to receive feedback on their individual planning processes, to receive suggestions for improvement, and to gain advice on the practice of other services. While some services, particularly in regional areas, have taken the step of liaising with other service providers in the local area to try to establish good practice and to tap into existing resources, many services are struggling with the challenge of developing individual planning processes in the absence of accessible guidance.

Monitoring

All services involved in the audit reported that there has been no recent monitoring by DADHC. The period of time reported to have elapsed since the last monitoring visit undertaken by DADHC of the services involved in the audit generally ranged from two to six years, although a number of services could not recall the last time a monitoring visit was conducted. At least four of the services we audited reported that there has been no monitoring by DADHC of their service for over four years. This information raises questions about how DADHC can be confident that individual planning is occurring in funded services, or that plans are meeting the needs and goals of people with disabilities. DADHC has informed the NSW Ombudsman that it is in the process of developing a Quality and Performance Monitoring System that will apply to both DADHC provided and funded services.¹¹ DADHC's monitoring activities are the subject of current consideration by the NSW Ombudsman.

DADHC was given opportunity to comment on the draft of this report.

Challenges for services

As part of the audit, we asked services about the issues that affect individual planning and present challenges for their agencies. In addition to the lack of available guidance, services reported the following key challenges:

¹⁰ *Funding Agreement: A Guide for Community Based Service Providers*, and Service Support and Development Officer position outline, on DADHC website: www.dadhc.nsw.gov.au, 7 July 2004.

¹¹ Briefing to the NSW Ombudsman, 27 May 2004.

Staff

Services advised that much of the responsibility for individual planning falls upon the shoulders of front-line staff, and this responsibility can be difficult for some staff members to juggle in addition to day-to-day service provision. Services also reported that the capacity of front-line staff can affect the planning process, including their ability to develop outcomes-focused plans, and complete sophisticated assessments.

Regional services reported that limited access to staff training is a significant issue, and one that affects individual planning. Most services stated that training costs are prohibitive given their existing levels of funding, and they are unable to access training provided to DADHC support staff. Many services are organising in-house training where possible or travelling further afield to try to tap into existing training programs. One service advised that it has explored the possibility of entering into a consortium with other services in its regional area to purchase training and assistance from consultants.

Service users

The changing needs of service users can create challenges for services. Many services acknowledged that the numbers of ageing service users is increasing, generally leading to an increased emphasis on medical and health needs, planning for alternative day activities, and reassessing needs to establish areas requiring additional support. Given the limited resources and services available in regional areas, these changing needs present challenges to services in accessing medical specialists and diagnostic clinics, as well as day services.

Services have reported challenges in planning for service users with dynamic needs, such as people with Acquired Brain Injury. Some of the issues identified have included maintaining service user focus on goals and addressing changing behaviour issues. From the plans we examined, it appears useful to review and develop plans on a more frequent basis for service users with dynamic needs.

The capacity of the service user can also present challenges to services in individual planning, with the planning process followed in relation to service users receiving outreach support potentially being quite different to what may be required for service users with higher support needs. Some services reported difficulties in ensuring plans and goals are client-directed where service users are not able to easily indicate their wishes or needs.

Access to support services

Regional services consistently reported that accessing community resources, programs and activities poses a challenge due to limited availability. Some services commented that the overall limitation in activity options affects the goals that service users are able to nominate, and also influences which goals may be achieved. Limited accessibility has been linked to day services, recreation activities, medical specialists, therapy services, and counselling support.

Services advised that it is very difficult to access behaviour intervention support in regional areas. Some services commented on the extensive waiting lists and short support period, while others stated that their service users have been deemed ineligible to access behaviour intervention assistance due to their low level of intellectual disability. Concurrently, some services reported that it is easy for service users with behaviour issues to dominate overall staff time to the detriment of individual planning.

Elements of good practice

Through the audit we have identified factors that appear to indicate good practice in individual planning (outside of those outlined in *Standards in Action*):

Clear and comprehensive procedures

Clear procedures that comprehensively outline the steps followed in the service's individual planning process (including setting timeframes, allocating responsibilities, monitoring, and review) benefit staff members, service users, and their representatives. It is helpful to distinguish procedures from policy so that the steps followed are easily recognisable and can be easily transferred to appropriate formats. Communicating the service's procedures appears to be greatly enhanced by the use of visual aids.

Defining individual planning terms

Including definitions of goals, strategies and objectives (where relevant) may assist services in achieving consistency in practice, as well as provide a resource for staff training. Providing concrete examples can also help to reinforce staff training.

Clearly linking assessments to plans

Undertaking comprehensive assessments of service users is of questionable benefit to the service user if the assessments undertaken do not inform their individual plan. Linking assessments to plan development can be achieved through timetabling assessments to occur as part of the pre-individual plan process, and ensuring that assessment outcomes are discussed as part of the individual plan meeting. Although assessments appear to often be skills-based, comprehensive assessments may include consideration of service user likes, dislikes, strengths, wishes and needs across a broad range of life domains.

Using strategies

Developing clear strategies as steps to achieve goals ensures that all parties understand what action needs to occur in order for the service user to reach achievement within agreed timeframes. The strategies need to be sufficient to provide clear direction to maximise the chance that they will be implemented, and goals achieved. Linking responsibilities and timeframes to individual strategies (or goals) can also prove useful for monitoring and reviews.

Differentiating between planning for needs and goals

While some services use individual plans purely to capture the goals of the service user, other services will use the one plan to capture the needs of the service user as well as their identified goals. The Standards are not prescriptive about how planning to meet the needs and goals of service users should be undertaken. For the services that opt to use individual plans to meet both the needs and goals of service users, it appears to be valuable to separate needs from goals within the document. This practice seems to improve the chances that goals will be client-directed, while assisting the service to plan around the individual needs of service users.

Prioritising goals

Prioritising goals with the service user assists in ensuring that the number will be manageable, the goals achievable, and the plan focused on what is most important to the service user.

Using timeframes

Linking timeframes to individual goals (or strategies), and using the timeframe to indicate the expected date of achievement, provides a useful means for differentiating between long-term and short-term goals. This practice can also help to flag if shorter review periods are required,

may assist staff in identifying relative priorities for action, and can provide a shorter timeframe for staff and service users to work towards.

Explaining the process

It is valuable to hold pre-individual plan discussions with the service user to ascertain their wishes and potential goals in a non-threatening environment, and it is helpful to discuss the planning process with the service user on repeat occasions. Service user handbooks or workbooks have the capacity to capture service user wishes, needs, potential goals, and priorities for action, and appear to be a useful method for ensuring that the service user directly informs their own plan. Incorporating service user resources into the pre-individual plan process may also provide a trigger for staff to sit down with the service user to explain the planning purpose and process.

Encouraging input

It is good practice for services to have mechanisms in place to encourage input from various sources, including staff and service user representatives, and to record this input as it is provided. Providing avenues for all parties to have input into the process, even if they do not attend the meeting, allows for the wealth of knowledge about the service user to be used effectively. Further, it is important that the input, once collected, is considered and applied in the planning process.

Keeping minutes

Keeping a record of what is discussed in the planning meeting (even in point or summary form) provides a means for identifying the origin of goals, allows the service to document any matters of contention, and records areas that the service user may wish to include as future goals.

Using progress notes

Progress notes that are linked directly to the individual plan (not in general progress or file notes) allow all parties to quickly ascertain whether goals are being implemented, what progress has been made towards achievement, and whether there are barriers to progress that may require attention. This is particularly the case where progress notes are tied to individual goals or strategies as it allows for ease of both monitoring and review.

Monitoring

It is imperative that services have a monitoring process, clearly delineate the position(s) responsible for monitoring the planning process and the plans themselves, and that the monitoring system is implemented in practice. It is also important that services have a clear understanding of the purpose of monitoring in identifying and responding to problems. It appears to be valuable to have a number of methods in place for monitoring individual planning within a service, and to make use of established processes (such as support and supervision meetings) to monitor progress towards goal achievement.

Clarifying the purpose of monitoring and review

It is important that services are clear about the purpose of undertaking monitoring and reviews of individual plans. One of the key reasons is to identify and address any barriers to progressing goals, such as client health, insufficient strategies, and resource issues. It is good practice to include procedures for responding to identified barriers and recording any amendments to the plan, to inform future reviews.

Scheduling

The services that regularly develop new plans and review current plans tend to have a scheduling system in place, such as house diaries, calendars, or matrices. It appears useful to

have planning meetings and reviews scheduled throughout the course of the year, rather than concentrated at one time, as this may allow greater focus to be given to the individual service user, and assist with managing the workload of service staff.

Reviewing plans more often

Reviewing plans more often than annually seems to help services in distinguishing between plan review and plan development, allows services to better evaluate progress towards goal achievement, and assists agencies to identify and respond quickly to any barriers to implementation. As a matter of course, it is good practice to set review dates according to the individual needs of the service user, and their goals.

Using a review form

For services that review plans only at the time that the new plan is developed, it may help to use a review form. This assists in separating the steps of review and development, and is helpful in capturing why some goals may appear from one year to the next.

Having a process that flows

It is important that individual planning is a process, not a collection of stand-alone activities. Although monitoring and reviews are critical activities in their own right, they have much greater import where they are linked back into the planning process. Similarly, identifying barriers to progress, or achievement of goals is important, but these actions take on more meaning when they inform the process. Developing a process that flows ensures that plans are working documents that are informed by assessments and reassessments, monitoring, and reviews.

Recommendations

DADHC is undertaking a trial implementation of a new system for monitoring disability services from late September 2004 to March 2005, with full implementation planned to commence in July 2005. This system is to be known as the Integrated Monitoring System.

1. In this context, we accept that DADHC will seek to ensure that it incorporates into the Integrated Monitoring System a way of monitoring the compliance by services of Standard 2.0 and Practice Guideline 2.1.
2. However, in light of the limited monitoring of services currently, we recommend that DADHC consider how it might better review whether services are meeting Standard 2.0 and Practice Guideline 2.1 in the interim period; that is, before implementation of the proposed monitoring system.
3. DADHC should advise this office of its response to Recommendation Two within two months of the date of this report.

Steve Kinmond
Deputy Ombudsman
Community and Disability Services Commissioner

NSW Ombudsman

Audit Tool

For use in Individual Planning project

Individual planning policy and procedures		
1	Policy and procedures exist?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (eg: in draft form)
2	P&p covers the following processes for individual planning:	<input type="checkbox"/> Process takes into account the service user’s wishes, needs and strengths <input type="checkbox"/> Process is sensitive to the service user’s age/life-stage, sex, linguistic, religious, and cultural background <input type="checkbox"/> IP developed within 3 months of service user entering service <input type="checkbox"/> IP developed following comprehensive assessment of service user <input type="checkbox"/> IP must be outcomes-focused and achievements able to be measured <input type="checkbox"/> IP clearly defines agreed objectives to be achieved and how they are to be achieved (incl monitoring, timeframes, and responsibilities of individuals) <input type="checkbox"/> IPs are aimed to be conducted in least restrictive environment with overall aim of achieving maximum level of independence for each service user <input type="checkbox"/> IP reviewed regularly, at least annually <input type="checkbox"/> Agency informs service users at time of registration that its service delivery centres on the IP process, and how. <input type="checkbox"/> Service users have the right to request a review of their IP at any time, and how this is communicated. <input type="checkbox"/> Significant changes to service user’s situation lead to reassessment of needs and goals. Modifications to IP are recorded <input type="checkbox"/> Agency seeks expert advice and assistance when needed to help in meeting the objectives of the IP <input type="checkbox"/> Agency actively encourages and supports involvement of service user, his/her family, guardian and/or advocate, key staff members and others as required in development and review of IP <input type="checkbox"/> Service user is given opportunity and encouraged to nominate who he/she wants to participate in planning process <input type="checkbox"/> Agency respects informed decision of service users not to participate in IP process <input type="checkbox"/> Where service user chooses not to have an IP, agency employs another method for ensuring service user’s needs are met
3	P&p are available to service users in appropriate formats	<input type="checkbox"/> Yes (identify formats) <input type="checkbox"/> No

NSW Ombudsman

Audit Tool

For use in Individual Planning project

Service User Information		
4	Name	
5	DOB / Age	
Presence of Plan		
6	Current IP exists?	<input type="checkbox"/> Yes Date: <input type="checkbox"/> No
7	Evidence of previous IP(s) for past 2 years	<input type="checkbox"/> Yes Dates: <input type="checkbox"/> No
Assessment		
8	Is there evidence in file of assessment undertaken of client prior to current / existing IP?	<input type="checkbox"/> Yes (Briefly outline what this assessment involved – eg: medical check-up, functional assessment, likes/dislikes) <input type="checkbox"/> No
9	What evidence is on file of some work undertaken prior to IP meeting towards identifying service user wishes, needs and strengths?	<input type="checkbox"/> None <input type="checkbox"/> Discussed wishes / needs / strengths with service user <input type="checkbox"/> Discussed service user wishes / needs / strengths with family / significant others <input type="checkbox"/> Discussed service user wishes / needs / strengths with other staff <input type="checkbox"/> Recorded observations of client likes / dislikes / strengths <input type="checkbox"/> Review of support notes / activities <input type="checkbox"/> Other (describe)
10	Is there evidence in the file of a change in	<input type="checkbox"/> Yes (outline what the change was – eg: increased support needs, death of parents, retirement from work, major illness)

	the service user's situation / circumstances since previous IP? <input type="checkbox"/> No (go to question 12)	
11	Is there evidence in the file that the change in circumstances resulted in a reassessment of needs and goals?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Content			
12	Is the current / existing IP outcomes-focused? (Ie: do the goals / objectives say what will be achieved)	<input type="checkbox"/> Yes Provide eg:..... <input type="checkbox"/> No Provide eg:.....	
13	Is achievement of goals able to be measured?	<input type="checkbox"/> Yes Provide eg:..... <input type="checkbox"/> No Provide eg:.....	
14	Does the plan clearly define agreed objectives to be achieved?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15	Does the plan clearly define how objectives are to be achieved? (Ie: are there strategies setting out what is needed to achieve the objectives)	<input type="checkbox"/> Yes (eg: plan includes steps that will be taken by service) <input type="checkbox"/> No (eg: no details, or steps are too vague or insufficient)	
16	Does the plan indicate how it will be monitored? (including who has responsibility for monitoring)	<input type="checkbox"/> Yes (eg: it states who in the service will monitor the plan, how often they will monitor it) <input type="checkbox"/> No (eg: there is no or insufficient detail to indicate what monitoring of the IP will occur)	
17	Does the plan indicate timeframes for achieving objectives?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

		
18	Does the plan indicate when it will be reviewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
19	Does the plan indicate who has responsibility for the implementation of each objective?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
20	The goals fall into the areas of:	<input type="checkbox"/> Health <input type="checkbox"/> Behaviour <input type="checkbox"/> Recreation / Leisure <input type="checkbox"/> Work <input type="checkbox"/> Skills development <input type="checkbox"/> Family / friends <input type="checkbox"/> Daily care routine (incl personal care, grooming, making bed) <input type="checkbox"/> Other (state)	
21	How many goals are listed?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> >6 (state number)	
Development			
22	Was the IP developed within 3mo of client entering the service? (where they entered the service in the last 2 years)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client has been with service for more than 2 years	
23	Comparing the current IP with the previous 2 IPs:	<input type="checkbox"/> All of the goals are the same <input type="checkbox"/> Some of the goals are the same (state number)	

		<p>.....</p> <p><input type="checkbox"/> None of the goals are the same</p> <p>.....</p> <p>.....</p>	
24	How has the service taken into account the service user's wishes, needs and strengths in the IP process?	<p><input type="checkbox"/> It has used information from a service user assessment (eg: needs assessment, documented likes/dislikes, strengths assessment)</p> <p>.....</p> <p><input type="checkbox"/> It has used information given by the service user about their wishes, needs and strengths</p> <p>.....</p> <p><input type="checkbox"/> It has used information from family / friends / significant others about the service user's wishes, needs and strengths</p> <p>.....</p> <p><input type="checkbox"/> It has used information gathered from file (eg: support notes)</p> <p>.....</p> <p><input type="checkbox"/> Other (state)</p> <p>.....</p> <p><input type="checkbox"/> There is no evidence to suggest the service has taken into account the service user's wishes, needs and strengths.</p> <p>.....</p> <p>.....</p>	
25	What evidence is on file to indicate that service user was given clear info and support to understand the IP process?	<p><input type="checkbox"/> None</p> <p>.....</p> <p><input type="checkbox"/> Notes indicate IP process discussed 1:1 with service user</p> <p>.....</p> <p><input type="checkbox"/> Notes indicate service user advocate / family, etc discussed IP process with service user</p> <p>.....</p> <p><input type="checkbox"/> File includes materials developed to explain IP process to service user</p> <p>.....</p> <p><input type="checkbox"/> Other</p> <p>.....</p> <p>.....</p>	
26	What evidence is on file to indicate that service encourages and supports involvement of service user in development of IP?	<p><input type="checkbox"/> None</p> <p>.....</p> <p><input type="checkbox"/> IP (or meeting mins) indicates presence of service user</p> <p>.....</p> <p><input type="checkbox"/> IP, mm, or file indicates service user input into IP development</p> <p>.....</p> <p>.....</p>	

27	What evidence is on file to indicate that service encourages and support involvement of service user's family / friends / significant others in development of IP?	<input type="checkbox"/> None <input type="checkbox"/> IP (or meeting mins) indicates presence of family, friends, guardian and/or advocate <input type="checkbox"/> IP, mm, or file indicates input of family, friends, guardian and/or advocate into IP development	
28	What evidence is on file to indicate that service encourages and supports involvement key staff in development of IP?	<input type="checkbox"/> None <input type="checkbox"/> IP (or mm) indicates presence of key staff members <input type="checkbox"/> IP, mm or file indicates key staff and /or relevant others' input into IP development <input type="checkbox"/> IP objectives reflect the IP meeting minutes <input type="checkbox"/> Other	
29	Was service user consulted as to IP meeting attendees?	<input type="checkbox"/> Yes - were their nominations included in the meeting? <input type="checkbox"/> No <input type="checkbox"/> Not evident from file	
30	Do the IP goals reflect the IP meeting minutes?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No meeting minutes on file	
Implementation			
31	Have the IP goals been implemented (steps taken to achieve goals) by service?	<input type="checkbox"/> Yes, service has taken action in relation to all IP goals <input type="checkbox"/> Yes, service has taken action in relation to some of the IP goals (state number) <input type="checkbox"/> No	

		<input type="checkbox"/> Not evident from file	
32	Has the service sought expert assistance to help in meeting IP goals?	<input type="checkbox"/> Yes <input type="checkbox"/> No, it isn't necessary <input type="checkbox"/> No, but it may be necessary	
Review			
33	Review date(s) of current IP:		
34	Has the service reviewed the current IP?	<input type="checkbox"/> Yes, it held a meeting with client and key parties (state who) <input type="checkbox"/> Yes, it held a meeting with staff only <input type="checkbox"/> Yes, the IP was reviewed by a staff member (what position?) <input type="checkbox"/> No, review not due yet <input type="checkbox"/> No, and overdue for review <input type="checkbox"/> No, and review date not specified	
35	Were review date(s) met for the previous IP?	<input type="checkbox"/> Yes, it held a meeting with client and key parties (state who) <input type="checkbox"/> Yes, it held a meeting with staff only <input type="checkbox"/> Yes, the IP was reviewed by a staff member (what position?) <input type="checkbox"/> No (outstanding for how long?)	