

Purpose

Life Without Barriers (LWB) is committed to enabling the people we support to have a lifestyle of choice and the opportunity to pursue their potential in a way that matters to them.

The LWB Individual Support Planning process provides the opportunity for people to share, explore and express both short term and life goals that bring meaning and purpose to their lives. As people share this picture of opportunity about themselves, their support, life long learning and participation activities, we listen, learn and act.

The Individual Support Plan (ISP) of each person helps us to determine the direction we need to take to best support them to achieve their goals, which in turn enhances their health and wellbeing. The ISP also ensures that LWB is committed, motivated and courageous in achieving excellence in service delivery, creating opportunities for growth, discovery and learning for the staff and people we support.

The Individual Support Plan

The ISP is closely aligned with the Client Profile, working together to guide service delivery. Where the Client Profile captures what is important for the person and their support requirements, the ISP focuses on what is important to the person, how they would like their support delivered and the things that will bring meaning to a person's life.

The Individual Support Planning processes and the person's ISP are designed to promote the following:

Being Part of a Community	<ul style="list-style-type: none"> Participating in local activities using community amenities.
Being Safe	<ul style="list-style-type: none"> Experiencing physical and emotional safety, and learning self-protective factors.
Choice and Control	<ul style="list-style-type: none"> Exercising human rights and responsibilities. Exercising control over their finances – making purchases and paying for things. Being independent and experiencing individual choice and control in their life. Choosing their supports and contributing to and providing feedback on how supports are provided.
Having Fun	<ul style="list-style-type: none"> Experiencing a sense of social wellbeing through social, leisure and recreational pursuits.

Building Relationships	<ul style="list-style-type: none"> Experiencing healthy, safe and respectful relationships
Being Heard	<ul style="list-style-type: none"> Seeking, receiving, and imparting information, ideas, opinions, and feelings through their preferred communication style
Sense of identity and belonging.	<ul style="list-style-type: none"> Expressing and experiencing Culture, Spirituality and Sexuality.

A well completed ISP provides person centred information for those directly working with the person to support them effectively and in line with their identified goals. LWB has created two versions of the ISP template, depending on the type of support the person is receiving from LWB:

[NDIS LWB 5101 Lifestyle Support – Individual Support Plan](#)

[NDIS LWB 5201 Shared and Supported Living – Individual Support Plan](#)

However, as the ISP is all about the person we support, they may choose to design their own template instead of using the LWB templates. To assist them to do this they can use the [NDIS LWB 5004 Create Your Own ISP – Essentials Checklist](#).

The ISP is completed by the Disability Support Leader (DSL)¹ in collaboration with the person we support and their support network.

Note: A DSL can delegate the development of the ISP to a suitable Disability Support Worker (DSW), however, it remains the responsibility of the DSL to ensure that the task is completed within the allocated timeframe and to the required standard.


Who needs to have an ISP completed?

Any person who receives Shared and Supported Living (SSL) and/or Lifestyle Supports (LS) from LWB is required to have a current ISP. The ISP is developed on the commencement of service delivery and reviewed at least annually.

Note: For people who receive both types of support from LWB, LS goal and review pages have been included in the SSL-ISP template, so only one template is required to be completed.

¹ All references to a DSL includes other Frontline Leadership roles, such as House Supervisors.

Developing an Individual Support Plan

<p>ISP Meeting</p> 	<p>The Disability Support Leader will:</p> <ul style="list-style-type: none"> • Explain to the person we support what an ISP is and that it is all about them, the things they want to do, explore and achieve. • Discuss with the person how they would like to plan their ISP, including when and where. They may like to have a formal meeting to gather all of the information and then a party or meal at a special place to celebrate it's beginning or completion. If they are unsure, help them find somewhere that is comfortable and private. • Ask the person we support who they would like to invite and how they would like to invite them. The person may like to develop an ISP in collaboration with all of their service providers, having one plan covering all aspects of the support they receive. • Use this opportunity to begin gathering thoughts and ideas regarding the person's goals and preferences, if relevant, to reduce any pressure that they may feel doing so at the ISP meeting. • Help the person we support to arrange their ISP meeting as previously discussed. • Communicate in a way to allow the person to feel comfortable talking about their support needs, to make informed choices and provide consent about what information they would like to share. This includes supporting the person to have conversations with their decision-making support network or authorised decision-maker. • Ensure the person's dignity, privacy and rights are always considered during the meeting. • Talk to the person we support and include them in all aspects of the conversation, using communication that is meaningful to them. Avoid talking about the person to their support network. • Look for non-verbal communication that might indicate the person we support is feeling embarrassed or uncomfortable with the conversation; offer to have a short break or come back to that section later if required. • Be sensitive and respectful in phrasing questions, responses and statements • Ask open-ended questions so that the information gathered is in the person's words, not simply a yes/no response to a question
	<p>The Disability Support Leader will:</p> <ul style="list-style-type: none"> • Ask the person we support if they would like to use the LWB templates to create their ISP, or if they would like to create their own individualised ISP template that is uniquely theirs.

Completing the ISP



- Refer to the [NDIS LWB 5004 Create Your Own ISP Template - Essentials Checklist](#) and share with the person we support that explains some ideas they may like to try and to ensure all the key essentials of an ISP plan are included in the design format of the person's choice.
- Support the person to access the materials and resources needed to create their vision of their ISP. Ensure the person has some 1:1 support time or assistance to work on developing their ISP, using the checklist to guide what to include in their plan.

OR

- Download the current version of the relevant ISP template from the LWB Disability Pathway (Lifestyle Support: [NDIS LWB 5101 Lifestyle Support – Individual Support Plan](#) or Shared and Supported Living: [NDIS LWB 5201 Shared and Supported Living – Individual Support Plan](#)).
- Refer to the following resources for step by step instructions and examples to assist in the completion of the ISP templates:

[NDIS LWB 5101a Lifestyle Support - Individual Support Plan - Example](#)

[NDIS LWB 5101b Lifestyle Support - Individual Support Plan Quick Reference Guide](#)

[NDIS LWB 5201a Shared and Supported Living - Individual Support Plan - Example](#)

[NDIS LWB 5201b Shared and Supported Living Individual Support Plan Quick Reference Guide.](#)

- List all of the person's goals in the My Goals section. Remembering that an ISP is not used for describing tasks and actions that are part of everyday active support
- Break down each goal into individual tasks including:
 - **Who** will be doing the task (e.g. the person we support, staff or someone else). Use the names of the people who will provide assistance whenever possible. It doesn't always have to be LWB staff members who will provide the support – whenever possible, facilitate community connections so that the person can enjoy a life not only surrounded by paid staff and not be restrained by rostering capabilities.
 - **Will do what** – a description of the task to be done (e.g. research holiday options). The number of tasks required will vary depending on the goal. Breaking the goals down into individual tasks assists staff and the person to work towards the goal step by step, not repeat effort, and keep track of what has been achieved and what is still left to do.
 - **By when** – Use specific timeframes and dates wherever possible. However, where the goal is regular and ongoing, recurring timeframes can be used. For example, "Each Tuesday", "Ongoing" etc. can be

used in the completed column and dates completed should be captured within the ISP Goal Support Record each time the task is completed. The timeframe should be relevant to the task. For example, if it is a task such as obtaining a catalogue or making a phone call to confirm details, the timeframe should be quick. Saving up money for a holiday should have a longer timeframe attached

- **Completed** – note the date the task was completed – ideally, this before the **By when** date.
- Discuss each section of the ISP template (as outlined below) with the person. If after selecting the LWB template, it doesn't fit the purpose of what the person wants to include in their ISP (e.g. they don't want to provide answers to the questions) or they find it not relevant to their support, refer to the [NDIS LWB 5004 Create Your Own ISP Template - Essentials Checklist](#), and work with the person to include what they want in their ISP. Contact the DSSC for further guidance if neither option is suitable.
- Record the names of the person's Support Networks in the areas of Friends, Family, Community and Other.
- Ask the person if they need assistance from people within their Support Network to make everyday decisions, person and sensitive decisions and decisions where formal consent is required, and how this support is provided. Use the prompts within the tables to ensure the discussion covers all aspects of decision making and reflects how the person would like communication to occur.
- Record the person's preferences regarding the characteristics and attributes of the people who support them. These preferences are for their support in general – if relevant, specific preferences regarding personal care support are to be captured in the person's Personal Care Plan.
- Ask the person to provide you with any information from their life story that they would like shared with their staff.
- Ask the person about the qualities that make them unique, and people like and admire about them, or anything that they're proud of that they'd like others to know.
- Record the person's dreams and aspirations for their future
- Ask the person how they like to direct their life and their support from LWB. Use the prompts in the template to ensure that the person's voice is heard and that the information captured accurately describes the person's wishes.
- Ensure that the person's personal and private information does not form part of their ISP. Examples of personal and private information include personal care such as dressing, bathing, personal hygiene, meal assistance, health care issues and positive behaviour support – all of which are delegated to specific support documents.

Finalising the ISP



The Disability Support Leader will:

- Sign the ISP (unless otherwise delegated), along with the person we support and/or their Authorised Decision Maker, and any other people involved in the plan development.
- Ensure the ISP is saved in the person's CIRTSS record via this pathway:
 - **LS:** Person's CIRTSS Record > Plans and Assessments > Add New Plan > Service Type – *Choose the applicable LS service type* > Plan Name - *select ISP - Lifestyle Supports* > Complete as per plan and attach document.
 - **SSL:** Person's CIRTSS Record > Plans and Assessments > Add New Plan > Service Type – *Choose the applicable SSL service type* > Plan Name - *select ISP - Shared and Supported Living* > Complete as per plan and attach document.
- All ISP forms, associated plans and related documents must also be saved in the client's CIRTSS/CRM record. Any previous ISP documentation is required to be finalised prior to new ISP documents being uploaded.
- Ensure, where possible (and if there is a safe, easy to access place it can be stored), that the ISP is printed and a copy maintained where the person resides or receives Lifestyle Supports. Provide a copy to the person we support if they would like a copy.
- Ensure all staff read the person's ISP and understand their responsibilities in supporting the person to achieve their goals and delivering support the way the person wants it.

Monitoring and interim Reviews of ISP



The Disability Support Leader will:


- Ensure all Disability Support Workers (DSWs) contribute towards continuously improving the way a person is supported to achieve their goals by recording progress, learnings and new ideas, as follows:

CIRTSS Progress Notes (as needed)

- Complete CIRTSS Progress Notes when support has been provided relating to a goal/progress is made towards achieving a goal.
 - **LS:** Use the subject category of ISP LS Goal Support
 - **SSL:** Use the subject category of ISP SSL Goal Support

ISP Goal Support Record Template (as needed, or at least every three months for LS and at least once a month for SSL)

- Review all CIRTSS Progress Notes with the Subject Category ISP LS Goal Support or ISP SSL Goal Support, as well as any relevant iReport incidents. This will assist with reviewing the person's progress towards achieving their goal over time.
- Have a discussion with the person, and their support network, about how they feel they're going with their ISP goals to highlight progress or barriers

	<p>for any goals. Record this discussion on the NDIS LWB 5005 ISP Goal Support Record – Template, capturing:</p> <ul style="list-style-type: none"> - A full list of the person's goals - the activities the person participated in - any progress (what worked, what didn't work, what needs to change or stay the same) - barriers to achieving a goal or new risks that have presented - whether the person would like to review their goal/s (this may involve removing or adding goals to the person's list). <ul style="list-style-type: none"> • Attach the completed template to a CIRTSS Progress Note, as follows: <ul style="list-style-type: none"> - LS: Progress Notes > Add New Progress Note > Subject Category: ISP LS Goal Support > Subject – Goal Support Record - SSL: Progress Notes > Add New Progress Note > Subject Category: ISP SSL Goal Support > Subject – Goal Support Record
<p>Annual Review</p> 	<p>The Disability Support Leader will:</p> <ul style="list-style-type: none"> • Ensure that the ISP is reviewed with the person and their support network at least annually, if the person requests a review, or if any of the following circumstances occur: <ul style="list-style-type: none"> - the person has achieved the goal - the person has become disengaged with the goal - the person expresses a desire for a review - the complexity or level of risk involved in the goal needs regular review - the goal includes tight/specific timeframes, which must be observed - feedback is received about required changes - the person has cancelled related supports being delivered by LWB - the person has made a complaint • Complete the annual review 16 weeks prior to the Service Agreement ending for people receiving SSL support and 8 weeks prior to the Service Agreement ending for people receiving LS support. (For people with NDIS plans spanning beyond a 12-month period, the ISP should be reviewed prior to the 12-month anniversary, with goals to be extended if relevant and new goals to be identified with the person and their Support Network.) • Ensure the review is thorough, and identifies what's not working, what has worked well, any preferences that have changed, goals that have been achieved, further supports required, goals that are no longer of interest and what supports will be required for the coming year. • Save to CIRTSS as follows: Person's CIRTSS Record > Plans and Assessments > Open plan that review relates to > Add New Review > Complete fields and attached document.