Washington State Department of Social & Health Services

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: INDIVIDUAL INSTRUCTION AND SUPPORT PLAN (IISP) AND RISK SUMMARY — POLICY 5.08

Authority: Chapter 71A RCW — *Developmental Disabilities*
Chapter 388-101 WAC — *Certified Community Residential Services and Support*

PURPOSE

This policy establishes the requirements for the Developmental Disabilities Administration (DDA) Individual Instruction and Support Plans (IISP) and the Risk Summary developed and maintained by the service provider. The IISP is the primary document that describes how habilitation and support will be provided in a way that promotes the benefits outlined in the *DDA Residential Guidelines* and is based on the client's preferences and assessed needs identified in the DDA Individual Support Plan (ISP). Service provider staff are expected to use the IISP to guide their service delivery. The Risk Summary is a one page document which is intended to provide staff with a synopsis of crucial information regarding safeguards in place for protection and may also include other important information.

SCOPE

This policy applies to the following DDA contracted residential service programs:

For adults:
- Supported Living (SL)
- Group Homes (GH)
- Group Training Homes (GTH)
- State Operated Living Alternatives (SOLA)

For children:
- State Operated Living Alternatives (SOLA)

DEFINITIONS

Goals mean what the person has identified, with the assistance of their support team, that they want to accomplish with the supports provided by the agency.

Habilitation means those services delivered by residential services providers intended to assist persons with developmental disabilities acquire, retain, and/or improve upon the self-help, socialization and/or adaptive skills necessary to reside successfully in home and community-based settings.

ISP means the person-centered services plan (Individual Support Plan) developed by the DDA Case Manager, the client, their legal representative and all service providers.

IISP means the Individual Instruction and Support Plan which describes how staff will provide habilitation and supports to meet the needs identified in the DDA ISP which are assigned to and agreed upon by the residential service provider.

Instruction means an active process of teaching a particular skill or subject in an attempt to move towards greater independence and /or maintain current skills and abilities.

Support means the implementation of services provided to meet assessed needs.

POLICY

A. Residential service providers must provide client services in a manner emphasizing instruction and support that work towards increased independence and community integration and/or maintaining skills and abilities.

B. Residential service providers are responsible to develop a written Individual Instruction and Support Plan (IISP) for each client supported by the agency describing the specific ways in which staff will provide assigned instruction and support as described in the DDA ISP.

C. At least every six (6) months, the data from goal progress will be reviewed. The IISP will be revised if needed in order to reflect current supports, goals and preferences. The summary of goal progress and revised goals (if applicable) will be sent to the case manager for review.

PROCEDURES

A. As part of the DDA assessment process, goals and supports will be identified. Residential service providers will review, contribute, and make change recommendations if needed. If the service provider is not a participant at the meeting, the service provider

will be given an opportunity to review the ISP and make possible changes to services assigned to the residential service provider prior to signing.

B. Residential service providers must develop an Individual Instruction and Support Plan (IISP) for each client supported by the agency per Chapter 388-101 WAC. The IISP must include the required elements as described in this policy or indicate within the IISP where in the client records this information is found. In addition to the IISP, residential service providers must also develop and maintain a Risk Summary.

1. A one-page Risk Summary and a current IISP must be available to staff when working with a client. The entire IISP must be kept in the client's home either electronically or in hard copy. When records are kept electronically, the Risk Summary must be kept in hard copy format in the client's home at all times.

2. For clients new to an agency, a draft IISP must be completed within thirty (30) days of the client receiving services from the agency. The provider has an additional sixty (60) days to finalize the IISP.

3. The IISP must include documentation of the participation and written agreement of the client and their legal representative (if any).

4. The IISP must include the date developed or revised, and the name and signature of the person who prepared the plan.

5. The IISP must be reviewed at least every six (6) months and updated as necessary, as the client's assessed needs change, as goals are achieved, and when requested by the client and/or their legal representative.

6. The IISP must be provided to the client, legal representative (if applicable), and case manager.

7. Service providers may use their own format as long as the Risk Summary and IISP contain all information described in this policy. The template provided as Attachment A *(IISP Template)* meets all requirements of this policy and may be used. Attachment B *(Risk Summary Template*) may be used in lieu of or in addition to the IISP Template to meet the Risk Summary requirement.

C. Contents of the IISP

1. General information including:

a. The client's first and last name;

b. The client's likes (preferences) and dislikes;

c. The client's skills and abilities;

d. The client's communication style and/or styles of communication which staff should use to be effective with the client;

e. Client agreement to the IISP and/or the legal representative's name (if applicable) and written agreement to the plan;

f. The date of the DDA Assessment meeting on which the IISP was based;

g. A list the individuals who participated in the IISP development (whether verbally or in writing);

h. A summary of relevant history; and

i. Date the IISP was developed or revised.

2. An Assessment of known risks and strategies or protocols in place:

a. Each of these areas must be reviewed and documented, or state that no known risks have been identified in the area:

1) Abuse / Neglect / Exploitation
2) Behavioral
3) Environmental
4) Falls
5) Legal
6) Financial
7) Medical
8) Other

b. A "Guide to Assessing Risk" for service providers is an optional tool available on the DDA website for use and reference in completing this review.

c. Considering likelihood and severity, risks that present immediate life threatening danger to the client or others identified in this section must also be documented on the one page Risk Summary.

3. A description of how instruction and support services will be implemented. This should be based on a review of domains of the DDA ISP, adding information of value that clarifies or adds specificity necessary for supporting the client. This does not need to restate all needs identified in the client's DDA ISP.

4. Goals the client wants to accomplish with the habilitative instruction of the service provider.

   a. These goals are typically developed with the person, their legal representative (if any), and others they choose to involve. This can occur during or separate from the DDA ISP meeting.

   b. The service provider uses these goals as a foundation to write measureable objectives defining the process to reach the goal(s) through active instruction and support.

   c. The goal should reflect what the person wants to accomplish (their goal) and what active process the staff will use (habilitation) in order to support the person to accomplish their goal.

      For example: If the person wants to go out to the same coffee shop each day in order to build a friendship with people in the coffee shop, the active process the staff will use could be rehearsal of appropriate greetings, responses, or conversation starters, modeling and reinforcement of appropriate interactions when at the coffee shop.

   d. The documentation should reflect the instruction the staff provided and measure the person's progress on meeting his or her goal.

      For example: Measurable documentation from the example above could be documenting the number of social interactions, the number of people who speak to the person, or the length of conversations at the coffee shop. (Measuring the number of times going to the coffee shop would not measure the person's habilitative progress.)

   e. Clients who are assessed at Support Levels 1 and 2 must have a minimum of two (2) habilitative goals.

   f. Clients who are assessed at Support Levels 3A, 3B, 4, 5 and 6 must have a minimum of three (3) habilitative goals.

   g. The DDA ISP goals assigned to the provider must be identified in the IISP.

   h. Habilitative goals must:

      1) Be specific and measurable;

2) Include goal measurement criteria and a timeline;

3) Specify the active role staff take to support the client to achieve the goal; and

4) Include documentation instructions.

i. Habilitative goals must be revised or changed:

1) When goal is achieved;

2) If the data indicates the instruction is not effective after a reasonable period, but no longer than six (6) months; and

3) When requested by the client and/or their legal representative.

5. Reference to other applicable support and/or service information such as Individual Financial Plan, Functional Assessment, Positive Behavior Support Plan and Cross Systems Crisis Plan.

6. A one-page risk summary document, which must be readily available to staff in the person's home in hard copy that includes, at a minimum:

a. Name;

b. Date written/modified;

c. A recent picture of the person (unless the client objects to this requirement);

d. A summary of risks and interventions for all risks which, considering likelihood and severity, risks that present immediate life threatening danger to the client or others;

e. Any other information staff will need in order to keep the person and others safe;

f. Service providers may use their own format to meet this requirement, or one of the templates provided. The template provided as Attachment A to this policy meets all requirements of this section as a stand-alone document. Attachment B is another method of meeting this requirement and may be used in lieu of or in addition to this IISP template to meet this requirement.

IMPLEMENTATION

IISPs completed after January 1, 2016, must meet the requirements of this policy.

EXCEPTIONS

Any exceptions to this policy must have the prior written approval of the Deputy Assistant Secretary.

SUPERSESSION

None.

Approved: */s/ Donald Clintsman* Date: July 1, 2015
Deputy Assistant Secretary
Developmental Disabilities Administration

Attachment A – IISP Template
Attachment B – Risk Summary Template
Attachment C – IISP Template Instructions

Likes:

Include what is important to the person, what "works", what brings them joy, areas where they excel, what really makes them happy

Person's Name

[Paste Photo here]

Dislikes:

Include things that make the person uncomfortable, that they don't respond well to, that may elicit a negative response, ways of interacting or other things that "don't work"

Risks!

Include all risks that present immediate life threatening danger to the client or others. Include things that should be restricted, supervision protocols, special dietary needs or behavioral triggers and techniques. You may also want to include other things that someone must know when supporting the person, especially those things to protect the safety and well-being of the person or others around them. More detail on risks will be in the risk section; this is a quick summary.

Skills and Abilities:

Include things the person is really good at, types of things they do well, special talents, especially those things that may not be readily apparent.

Communication Style:

Include how the person best communicates (verbally, English, ASL, gesturally; anything someone needs to know to better understand them, and the manner they prefer others to communicate with them; if they use technology, include that, how to use it and what to do if it isn't working.)

Name First and Last Name	ISP date Click here to enter a date.	Date of this IISP Click here to enter a date.
Individuals who participated in IISP development Insert everyone who participated – start with person; be sure to include their guardian (or note that the person and/or guardian was invited to participate and choose not to if did not). Also include any friends, family and staff included in the process. Participation includes people who gave input outside of a formal meeting through written or verbal input (such as completing a survey or over the phone)	Preparer Name insert printed name of plan writer	
Signature of person indicating their agreement with plan Date	Signature of Preparer (writer)	
Legal Decision Maker: ☐ Self ☐ Guardian Choose an item. Click here to enter text. Guardian Signature (if applicable):	Name of Residential Agency Residential Agency Name	

I have several documents and plans that provide my staff with instructions on how best to support me, including things that are important **for** me, as well as things that are important **to** me. All people who support me need to read, understand and follow them.

The Direct Support Professional's role is to actively work with me to support me to grow, develop and have a quality life.

This is what the plans are called and where they can be found:

Check if applicable	**Plan Name**	**Where to find it**
☐	Person Centered Plan (PCP)	
☐	Individual Support Plan (ISP)	
☐	Individual Financial Plan (IFP)	
☐	Functional Assessment (FA)	
☐	Positive Behavior Support Plan (PBSP)	
☐	Cross-Systems Crisis Response Plan (CSCRP)	
☐		

HISTORY – important events in my life**:**

Provide brief narrative of important information from person's history. Especially include information that could provide context, insight or a deeper understanding of who this person is. Alternatively, if the person has a description of their history documented in their Functional Assessment that helps the reader understand the "whole person"; you could refer to that section here instead of repeating it.

Identified Risks and Interventions

	RISK ISSUES – Specific issues or protocols needed to ensure my safety if applicable:
	Abuse / Neglect / Exploitation
Likelihood: ***Choose an item.*** Consequence: ***Choose an item***.	State that no additional direction or explanation needed *OR* Describe particular vulnerabilities and supports / strategies in place to mitigate risk Risks: Interventions:
	Behavioral
Likelihood: ***Choose an item.*** Consequence: ***Choose an item***.	State that no additional direction or explanation needed *OR* Describe particular vulnerabilities and supports / strategies in place to mitigate risk Risks: Interventions:
	Environmental / Specialized Equipment
Likelihood: ***Choose an item.*** Consequence: ***Choose an item***.	State that no additional direction or explanation and no specialized equipment needed *OR* Describe particular modifications to environment, specialized equipment, and any instructions for use or future modifications and supports or other strategies in place to mitigate risk Risks: Equipment: Interventions:
	Falls
Likelihood: ***Choose an item.*** Consequence: ***Choose an item***.	State that no additional direction or explanation needed *OR* Describe particular vulnerabilities and supports / strategies in place to mitigate risk Risks: Interventions:
	Legal
Likelihood: ***Choose an item.*** Consequence: ***Choose an item***.	State that no additional direction or explanation needed *OR* Describe particular vulnerabilities and supports / strategies in place to mitigate risk Risks: Interventions:
	Financial
Likelihood: ***Choose an item.*** Consequence: ***Choose an item***.	State that no additional direction or explanation needed *OR* Describe particular vulnerabilities and supports / strategies in place to mitigate risk Risks: Interventions:
	Medical (including allergies, skin integrity)
Likelihood: ***Choose an item.*** Consequence: ***Choose an item***.	State that no additional direction or explanation needed *OR* Describe particular vulnerabilities and supports / strategies in place to mitigate risk Risks: Interventions:
	Other
Likelihood: ***Choose an item.*** Consequence: ***Choose an item***.	State that no additional direction or explanation needed *OR* Describe particular vulnerabilities and supports / strategies in place to mitigate risk for any area not captured above Risks: Interventions:

Instruction and Support Service Implementation

My ISP identifies my assessed needs and who is responsible to meet those needs ***– please be sure you have read and understand my ISP***. In some cases, it is very straightforward or there is nothing in an area for which I need your support. In some areas more explanation is needed so you know my unique preferences, ways to best support me, how to provide instruction, or the specific modifications, technology or adaptations to support my needs. That information is below:

INSTRUCTION AND SUPPORT DETAILS – going beyond the ISP:	
Home Living	
Choose an item.	Click here to enter text.
Community Living	
Choose an item.	Click here to enter text.
Lifelong Learning	
Choose an item.	Click here to enter text.
Employment Activities	
Choose an item.	Click here to enter text.
Health and Safety	
Choose an item.	Click here to enter text.
Social Activities	
Choose an item.	Click here to enter text.
Protection and Advocacy	
Choose an item.	Click here to enter text.
Medical Supports	
Choose an item.	Click here to enter text.
Behavior Supports	
Choose an item.	Click here to enter text.

Habilitative Goals

Name	Goal Revision date	Goal#

Residential Guideline Value(s) This goal works toward (check all that apply):

☐ Competence ☐ Health and Safety ☐ Integration (Community) ☐ Relationships ☐ Power and Choice ☐ Status

Goal		
Current Baseline	**Measurement**	**By When?**
Staff Instructions		**Documentation**
Criteria and timeline for revision		

Date of Review	Goal Progress	Summary of Goal Progress	Changes made (if any)	Printed Name and Signature of Reviewer
	☐ Occurring as expected ☐ Not occurring as expected			
	☐ Occurring as expected ☐ Not occurring as expected			
	☐ Occurring as expected ☐ Not occurring as expected			
	☐ Occurring as expected ☐ Not occurring as expected			

Habilitative Goals

Name	Goal Revision date	Goal #

Residential Guideline Value(s) This goal works toward (check all that apply):

☐ **Competence** ☐ **Health and Safety** ☐ **Integration (Community)** ☐ **Relationships**
☐ **Power and Choice** ☐ **Status**

Goal		
Current Baseline	**Measurement**	**By When?**
Staff Instructions		**Documentation**
Criteria and timeline for revision		

Date of Review	Goal Progress	Summary of Goal Progress	Changes made (if any)	Printed Name and Signature of Reviewer
	☐ Occurring as expected ☐ Not occurring as expected			
	☐ Occurring as expected ☐ Not occurring as expected			
	☐ Occurring as expected ☐ Not occurring as expected			
	☐ Occurring as expected ☐ Not occurring as expected			

Habilitative Goals

Name	Goal Revision date	Goal #
Residential Guideline Value(s) This goal works toward (check all that apply): ☐ **Competence** ☐ **Health and Safety** ☐ **Integration (Community)** ☐ **Relationships** ☐ **Power and Choice** ☐ **Status**		

Goal		
Current Baseline	**Measurement**	**By When?**
Staff Instructions		**Documentation**
Criteria and timeline for revision		

Date of Review	Goal Progress	Summary of Goal Progress	Changes made (if any)	Printed Name and Signature of Reviewer
	☐ Occurring as expected ☐ Not occurring as expected			
	☐ Occurring as expected ☐ Not occurring as expected			
	☐ Occurring as expected ☐ Not occurring as expected			
	☐ Occurring as expected ☐ Not occurring as expected			

Risk Summary

Recent Photo

Name: Click here to enter text.

Date revised: Click here to enter a date.

This form is a summary of information from the IISP and should be accessible in hard copy to staff in order to promote awareness of risk which require ongoing caution / action of the staff. Considering likelihood and severity, the form includes risks that present immediate life threatening danger to the client or others. This form can be edited and modified to capture and convey the information in a usable format.

Rating (Highlight One)		Score	Risk Category	Details/Comments
Moderate	HIGH	6	Falls	Click here to enter text.
Moderate	HIGH	Choose an item.	Choose an item.	Click here to enter text.
Moderate	HIGH	Choose an item.	Choose an item.	Click here to enter text.
Moderate	HIGH	Choose an item.	Choose an item.	Click here to enter text.
Moderate	HIGH	Choose an item.	Choose an item.	Click here to enter text.
Moderate	HIGH	Choose an item.	Choose an item.	Click here to enter text.
Moderate	HIGH	Choose an item.	Choose an item.	Click here to enter text.
Moderate	HIGH	Choose an item.	Choose an item.	Click here to enter text.

Emergency Agency Contact Numbers:

Agency On-Call Number:

Supervisor Number:

Agency Plan / Personal Support Plan

_____

_____

_____

_____

_____

_____

Completed by: _____

Signature: _____

IISP Template Instructions

The IISP Template as a whole has been designed as a guide to meet the required elements in DDA Individual Instruction and Support Plan Policy. One of the important elements of this plan is getting a "snapshot" of the person – things that matter to them, that they want the people who work with them to know, and/or that are essential for others to know in order to support them. The best way to find out the information is to spend time with the person and others who know them really well and ask them, as well as use observations and check them out (for example – you do a lot of puzzles, what do you like about them?). You can be creative with pictures, expand or contract areas to better fit the information, or take other creative liberties to be reflective of a true person-centered plan.

Page 1 of the IISP (this first page can also be used as the "one-page risk summary"):

Likes:
Include what is important to the person, what "works", what brings them joy, areas where they excel, what really makes them happy.

Dislikes:
Include things that make the person uncomfortable, that they don't respond well to, that may elicit a negative response, ways of interacting or other things that "don't work".

RISKS!:
This section is required to include all risks that present immediate life threatening danger to the client or others. Include things that should be restricted, supervision protocols, special dietary needs or behavioral triggers and techniques. It may also other things that someone must know when supporting the person – especially those things to protect the safety and well-being of the person or others around them. More detail on risks will be in the risk section - this is a quick summary.

Skills and Abilities:
Include things the person is really good at, types of things they do well, special talents, especially those things that may not be readily apparent.

Communication Style:
Include how the person best communicates (verbally, English, ASL, gesturally; anything someone needs to know to better understand them, and the manner they prefer others to communicate with them; if they use technology – include that, how to use it and what to do if it isn't working.

Date: Use the footer to include the date, or add a date somewhere on the first page.

Note:

During Peer Mentoring Curriculum, staff will get instruction on finding information that would go onto a one-page document and be given time and the assignment to complete one with a person with whom they work. This page of the instructions along with the notes below will be used in this course.

You should check in with the person before finalizing the plan to be sure that it is accurate.

After you have finished the "one page", share it with your supervisor or the person who writes / updates plans in your agency (if that is not you). They may want to use in updating the person's plan or suggest changes that have come from previous person-centered efforts.

Page 2 IISP Instructions

Name: Use the person's legal first and last name, and include a name they prefer to go by if applicable – for example: John (Jack) Johanssen or Bonnie June (BJ) Smith.

ISP Date: The IISP should always be based on the current information in the ISP. This means if the ISP is revised, the IISP must also be revised. Use the ISP meeting date. You do not need to wait until you receive the finalized copy of the ISP in order to write or revise the IISP; since you will be participating in the meeting the information should be consistent. If you finalize the IISP prior to receiving the ISP, you should compare the plans to ensure that you haven't missed anything and make any final updates needed.

Date of this IISP: You can use the date the IISP is written. If writing the IISP occurs over a long period of time, you may want to change this date to the date it was finalized and printed. You do not need to wait for approval signatures to implement the plan. Remember that this plan is intended for staff use – so having it available to staff and an acknowledgement that staff have read and/or been trained to the plan / updated plan is important. There should be as little time as possible between the planning meeting(s), writing the plan, obtaining required signatures (ok to implement without signatures), having the plan available, and ensuring the staff are familiar with the plan / aware of their responsibilities in implementing the plan.

Individuals who participated in IISP development: This list includes people who attended a meeting (if any), and those who were interviewed, gave verbal or written input to the IISP topics. The person should always be a participant in IISP development, even if they choose not to participate in a formal meeting; their input is essential to having the plan be person-centered. If the person has a legal guardian, they also must be invited and encouraged to participate. If they choose not to participate, document the attempt to include them. Be sure that when deciding who is asked to participate that the person supported has the opportunity to involve anyone they choose to involve.

Preparer Name / Signature of Preparer: This should be the name of the person who is physically writing or ultimately editing and approving the plan. The signature of writer is required by WAC 388-101-3480.

Signature of person indicating their agreement with plan / Date: WAC 388-101-3480 requires: "Document the client's agreement with the plan as well as the client's legal representative if applicable".

Legal Decision Maker: Check "Self" if person is their own decision maker; no other action required. If person has a Guardian; choose that box and enter their name. Obtain their signature if possible. The WAC requires documentation of their agreement; you may meet this requirement through another written form such as printed email confirmation.

Name of Residential Agency: Include the name of your agency here. You can include a logo.

Table referring to other plans: This is not a requirement of the IISP if the IISP is a complete stand-alone document. If you refer to other plans within the IISP, then you must use this table or

a similar tool to reference where staff can find the documents. Add / change plans and rows as needed to make this section applicable.

History: If the person has a Functional Assessment with a history section that gives a complete picture of the whole person (not just of their challenging behaviors), you can refer to that section instead of repeating it here. If you choose to repeat the history or portions of it; then be sure you are consistent and updates get made in both documents. This history should be a brief picture of important aspects and events of the person's life and give staff context of the person's life experiences and events have occurred in the past that could be helpful in supporting the person.

Identified Risks and Interventions IISP Instructions

First, fully review the person's ISP and any other information which you have available to consider potential risks and appropriate interventions to mitigate those risks. For additional guidance on things to consider and how to assess risk; refer to the Guide to Assessing Risk which is available on the DDA website.

For each topic in this section:

1. Select the most appropriate "Likelihood" from drop-down menu. You are anticipating how likely is it that this risk will occur / present itself. The choices are: rare, unlikely, possible, likely, and almost certain.
2. Select the most appropriate "Consequence" from the drop-down menu. Here you are indicating *if* the risk occurs – how bad it would be. The choices are: negligible, minor, moderate, major and catastrophic.
3. If there is no specifically assessed risk, the categories selected would typically be "rare" and/or "negligible" selections for likelihood and consequence. In these cases, there may be no additional direction or explanation needed and you can simply note that in the appropriate section(s). Be sure you note this to show you have considered the risks rather than leaving a section blank.
4. When there is assessed risk; the risk(s) should be listed and then the Intervention(s). Add additional rows to the table as needed / desired if there are several risks that fall into a category. Provide enough detail to alert the person to immediate interventions. Refer to plans that give greater detail when they exist. An example of this would be when there is a risk of the person harming themselves by ingesting chemicals, so many household items are locked up. You would include the risk and interventions (locking chemicals) here, however you would also reference their PBSP / FA / Restrictive Procedures Plan / Special protocols as appropriate.
5. Equipment could be used in any of the categories, but is specifically added as a prompt in the Environmental / Specialized Equipment section in order to ensure it is considered.

Note: This section should be updated immediately if there are any additional risks and/or interventions identified

Instruction and Support Service Implementation Instructions

This section corresponds to the domains in the ISP which describe the person's assessed level of needs for type and frequency of support in a number of areas within each of the domains. The ISP includes assessment of what type of support the person would need *if* they were to do something (such as work) that doesn't apply currently. If it is not clear from the ISP, you can clarify which supports are not being provided as well as those that are. It is not necessary to include each sub-category under the domains; however you can choose to do so.

Depending on the level of detail included in the ISP and the complexity of supports within a domain, you may need to:

- Provide extensive information about how staff support the person's needs, including specific information and/or strategies to use in that support

- Provide some information and refer to where staff would find additional detailed information (such as a seizure protocol, activity calendar, or PBS Plan
- Provide some general information such as strategies to support the person or details about the way in which they prefer to be supported as it relates to a particular area (such as that staff should always talk to Mary and let her know what they are going to do prior to providing hands-on personal care)
- Provide information about how instruction should be provided in areas that aren't a focus of the goals which will be measured, but have specific detail about the way in which instruction should be provided and/or documented
- Note that there is no additional instruction needed in the area and refer to the ISP

When determining whether to repeat information or refer to a plan, consider how much detail is needed, what will be the most accessible way for staff to obtain needed information, and how to ensure plans remain consistent and current.

Habilitative Goal Instructions

Copy additional Goal pages as needed to have a page for each of the goals. Refer to policy for minimum amount of goals. While there is no maximum on goals; ensure that there aren't too many goals at one time to give the proper amount of time and attention to goal accomplishment.

Name: Include First and Last name

Goal Revision Date: Write date goal is either initially written, or date that the goal is updated within this template.

Goal #: Select from drop-down menu (#1-6), or you can choose another means to quickly identify this goal (such as a key word or numbering system that works with documentation systems in place) and replace the drop-down category.

Goal: Describe the goal in person-centered, specific, and measurable terms. Starting with the person's name is typically a good way to ensure the goal is written for the person, not for the staff ("Jack will…" or "BJ will…." not "staff will…"). In some cases, the goal will restate the person's goal and/or and be very apparent how it connects with something important to them. In some cases, you may need to be more explicit as to how the short-term goal connects with a long-term goal. When that is the case, be sure to include this information in the goal description.

Some examples:

- Mary will lose 25 pounds in order to reach her goal of fitting into her blue dress.

- Jack will safely access the community without staff at least 3 times per week for 30 minutes or more.

Current Baseline: This should describe the current measurement for the goal. It should be in the same terms as the measurement goal; see below for examples. It is not necessary to establish a *scientific* baseline; if needed, use an estimate. Do not delay goal implementation to establish a baseline. If you have no starting point, you can write the measurement goal in terms of change in measurement instead of absolute (for example: a 25% improvement, a 30% decrease).

Measurement: Look for the most natural and accurate way to measure goal achievement. If you are unsure, ask more questions about what it will look like when the goal is achieved; how will you know when you are successful? Examples of measurements: duration, frequency, weight, blood pressure, glucose levels, currency, percentage of completion, success rate, type or amount of supports needed, self-rated survey, number of times something occurs, number of days in a hospital, number of incidents. In this section, document the measurement that you are working to achieve.

NOTE: You should be measuring the person's goal progress; not the actions the staff are taking.

By When: Specify when you are expecting to achieve the measurement in previous section. Typically, this should be no longer than six months since that is the minimal amount of time for goal review. The goal may be worked on much longer than six months with the goal is set in increments with shorter-term goals to be reached over each consecutive time period.

Staff Instruction: In this section, describe exactly how the staff support this goal; what steps they follow and what strategies they use. There MUST be an active role for staff in the IISP goal; this is meant to describe goals that the person is receiving supports to achieve.

NOTE: If the person does not need any support with this goal and staff are only measuring progress, then they are not providing habilitation support for the goal.

Documentation: Specify where, how, and when staff should document this goal. Ensure that the documentation method supports measurement of the goal. Narrative format is typically not effective for goal documentation.

Criteria and timeline for revision: Describe when the goal will be revised. The minimum is every six months and when requested by the person or their guardian. You should also revise when the goal is achieved. Consider how often you will review the goal (to know if it has been achieved or needs to be revised). Also consider if you should review the goal after a specific length of time, at milestone measurements or a certain number of refusals to work on goal.

Revision Table: This section can be used to document the goal review and reflect minor changes in the goal. When a goal is discontinued, it should be noted on this form and kept as a part of the person's record. When there are major changes to the goal, it is generally advisable to re-write the goal. That can be noted here and a new goal page created. Other methods of goal review can be used in place of this table.