

## **MODULE 5 DSP NOTEBOOK**



# INDIVIDUAL SERVICE PLAN DEVELOPMENT AND IMPLEMENTATION

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## INTRODUCTION

"My name is April. This year I ran my own ISP meeting by myself. To get ready for the meeting I told my staff at my house what was important to me and they made a list for me. I told staff the most important things first.

We talked about me moving to a new house. This was most important to me. I invited people to my meeting. I told my house manager that I wanted to have food at my meeting so he brought some. I was a little shy at first but then I told everyone what I wanted."

Submitted by April, self-advocate from Chicago Heights, IL



## What is the Individual Service Plan (ISP)?

The Individual Service Plan (ISP) is the written details of the supports, activities, and resources required for the individual to achieve personal goals. The Individual Service Plan is developed to articulate decisions and agreements made during a person-centered process of planning and information gathering. The general welfare and personal preferences of the individual are the key consideration in the development of all plans.

The individual and his/her team are responsible for developing the individual plan of support. These teams, called interdisciplinary teams (IDT), are composed of people who care about and know the individual. The team may also ask specialists, consultants, or specific provider staff to contribute to the plan by completing evaluations, or by observing and collecting information that is basic to the preparation of the plan.



The IDT is ultimately responsible for assessing and documenting each person's:

- Personal choices and preferences.
- Significant health care, mental health or behavioral needs and related maintenance needs.
- Safety and financial skills.

The teams translate this information into goals and objectives, which are then contained within the written plan. The plan results in outcomes that maintain or change services or supports to reflect what is most important to and most important for the individual in their daily life.

Service plans could be known as:

<b>IPP</b> s' Individual	 Plans

- ISPs' Individual \_\_\_\_\_ Plans
- IHPs' Individual \_\_\_\_\_ Plans
- IEPs' Individual \_\_\_\_\_ Plans

These are probably the most common names for service plans.

## **Description of Individual Service Plan for Adults**

Although each agency has its own ISP format, there are some basic elements and information contained in almost all plans as listed in the **Appendix** of this Module.

Note: Because of their highly individualized nature, not all service plans contain all the components listed. Some plans may have additional information not listed in the Appendix.

#### Life Goals

Individual Service Plans should reflect the goals of the individual served. Because we are all different and unique people, each person's ISP should be unique and address the needs and desires of the person.



To begin the process, we must first learn how a person **wants** to live. In your role as a DSP, you can continually encourage people to experience new things. This enables the person to exercise greater choice in life because they have the experience to do so. After we learn what a person wants, we can then decide what needs to be done to help the person move toward that life.

Good plans are rooted in what is important to the person, while taking into account all the other factors that impact the person's life.

#### Life Changes

Just as people change, service plans need to be revised to reflect growth, new interests and desires. Service plans are reviewed a minimum of once per year at Individual Service Plan meetings. Sometimes these meetings are called *annuals*.

More and more, agencies are getting away from that practice and holding meetings to discuss these plans on an *as needed basis*.

In a year's time, much in your own life changes. This includes developing new interests and desires, changing where you live or work, who your friends are, etc.

## Activity:

On a separate piece of paper, list the changes that have taken place in your own life in the past year. Include interests, dreams, goals, relationships, births, deaths, etc. Then we will discuss how you would feel if you had to wait for an annual meeting to make adjustments to your plans.

## **ISP Scavenger Hunt**

**Directions:** Work with your assigned group to find the answer to as many of the following questions as possible.

1. Where is the following information found in the ISP? Use page number(s) to indicate the location(s). **Note** - it may be in more than one location.

Assessment results	Personal Preferences	
Background/Historical	Personal Rights	
Communication Style	Personal Values	
Education	Personality	
Financial	Recent Life Changes	
Goals	Social Relationships	
Interests & Activities	Strengths & Weaknesses	
Learning Style	Vision for the Future/dreams	
Medical/Dental/Nutritional	Vocation	
Personal Description		

- 2. How does this person communicate?
- 3. List one of this individual's favorite activities.
- 4. List one of this individual's goals.
- 5. How will this goal be achieved?
- 6. When is this goal to be met?
- 7. What responsibility do you as a DSP have in supporting the individual in achieving this goal?
- 8. Does this person have a behavior management (intervention) plan? If so, what is

your role in implementing it?

- 9. What is this individual's current medical condition? What can you do to support his/her health?
- 10. Name a recent life change.
- 11. List five things below that you would like to know more about in order to provide support to this individual:
  - 1.
  - 2.
  - \_\_\_
  - 3.
  - 4.
  - 5.

## What Makes A Good Service Plan?

How do you know that the ISP you just reviewed is an accurate reflection of the person? Things to check for:

- It was unique to this individual
- Focused on abilities
- Showed the person's choices and preferences
- Was respectful
- People significant to the individual were involved
- Identified social connection
- Maintained confidentiality
- Hopes/Dreams/Goals are a priority to the individual
- Hopes/Dreams/Goals are realistic
- Hopes/Dreams/Goals are precise & measurable
- Hopes/Dreams/Goals state how they are to be met

The plan should include a personalized statement of the person's expectations for the future and state who will be responsible for providing the supports and services to reach those goals. Additionally, the plan should address natural supports and connections for people with other citizens of the community.





## What is the IDT?

The Interdisciplinary Team (IDT) consists of at least the person, parents (except when the person or the person's guardian does not desire them to participate), the guardian, as well as representatives of disciplines and services necessary to identify the person's needs and to design services and alternatives to meet them. At least one member of the team must be a Qualified Intellectual Disabilities Professional (QIDP).

The IDT process assesses the strengths and needs of persons with mental disabilities with input from the person requesting and/or receiving services and from those providing services. The IDT works to develop and implement the person's service plan.

## Who Makes Up the Interdisciplinary Team?

A number of people are involved in developing the ISP. The most important member of the team is the person being served and there should never be a meeting without the

person. Its primary purpose is to assist the individual with developmental disabilities in making decisions about life goals.

#### **Members:**

#### The **person supported** and

the team of **professionals**, who usually include the following:

- QIDP
- Psychologist/Psychiatrist
- Social Worker
- Doctor/Nurse
- DSP
- Nutritionist
- OT/PT
- Teacher
- Residential Representative
- Day Program Representative
- Vocational Rep/Job Coach

*Note: It is usually the DSP who works most closely with the person being supported. Your role is vital to the team.* 

#### Non-Professionals

- Friends
- Family
- Guardians
- Co-Workers





## The DSP's Role in the Interdisciplinary Team Process (IDT)

Your role with the IDT is to assist the QIDP in determining the best course of action for the persons you will be supporting. How will you do that? By getting to know the persons you support and learning their likes and dislikes, documenting your observations, and making recommendations about what you think should be included in their plans. You may be asked to document certain behaviors. It will be up to you to report your observations about the wants and needs of the person. Others can then develop a plan, with the person's input, to meet their wants and needs in order to support change in the person's behavior. This is not an easy job.

How will you know what supports are needed by the persons with whom you will be assisting? First, build a relationship with them and get to know them as a person. In order to do this it is very important to understand that you need to listen to people objectively, without judgment. This is essential to the service planning process. In fact, one of the most important roles of the DSP is the day-to-day getting to know the people they support and what they want, then representing that to other members of the team.

#### Remember, your role is vital in developing and implementing the ISP.

When implementing the ISP it is important that you...

- **Be Consistent** Lack of consistency leads to confusion.
- Offer a sufficient number of trials Individuals may need a lot of practice to attain their goals. Look for opportunities to practice and reinforce learning in natural settings and across environments. (E.g., Spending and counting money at Wal-Mart; using a napkin at McDonalds; etc.)
- **Understand the ISP** You need to understand your role in each area of the ISP.
- **Implement the ISP in positive manner** Offer praise and encourage the individual using positive body language and tone. Treat the individual with dignity and in a non-condescending manner. Explain rather than demand or threaten. Support the individual in achieving his/her goals.
- **Document all required behaviors, successes and concerns related to the ISP** – The ISP is constantly changing to meet the needs, goals and desires of the individual for whom it is written. Documentation will help identify those areas that need adjustment.

*NOTE:* Be sure to communicate with your supervisor when a goal is not working, or you are having a difficult time with the implementation of a goal.

## **Family Involvement**

Don't underestimate the importance of family involvement. Family members can provide a wealth of information useful in the planning process. Also, they act as a natural support system for the individual and give meaning to his/her life. We should respect and use them as resources.



At times, family members may not acknowledge their relatives as adults or may resist implementing portions of the service plan. The more involvement they have in the planning process, the less likely this will be a concern for them.

Your responsibilities include helping family members:

- see their relative as a person with dreams, hopes, and skills;
- understand the individual's strengths aptitudes, and competencies;
- identify how they can serve as resources and supports for the individual's active participation in community life; and
- respect the person's life goals and achievements.

People should be selected for the team based on their expertise, interest, connection, and respect for the person for whom the planning is intended.

Information from the team members can be in the form of assessments, reports, anecdotes or test results.

## The person with a developmental disability is by far the most important member of the IDT.

## What Is Person-Centered Planning?

**Person-Centered Planning** is a set of approaches designed to assist someone to plan their life and supports. It is used most often as a life planning model to enable individuals with disabilities, or otherwise requiring support to increase their personal self-determination and improve their own independence.

It is important to remember that a person-centered plan is a means *not* an end. The

person-centered plan is a process, not a piece of paper. The life that a person wants is the outcome, **not** the plan that describes it. Person-centered planning is a written planning tool giving a description of where the person wants their life to go and what needs to be done to get there.

We've talked a bit about what person-centered planning is, but sometimes knowing what it *isn't* makes things even clearer. A person-centered plan *isn't*.

- Stagnant (it must be revisited and re-evaluated)
- Limited to available services
- ✤ Unrealistic
- ✤ A written plan, separate from a process
- ✤ A mystical quick or easy process.

Person-centered planning involves: keeping the focus on the **person** and his/her abilities. Person-centered planning means **individually** tailoring things for the person.

It starts with the person at the center and grows outward. It utilizes available **resources** to assist the person in obtaining his/her goals and objectives. It incorporates what is important to the person. It focuses on the **strengths** of the person, not the person's deficits or limitations or those of the system.

At all times we should demonstrate **<u>respect</u>** and **<u>dignity</u>** in all that we do to support a person with a developmental disability. `This includes protecting the person's **<u>confidentiality</u>**.



## **QUIZ - What Is Person-Centered Planning?**

(Fill in the blanks with the information from the previous page.)

#### **Person-centered planning involves:**

- keeping the focus always on the \_\_\_\_\_ and his/her abilities.
- \_\_\_\_\_\_ tailoring things to the person.
- planning for the person utilizing available \_\_\_\_\_\_ to assist the person in obtaining his/her goals and objectives.
- incorporating what is important to the person. It focuses on the \_\_\_\_\_\_ of a person, not the deficits or limitations, nor those of the system.
- demonstrating \_\_\_\_\_\_ and \_\_\_\_\_ in all that we do to support a person with a developmental disability.
- protecting the person's \_\_\_\_\_\_.

Remember what we learned about **people first language**. The way we speak shows respect or a lack of respect for an individual. We should focus on an individual's strengths, not their problems. Our words should reflect this focus. The ISP should also reflect this and be written in people first language.

## Individual First, Disability Last!



## Definitions

**Age-appropriate** - programs, possessions, settings and activities which are appropriate for a person's chronological age. Age Appropriate Activities include:

- Preparing Meals
- Reading newspaper
- Completing crossword
- Playing checkers
- Listening to music

**Choice** - exposing the individual to an assortment of experiences that could serve as a basis for decision making. (John is given a chance to taste whole wheat bread as well as white bread and then make a choice.)

**Preference** - an individual's personal choice after being exposed to an assortment of things or experiences. (John indicates he prefers whole wheat bread to white bread. How does he know? Because he has tasted both.)



## **Natural Rhythm of Life**

In our society the majority of people typically go to work or school during the week with weekend activities more relaxed and focused on leisure and social activities. For most people, this is the natural rhythm of life. People with disabilities should be offered the same conditions as are offered to other citizens to live as normal a life as possible. Rhythm of life includes natural rhythm of a day, a week, a year and the life cycle itself. Included in this natural rhythm of life are certain life conditions such as housing, employment, exercise, recreation and freedom of choice.

#### As part of this natural rhythm of life, people with disabilities should be:

- Enjoying meals with others in restaurants and at picnics
- Working in regular industries
- Supported in regular homes and apartments
- Seen moving almost everywhere in our neighborhoods
- Worshipping in regular churches, synagogues, and mosques
- Cheering for their favorite local athletic teams
- Going on vacations to break up routines

## **Community Inclusion**

Community inclusion is an integrated setting where people of all abilities and backgrounds work, live, go to school, or play together. Community inclusion includes at least six components: Presence, choice, competence, respect, participation and belonging.

**Presence** - Persons participate in all settings where people without disabilities are present, including classrooms, planning meetings, businesses, neighborhoods, and community events.

**Choice** - Persons will have multiple life experiences from which to draw. These various experiences will help him/her make decisions on what activities he/she wants to participate in as well as choose who will participate with them in those activities.



**Competence** - Persons are recognized for their strengths, contributions and, thus, have additional opportunities from which to learn.

**Respect and Valued Roles:** People are seen as a person--as well as a being valued by others, not seen as a bother.

**Participation** – Persons engaging with others, having a wide variety of relationships, being known and knowing others, being part of the event--not just an observer.

**Belonging** – People's feelings are valued by others. For example, when others call just to talk or invite him/her to go to a party, out to eat, to the movies, or to just "hang out."

#### **Inclusion is NOT:**

- When volunteers spend time with people out of pity or charity.
- "Special" activities or programs only for people with similar disabilities.
- Going on a series of unrelated activities, just to get out.
- Going everywhere (work, shopping, out for a walk) in groups.
- Only going places with other people with similar disabilities.
- Only interacting with people who are paid to take care of you (staff) or people with whom you do not choose to be with.

#### The Benefits of Inclusion

Some of the benefits to persons served and their families include:

- Better health.
- Increased feelings of well-being.
- Psychosocial development
- Improved esteem.
- More opportunities and access to resources.
- The protection of being known by other people. (Others are more likely to report or check on problems and become involved.)
- Greater life experience.
- Greater variety of relationships.
- Incentive to learn appropriate social behavior.



## The Role of the DSP in Supporting Community Inclusion

Residential staff can support inclusion by:

- Offering choices.
- Providing training to develop the person's skills for future inclusionary activities.
- Supporting people's participation at actual community and social events. As much as possible, try to promote people's individual participation in community activities rather than as part of a group. People may have trouble making new friends and being looked at as an individual if they arrive in a group.
- Researching information about community resources and sharing this information with persons served.
- Helping people learn social skills and other skills as needed.
- Analyzing inclusion barriers and helping the person overcome these barriers.
- Using a respectful tone of voice and friendly words when addressing individuals in public.
- Not speaking for or about the person. Problem behaviors should be dealt with as discretely as possible.
- Being prepared for questions about the person's disability. Plan ahead and discuss how the person would like information shared, if at all. Each person has a different "comfort level" regarding privacy. Pay particular attention to, and do your best to support, each person's unique needs and expectations.

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- Trying to help people fit in with others by assisting them in their dressing, grooming and communication skills.
- Making sure the person has the training and skills necessary to become independent. For instance, training the person how to use the bus can pay off in a lifetime of inclusion and freedom from relying on staff for every transportation need.
- Being prepared to advocate for and educate others about the benefits of inclusion.
- Understanding when to get involved and when to stay out of the person's relationships. Instead of sheltering people from potential dangers by isolating them, support staff should help the person manage risks in real and sometimes complex situations.
- Teaching daily living, vocational, and educational skills in natural settings in a functional and empowering way.
- Networking to find contacts and allies in the community who may have information about social or vocational opportunities.
- Developing strategies to minimize persons' risks and barriers and help the person understand the importance of making good choices that will reduce such risk.
- Ask individuals to go with you to any community group speaking engagements you may present at. Individuals can explain what his/her life was like before coming to the community program they participate in and how the program has impacted his/her life.
- Allow individuals to order their own food, etc. when in public.
- Ensure that the people have access to opportunities and education to facilitate building and maintaining relationships.
- Provide information about human, legal, civil rights and other resources and assist individuals to use information for self-advocacy and decision-making about living, working, and social relationships.

#### **Resources Available for Vocational Opportunities**

In your role as DSP, you may be asked to assist with vocational opportunities. DSPs can support people who are seeking vocational opportunities by first helping them research community resources that could provide those vocational opportunities. When these are identified, DSPs can assist with the application process.

Tips for researching community resources:

- Look in the local newspaper or weekly shopper
- Contact the Chamber of Commerce for a list of organizations, groups and clubs and contact those
- Contact the local tourism office
- Look in the yellow pages
- Ask family, friends and co-workers
- Contact the local community education office
- Search the Internet
- Contact the local library
- Contact out the local park and recreation office
- Check out local volunteer agencies
- Check with public schools and colleges





## **Teaching Functional Skills**

*Functional Skills* are those tasks that most people do on a regular basis as part of their daily living routine. If a person is unable to perform these tasks, someone would probably need to do it for him or her. Consider all the things that must be done for the person served and find ways to get them more involved, even if initially it is only a small part of the task. This type of teaching is sometimes called "Active Treatment". The types of skills that need to be taught depend on each individual's needs and wants. The skills may range from teaching someone to brush their teeth or make their own breakfast to learning how to search for and find a job or use public transportation. The goal of teaching is to add skills that will improve the person's independence and quality of life. In order to determine if your interactions with the individual are "functional", ask yourself these questions:

- Did the person **LEARN** something as the result of your interactions that will allow the individual to function more **INDEPENDENTLY**?
- Did the individual **INCREASE HIS/HER SKILLS** as a result of the services you provided?
- Did the activities help **PREVENT THE LOSS** of skills the person already had?

## Tips for Teaching Functional Skills

- Encourage the person to do as much as possible for themselves
- Know each person's goals and objectives and consistently implement formal and informal training
- "Teach" people rather than "do" for them
- Get people actively involved in the routine of the home (doing chores, making choices, etc.)
- Do things *with* people not *for* them (One noted teacher/author on this subject jokes that staff fingerprints should never be found within areas where individuals served receive **quality** services. That's because individuals served are performing all the tasks, not staff, even if they are doing it with hand-over-hand guidance.)
- Use language stimulation techniques throughout the day
- Offer opportunities for choice
- Be a good role model
- Look at every interaction as an opportunity to *teach* something

## **Stimulation Activities Compared To Real Activities**

Teaching Functional Activities also means assisting people in identifying and experiencing **real** activities. Consider how to incorporate real activities into lives of the people you support. Write your ideas for "real" activities which promote the same stimulation effects.

Stimulation Activities	Real Activities
Smelling different bottled scents.	
Touching stuffed animals.	
Feeling a soft cloth on your face or mouth.	
A paid staff member talking to you as a scheduled activity.	
Going for a ride in the van with the group.	
Touching a variety of baby toys in a bag.	
Catching a ball in the yard at the group home.	
Sorting different shaped blocks.	
Walking up and down a hallway.	

## **Learning Styles**

We all have a preferred way of learning and learn in a variety of ways--by seeing, hearing, touching, doing, etc. People with developmental disabilities are just like us. They have preferred ways of learning too. In order for DSPs to identify and use various instructional strategies, and effective teaching techniques, it is important to understand different learning styles. Often times we learn using a combination of ways, although, we usually have one preferred way of learning. In each person's ISP you will find information on which learning style is most effective to teach new tasks. The three primary learning styles are: **visual, auditory, and kinesthetic**.

**Visual** learners tend to learn by looking, seeing, viewing, and watching. Visual learners need to see an instructor's facial expressions and body language to fully understand new information. They tend to sit at the front of the room to avoid visual distractions. They tend to think in pictures and learn best from visual displays. During a lecture or discussion, they tend to take detailed notes to absorb information.

**Auditory** learners tend to learn by listening, hearing, and speaking. Auditory learners learn best through lectures, discussions, and brainstorming. They interpret the underlying meaning of speech by listening to voice tone, pitch, and speed and other speech nuances. Written information has little meaning to them until they hear it. They benefit best by reading text out loud and using a tape recorder.

**Kinesthetic** learners tend to learn by experiencing, moving, and doing. Kinesthetic learners learn best through a hands-on approach and actively exploring the physical world around them. They have difficulty sitting still for long periods of time, and easily become distracted by their need for activity and exploration.





The table below shows some of the methods that appeal to visual, auditory, and kinesthetic learners. Training should take into account all three styles.

VISUAL	AUDITORY	KINETHESTIC
PowerPoint slides	Lectures	Role plays
Videos/Slideshows	Group discussions	Simulations
Flip charts	Informal conversations	Practice demonstrations
Readings	Stories and examples	Writing/Note taking
Demonstrations	Brainstorms	Activities

Knowing people's preferred learning style will help us develop appropriate learning strategies. Let's look more closely at some ways in which we assist people with developmental disabilities in learning a new task.

## **Task Analysis**

Any skill can be thought of as a chain of small steps. These small steps are identified by completing a **Task Analysis**. Each step, or link in the chain, serves as a cue to do the next step. Sometimes a task an individual is learning is too complicated for

the person to learn all at once (e.g., brushing your teeth). Therefore, we break the task down into *teachable steps*. This allows the learner to develop multi-step, complex skills that would otherwise be difficult to acquire. Identifying the step-by-step sequence does this. This requires a task analysis.



#### **How Does Task Analysis Work?**

- Determine what task you want the student to perform.
- Figure out what steps will be required to complete the task.
- Teach the student one step until the student displays mastery of it.
- Decide what order to teach the steps in. You might want the person to master the last step, then second to last and so on until the entire task can be done independently. Or vice versa, you can work from the first step to the last. This is known as **chaining.** We will learn more about this later.
- As each part of the process is learned, add it to the chain until the task can be completed independently.

## You should note that much of our own learning is done in steps. Many of the things we learn, remember, and do are done in this process.

For example, the Task Analysis for teaching someone how to eat with utensils might look something like this:

- 1) Sit in seat at table
- 2) Identify fork and knife
- 3) Pick up fork with less dominant hand
- 4) Pick up knife with dominant hand
- 5) Put fork into meat or other food to hold in place
- 6) Use knife to cut meat or other food into bite-sized pieces
- 7) Remove fork from food
- 8) Put knife down on plate
- 9) Pick up fork with dominant hand
- 10) Use fork to pick up one piece of bite-sized food
- 11) Raise fork with food on it to mouth
- 12) Open mouth
- 13) Put food into mouth
- 14) Close mouth
- 15) Put fork down onto plate
- 16) Chew food
- 17) Swallow food
- 18) Start process again.



Author: Tom McIntyre at <u>www.BehaviorAdvisor.com</u>; Retrieved June 27, 2011

#### **Task Analysis Activity**

## Your instructor will guide you through the next activity. After completion, please consider the following questions:

1. What happens when each staff does a task differently when helping a person with a developmental disability learn to do a task?

- 2. Why is it important to do a program plan the way it is written?
- 3. What should staff do if the program plan doesn't seem to be working?

Also consider. . .

- Is there more than one way to do the same thing?
- What happens if each of you does a task differently with an individual?
- Why is it important to implement an individual's training plan the way it is written?

### **Techniques for Teaching New Skills**

By building one step onto another learned step in the sequence, a strong chain can be created. This is called **CHAINING**. There are two kinds of chaining, forwards and backwards. You'll learn more about these later.

#### Shaping

*Shaping* is a way of adding behaviors to a person's repertoire. Shaping is used when the target behavior does not yet exist. In shaping, what is reinforced is some approximation of the target behavior.

**For example**: In playing the game "Hot & Cold," you hide a prize and then reinforce any movement that takes the player closer to the prize. Each of those successive movements is a closer approximation of the desired behavior. If the prize is under the couch and the player is moving toward the couch, every time the player takes a step toward the couch, you are yelling "hotter," and you are reinforcing the behavior. If the player moves away from the couch, you would yell "colder" (non-reinforcing).

#### Chaining

*Chaining* is the process of working forward or backward, step-by-step, to accomplish a task. For example:

- *Forward chaining* is a procedure that teaches a task from start to finish. It involves teaching people one step at a time, working forward step by step to accomplish a simple task.
- **Backward chaining** involves teaching the last step first.



#### Modeling

*Modeling* is a training method in which the individual learns by observing another perform the behavior that is to be learned.

#### Prompting

*Prompts* are signals or cues to perform in a specified manner.

- **Verbal** prompts use words to initiate, continue or complete a task
- **Gestural** prompts use a hint or suggestion without using physical contact
- **Physical** prompts use physical touch to initiate, continue or complete the task
- **Hand-Over-Hand** is a physical prompt that involves actual physical guidance

#### Fading

*Fading* involves reducing the amount of information given in order to decrease dependence.

Remember, as staff members you are always teaching, whether it is by active involvement with the individual or by modeling appropriate behavior with staff and/or individuals. (Dale DiLeo, *Enhancing the Lives of Adults with Disabilities*.)

## **Discovering Reinforcers**

A reinforcer is any stimulus or event that when it follows a behavior, increases the probability that the behavior will occur again. Positive and personal reinforcers include actions, consequences, or rewards that can cause an increase in desired behavior. Activities or incentives can be used, for example, to promote lifestyle changes such as increased exercise in free-time activities; healthy snacks, etc. When choosing personal reinforcers, it is important to:

- Get to know the person well
- Ask the person to help choose the type of reinforcers he would like to earn
- Observe what the person enjoys doing

#### **Positive Reinforcement**

A stimulus that, when added to the environment as a consequence of a behavior, results in an increase (frequency, duration, or intensity or maintenance) of that behavior.

#### **Effective Reinforcers**

- Are age-appropriate and are provided immediately after the behavior has occurred
- Are paired with a clear verbal description of the behavior
- Are varied enough to maintain interest.

#### **Types of Reinforcers**

- **Primary** (substances that sustain life food, water, etc.)
- **Secondary/Social** (conditioned reinforcers that are generalized from primary reinforcers money, social interactions, tokens, etc.)

A smile, comment and/or compliment can go a long way toward increasing or maintaining positive behavior!



#### **Negative Reinforcement**

A behavior is more likely to occur again because the behavior allows a person to stop something that the person dislikes or finds unpleasant. A negative reinforcement is anything that, when taken away contingent on a response, tends to increase the probability or rate of that response.

> **For Example**: Driving in heavy traffic is a negative condition for most of us. You leave home earlier than usual one morning and don't run into heavy traffic. You leave home earlier again the next morning and again you avoid heavy traffic. Your behavior of leaving home earlier is strengthened by the consequence of the avoidance of heavy traffic.

#### PERSONAL REINFORCERS EXERCISE

Identify 3 items that are usually primary reinforcers for you:

1	 	 	 
2	 	 	 
3.			

Identify 3 secondary/social reinforcers for you:

1.				
0				
۷.	 	 	 	





## Documentation

**Documentation** means "Providing a written record of an action, event, item, issue, or thought that is important or meaningful."

It is important to remember that the things you record are **legal documents!** 

The following tips can help you document important information so that it will be accurate and meaningful to those who may need it now, or later.

- Do not sign a document that has inaccurate information.
- If two people witnessed an incident, each person should make separate reports or entries. You should never document for another person or from another person's perspective.
- Always include the date (day, month, and year) on all documents.
- Always include the time of day on all documents using a.m. or p.m. for all times.
- Be careful about using abbreviations or acronyms that some people may not understand.
- Ensure the privacy of people on all documents. When referring to another person in an individual's document you may want to describe the relationship to the person (e.g., coworker, roommate, another staff person, cousin, sister) and the person's initials.
- Always use your signature.

#### **Completing Documentation in a Timely Manner**

It is important to document events as soon as possible after things happen so you can remember all the details of what occurred. Your recollection of the events that happened will not be as clear and accurate if you wait even a day or two after the occurrence. This also results in poor communication with co-workers, family members or guardians, and the people you support.

If there is no documentation about a situation, other people providing supports may not have all the necessary information needed to make the best decisions when handling the situation afterwards.

If you forget to document something on the day it happened, it is important to begin your documentation with a statement that indicates your entry was made some time after the event occurred. This is usually called a "late entry."

#### The Benefits of Good Documentation

Keep in mind that the report you are writing may later be read by people who do not know the persons involved. They should be able to easily understand the situation despite the fact that they do not know the people involved.

#### **Examples of OBJECTIVE Documentation:**

- He was crying and his hands were visibly trembling afterwards.
- She stated that she didn't know what to do.
- I have never encountered a similar situation while working with this individual.

#### **Examples of SUBJECTIVE Documentation:**

- He was so upset afterwards.
- She didn't know what to do.
- Something funny was going on.

#### Module 5 DSP Notebook Individual Service Plan Development & Implementation

#### Always include the four W's:

**NOTE:** The examples used here are for reporting suspected abuse, neglect and exploitation.

- Who This includes everyone involved.
- What Start at the beginning and explain step by step until the end of the incident.
- When Note the exact time, day/month/year and hour including a.m. or p.m.
- Where The exact location, address, inside or outside, what room?

#### WHO?

- Who is the suspected perpetrator?
- Who is the suspected victim of abuse, neglect, or exploitation?
- Who are the individuals that witnessed the incident?
- Who else may have been involved in the incident?

#### WHAT?

Document what happened step-by-step. Start at the beginning of the incident and include all details until the end of the incident. Report only the facts and write an objective description of your observations in your report. Do not write your feelings, opinions, and attitudes. Also do not make judgments about the situation.

#### Here is an example:

December 9, 2010. At 9:00AM this morning, I heard a sound from the back bedroom. I went to the back room and knocked on the door. The staff person said, "We are OK, don't worry." I asked if I could come in. The staff person said, "yes." I opened the door and saw Amy sitting on the floor on the right side of her bed. Amy was crying and holding her wrist. I asked Amy if she was OK. Amy stated, "My wrist hurts." I then examined Amy's wrist. There were no visible signs of injury. Two hours later, I examined Amy's wrist and there was visible bruising about 2 inches in diameter."

 Report only the facts and objective descriptions of your observations in your report.

## WHO?



#### Module 5 DSP Notebook Individual Service Plan Development & Implementation

• Do not write feelings, opinion, attitudes or judgments. Include any other important statements and details, such as your relationship to the victim.

#### WHEN?

Note the exact time of the incident, including the month, day, year, and time of day with a.m. or p.m. noted.

#### WHERE?

- Note where the incident occurred
- Outside or inside
- The address of the place of the incident
- The exact room the incident took place
- The exact place in the room where the incident took place

#### **Types of Documentation**

Depending on the situation, agency procedures, and local and state laws, you may need to document for any number of reasons. Here are some possible types of documentation you will be doing:

- Health related documentation
- Personal goals and individual program documentation
- Behavioral support plan documentation
- Incident and accident documentation

You may also be required to provide verbal reports or faxed or e-mailed copies of reports to certain external agencies or people. It is important for you to be familiar with the right place to document and report these types of incidents.



WHEN?

Ensure people's privacy in documents. Refer to their relationship with the person such as, "coworker," "roommate," etc., and then use initials to identify them.

Things **not** to document are:

- Complaints about other staff
- Disagreements you have with agency policy
- Your own personal problems
- Negative comments made by other co-workers
- Negative comments about people served



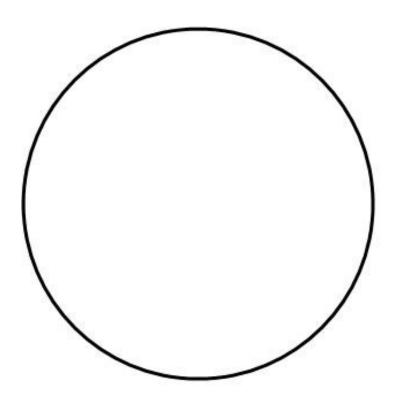
## **Documentation Scenario**

You are a DSP working the afternoon shift at one of the CILA homes. You are working alone on this particular day. You have assisted the 3 women with the evening meal and now it's time to clean up the kitchen. One of the women, Linda, begins to wash the dishes and Marley begins drying the dishes. The other lady wants to go watch TV. You went into the other room to turn down the volume of the TV. Marley starts telling Linda that she does not know how to do dishes. While you were out of the room you heard arguing and loud voices in the kitchen. As you walk into the kitchen to see what's happening, you see Linda slap Marley and Marley drops the dish. Marley begins to cry and calls Linda a "Stupid jerk." You separate the women, help them to calm down and help get the kitchen cleaned up. Now it's time to write the progress/service notes on this situation.

Linda's file:

Marley's file:

## A Penny Is....?



## Martin Luther King said:

## "I have a dream."

## He didn't say:

## "I have an annual plan with

## quarterly goals and objectives."

Inclusion News, 1997-1998



## **Sections of the Service Plan**

Most service plans contain the following information:

**Personal Description-** This section describes the person. It goes beyond the old way of describing a person (e.g., 25-yr. old black male with Down syndrome).

**Medical/Dental/Nutritional-** This section contains a summary of significant medical issues. This includes any medication the person takes and the reasons. There may be nutritional information mentioned here, as well.

**Background/Historical-** This is a summary of significant events that have happened in the individual's life. These events may be a clue as to what shaped who the person is today.

**Social Relationships-** Here is where details of the person's social life are outlined. Important people are mentioned, as well as all types of relationships (e.g., family, friends, work, staff members). Some of these relationships may be positive and others not. Sometimes we draw maps to show how these people are related. These show graphically, the connections between people. This area would indicate whether the person prefers to be with people or by himself/herself.

**Goals/Objectives-** This section identifies the areas targeted for development. The information for this section is gathered through interviews, assessments, and ongoing interactions with the person. Goals can be from any area, but they need to be important to the person, not necessarily the staff providing input into the plan. We must set goals in various areas to obtain funding. This includes economic self-sufficiency, daily living skills, and community integration. We look at what the person wants to learn and prioritize short and long-term goals based on the person's preferences.

**Interests and Activities-** This is where we learn what interests the person outside of work and home responsibilities. Leisure activities, hobbies, sports, or just about any other interest can be listed in this section.

**Personal Values-** This section makes a statement about what is important to the person. This is useful to know because often times we are motivated by what we value the most.

**Personality, Feelings, & Emotions-** We need to know these things about the person in order to develop a supportive environment. Therefore, getting to know the person is essential.

**Sources of Comfort and Discomfort-** This section will outline what things provide comfort as well as, discomfort to the person. You may want to remember that we can never know everything about a person. So, this section may have information only known to the staff who wrote it. Further, as people grow and change, this area of the plan may have to undergo change. Again, you will learn much about the person as you interact with him/her.

**Assessments-** The results of assessments or tests may be included here. For example, PT/OT, IQ, speech and language, etc.

**Strengths and Needs-** Here we learn about the abilities as well as areas which require support.

**Vocation-** This section will describe the kinds of work the individual likes to do or would like to do.

**Education-** A summary of the person's educational background as well educational goals.

**Financial** - This area discusses financial information about the person including sources of income and needs for the future.

**Communication Style-** The best way to communicate with the person would be spelled out here. People can and do communicate in a variety of ways and it is important for you to understand how to communicate with each person you will be working with.

**Learning Style-** How the person learns is outlined. This includes strategies you can use to work most effectively given the person's specific situation.

**Personal Rights-** In this area, we would learn which rights are most important to the person. Also, what, if any, rights restrictions might be in place and details of the situation.

**Recent Life Changes-** Anything that has recently occurred in a person's life which may have an effect on his/her day-to-day functioning should be noted here. This is another area that would be updated continually.

**Vision for the Future-** Just as we have dreams and hopes for the future, so do people we support in our programs. You need to get to know the person. This will assist you in identifying his/her hopes and dreams. Then you can assist the person in realizing them.

Each ISP is tailored to the individual. Therefore, not all service plans contain all of these components. Some plans may have additional information not listed here.

Additional Information: Service Plans are developed and signed by the individual or guardian, the QIDP, and all service providers. Service Plans explain significant changes in services or providers and indicate that the individual, family members and Service Facilitator participated in the decision process regarding these changes.

Service Plans contain at least one measurable goal. Service Plans contain an explanation of instructional methods for assisting the individual in moving toward accomplishment of his/her goal(s) and a way to monitor the individual's progress in achieving the goal. It also contains the name(s) or role(s) of the person(s) responsible for assisting the individual in achieving the goal.