INDIVIDUAL DEVELOPMENT PLAN FOR OLD AGE HOMES IN THE FULL GOSPEL CHURCH OF GOD IN S.A.

INTRODUCTION

The older Persons Act NO.13 of 2006 has now become an important piece of legislation dealing with all persons over the age of 60 years. As is the practice with all Acts there is a need for Regulations that are directed at the practical implementation of an Act. The Regulations pertaining to the Older Persons Act were finalised early in 2010 and as from 1St April 2010 the regulations allowed for the implementation of the Act. An integral part of the Regulations is the Minimum Norms and Standards that must be in practice in all old age homes even if they are not subsidised by the State.

Of vital importance to us in this instance is the Individual Development Plan (IDP.) By definition this is an individual support plan or in other words a personal plan of support and care. It is a plan that must be developed and suited to each individual and considers the needs of the individual.

The IDP is to be developed by the medical head, social worker and the care officer. Others who should be included in the IDP would be community groups (such as the local church / assembly) and "significant others" (such as the family.)

As a document the IDP will cover wishes of the service user (the older person involved,) and their particular network translated into meeting their particular needs. All actions in the IDP must be time bound and linked to a reason e.g. an Activity could be "attend church" and "why must they attend church."

Old Age Homes are required to review and evaluate the IDP of each individual periodically and must be developed within 4 weeks of a person be admitted into a residential care facility.

Included in the IDP should be the following:

- The individual goals
- Types of services / programme
- The strengths, capabilities, talents, interests and wishes
- Family strengths
- Estimated length of participation in the programme
- Anticipated follow up services

There are four core values that need to be addressed by the IDP namely:
Belonging – nobody must feel rejected or neglected

POSITIVES	NEGATIVES
• Attached	Craves affection
• Loving	Craves acceptance
• Friendly	Promiscuous
• Intimate	'Cult' vulnerable
• Co-operative	Clinging
• Trusting	Overly dependent
• Happy	Unattached
	Guarded
	Lonely
	Aloof (not part of the group)

Isolated
Distrustful
Rejecting

Relationships of trust / intimacy

Mastery – the ability of the individual to change

POSITIVES	NEGATIVES
• Achiever	Non- achiever
• Successful	Failure orientated
• Creative	Avoid risks
• Problem solving	Fears challenges
• Motivated	Unmotivated
• Persistent	Give up easily
• Competent	Inadequate
	Over achiever
	Arrogant
	Risk seeker
	Cheater
	Delinquent
	Workaholic

Be able to achieve

Generosity – the ability to participate

POSITIVES	NEGATIVES
• Caring	Over involved
• Sharing	Over submissive
• Loyal	Selfish
• Empathic	Affectionless
• Pro-social	Narcisstic
• Supportive	Disloyal
• Considerate	Hardened
• Altruistic	Anti-social
	Exploitative
	Co-dependency
	Inappropriate bonding
	Exploitative

Sharing the joy of helping

Independence – individual needs met

POSITIVES	NEGATIVES
• Autonomous	Reckless
• Responsible	Bullies
• Make appropriate choices	Sexual prowess
• Confident	Manipulative
• Inner control	Rebellious
• Self-discipline	Defies authority
• Leadership	Submissive
• Assertive	Lacks confidence
	Inferiority

Helplessness
Undisciplined
Easily led
Dictatorial

Develop skills and confidence to assert positive leadership abilities and self-discipline

STAGES IN DEVELOPING THE IDP

1. Information gathering
2. Decision making – input from the resident, as well as the services and support provided at the home
3. Action planning – who, what, when, where, why.
4. Implementation – time bound
5. Review – every 6 to 8 weeks.

A copy of the IDP must be given to the following:

1. The resident
2. The family / next of kin
3. The caregiver / volunteers.

ROLE CLARIFICATION

There is a need to distinguish between the service provider and the service user. The assessment of the service user must take place within 4 weeks of being admitted to the facility. This assessment should include goals that have been formulated and also setting a baseline evaluation and the mentoring of the resident.

FIELDS TO BE INCLUDED IN THE IDP

1. NAME AND ADDRESSOF ORGANISATION
2. BACKGROUND INFORMATION OF SERVICE USER
    a. Name
    b. Age
    c. Date of Birth
    d. Gender
    e. Home address
    f. Postal Address
    g. Telephone
    h. Name of Municipality
    i. Name of next of kin – telephone and address
    j. Name of alternative family member and address
3. PRIMARY CARE GIVER
    a. Care giver in residential facility
4. DIAGNOSIS / REASON FOR ADDMISSION
5. COMPREHENSIVE ASSESSMENT REPORT
    a. This relates psycho – social functioning

    b. Physical issues
    c. Neurological issues
    d. Functionality
    e. Cognitive and perceptual issues
    f. Date of admission
6. REPORT BY MEDICAL PERSONNEL
7. DATE OF ASSESSMENT
8. RELIGION
9. EDUCATIONAL QUALIFICATIONS
10. EMPLOYMENT
11. POSSIBLE CONTRIBUTION TO THE HOME
12. SERVICE USER ASSESSMENT
13. ASSESSMENT OF FAMILY
14. SIGNATURES SERVICE USER / SERVICE PROVIDER / CARE GIVER / FAMILY MEMBER

SHARING OF DECISIONS AND ACTION PLAN

This is to be divided into two sections:

1. Short term goals – create a list of needs of the individual based on the knowledge, skills and condition of the person
2. Long term objectives create a list ditto

Objectives must be:

- Specific
- Measurable
- Achievable
- Realistic
- Time - frame

Needs – problems of the resident to be addressed
A developmental assessment is maintained
Psychological aspects are noted and addressed
Family reunification is realised
Plan for other issues – medical degeneration

REVIEWING / EVALUATION OF PROGRAMMES ATTENDED

- Frequency of evaluation
- Achievements – listed
- Challenges
- Remedial actions required

IDP **FORM**