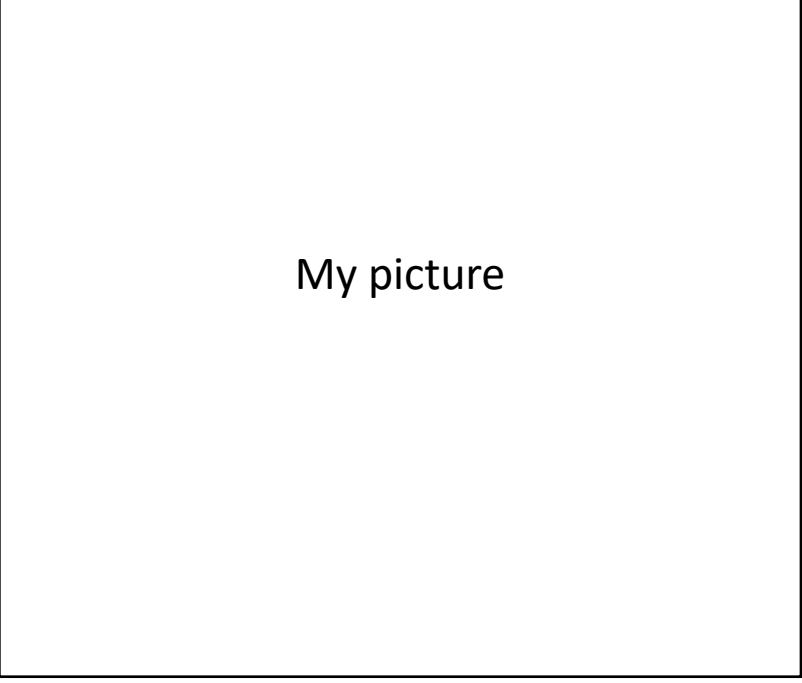








# My Life Meeting



<p>My Name:</p> 	
<p>The name of this meeting:</p> 	
<p>Name of Day Service Key Worker:</p> 	
<p>Name of Residential Key Worker:</p> 	

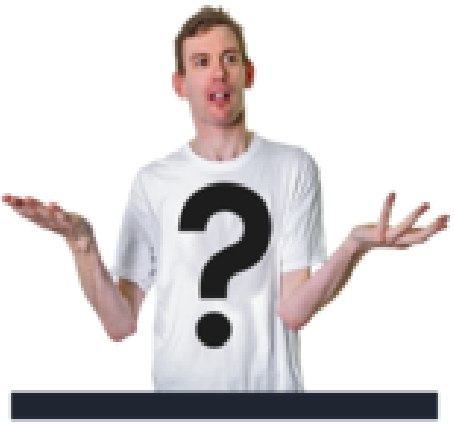


# Review Meeting

Date of the meeting:



Where is my meeting taking place?



Day Service



Residential home



Family home



Café



Restaurant



Other:



Who is attending my meeting?



Day Service Key Worker



Residential Key Worker



Family



Friend



Other:

?

---

What does my All About Me look like?



Book



Folder



Poster



DVD



Laptop



Presentation



Objects of Reference



Other:

?

\_\_\_\_\_



A **goal** is something we make plans for and aim to finish in the future.



Am I happy with the work that was done on my All About Me goals from last year?



Yes



No



What was the best thing that happened for me last year?



What good things happened me last year?



What bad things happened me last year?



A **barrier** is something that stops me from reaching my goal.



Did any barriers stop me completing my goals??



Yes



No



What were the barriers stopping my goals?

Transport



Money



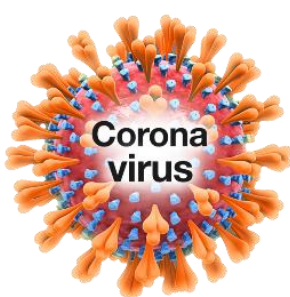
Available Staff



Training

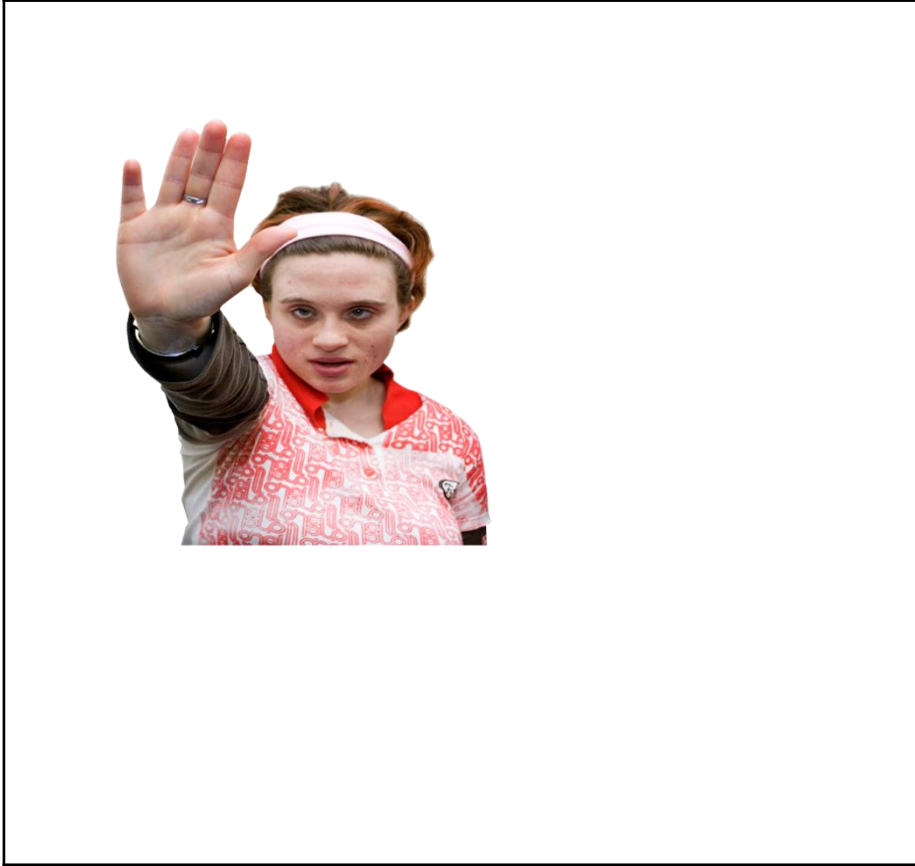


Coronavirus

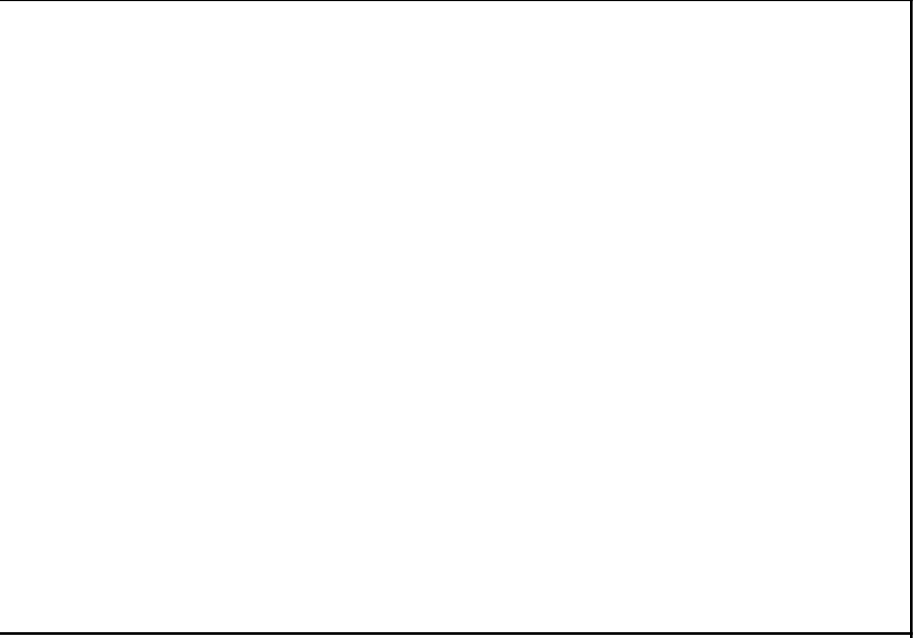
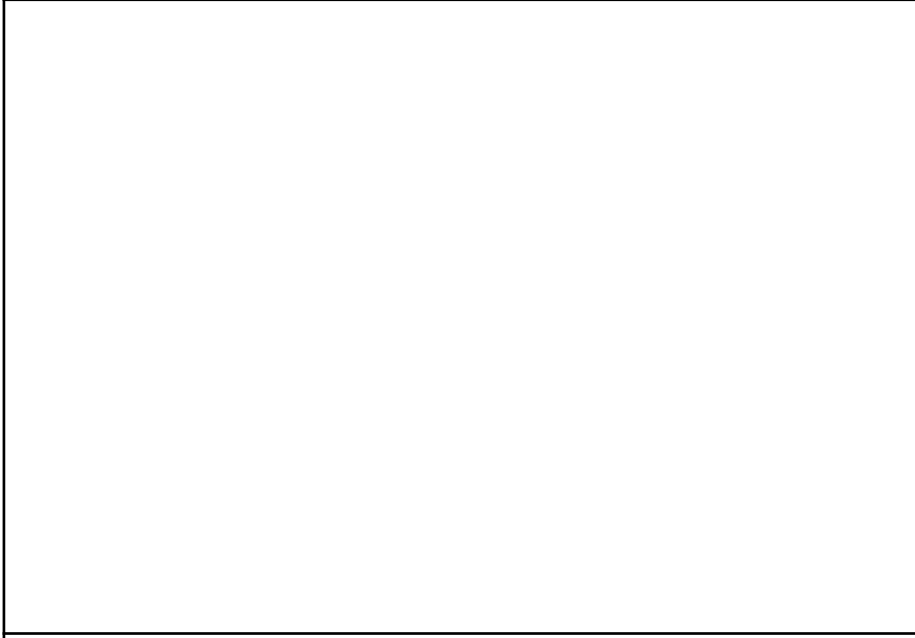


Other

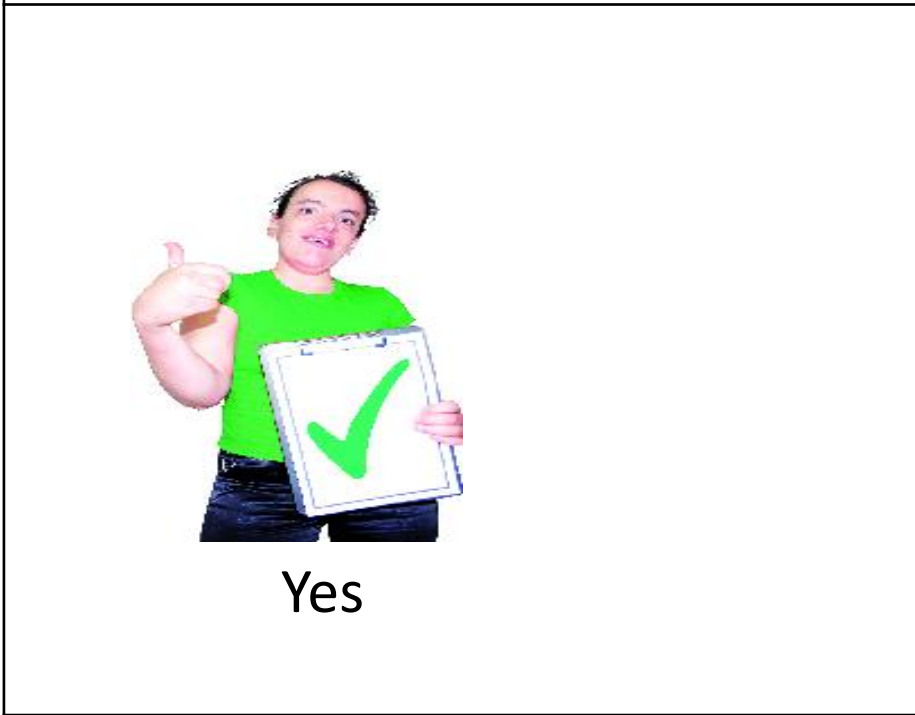




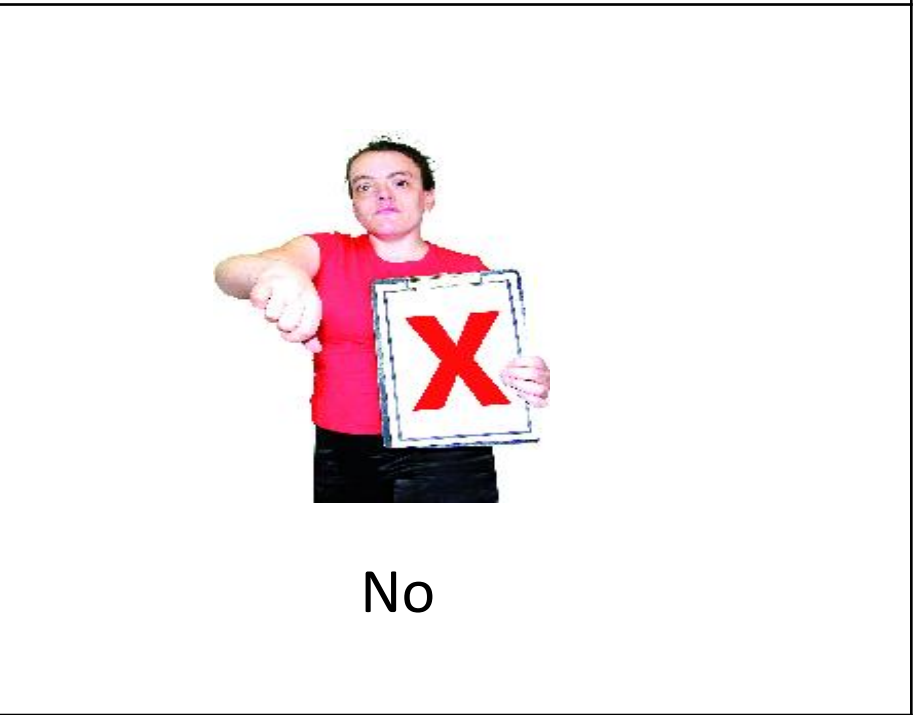
What steps were taken to remove these barriers stopping my goals?



Am I happy with the steps to remove the barriers stopping my goals ?



Yes



No



A **vision** is thinking about a plan for your future, using your imagination to think of ideas and not having any barriers for the plan.



Think about where you would like to live.



Think about where you would like to work.



Think about where you would like to go.



What are my goals for this year to help me with my vision?



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**St Michael's House**  
Comprehensive Assessment of Need



Person's Name:

Completed By:

Signature: \_\_\_\_\_

Consulted with:

Date Assessment Started:

Next Review Date:

Date of "All About Me" Started (if applicable):

Date of Last Wellbeing Outcome Review Meeting:

Name of Residential Service (if applicable):

Name of Day service (if applicable):

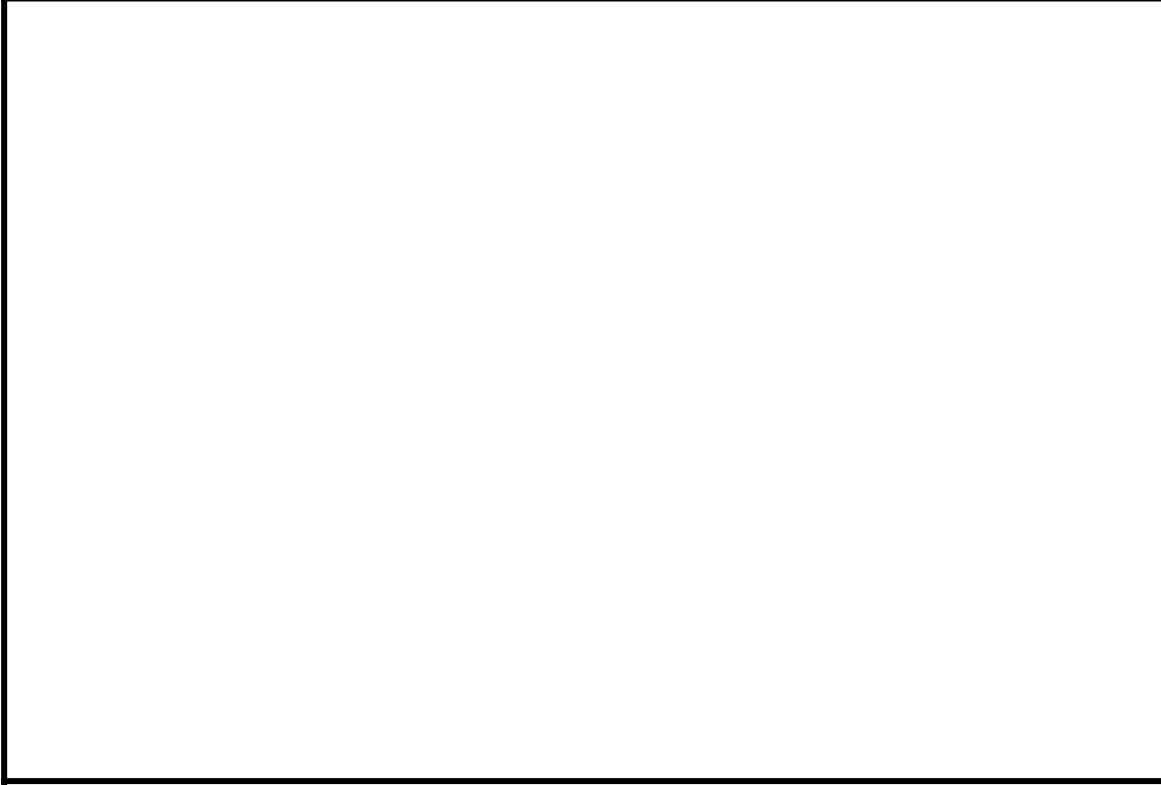
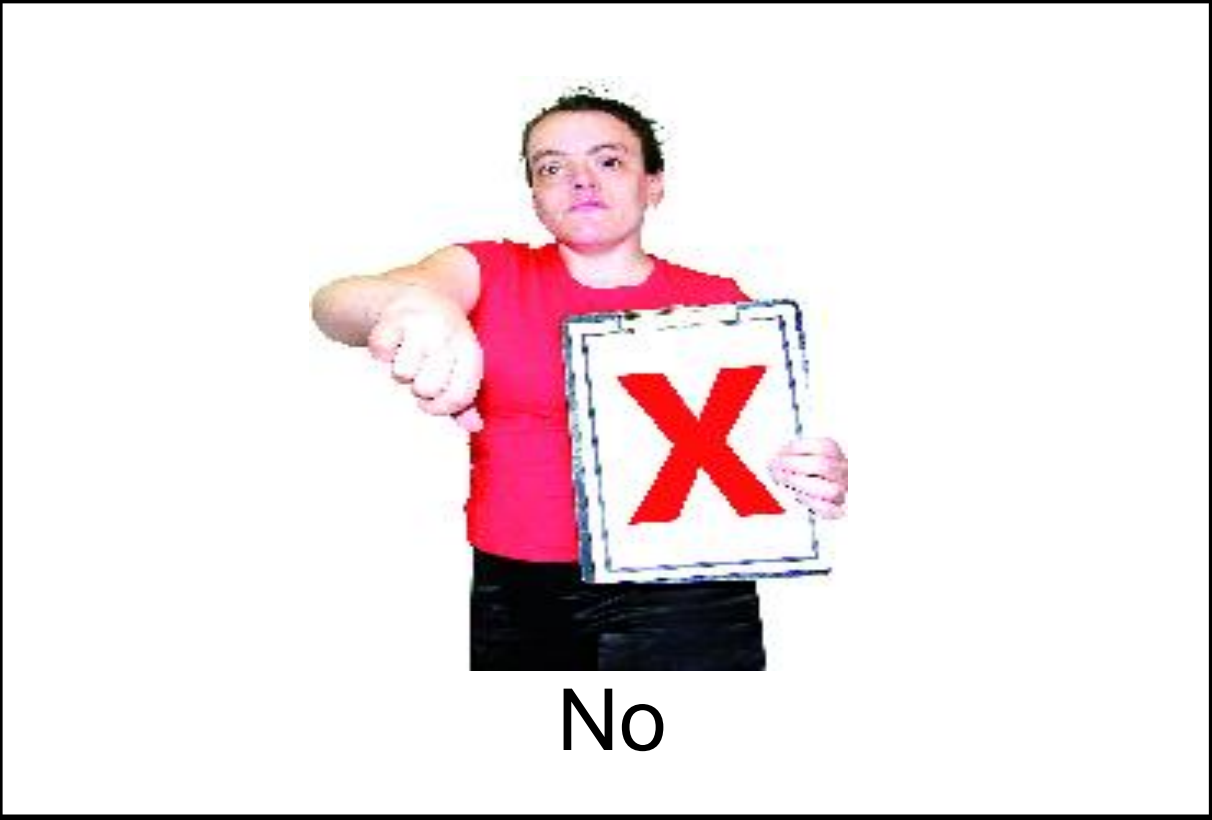
Note: The signature, name of the worker and date should only be original and added when there is an update to information on this page. The updated page(s) should be printed and included with the current document. The out of date page should be archived.

Service User's Signature: \_\_\_\_\_  
 Staff Name:     Staff Initials:     Date:

My **Assessment of Need** helps staff to understand how they should support me and how you want the support.



Am I happy with my Assessment of Need?



Do I want to be involved in my Assessment of Need?





**Communication** means getting your message across and understanding other people. This can be done by speaking, using pictures, using Lámh signs and many other ways.



Do I have support plan for my communication?



Yes



No



Am I happy with my communication support plan?



Yes



No



Do I need a support plan for my communication?



Yes



No



**Social Supports** are people and plans that help me have friendships and live in the community.



Do I have a support plan for my social supports?



Yes



No



Am I happy with my Social Supports support plan?



Yes



No



Do I need a support plan for my Social Supports?



Yes



No



**Emotional Wellbeing** plans make sure I have the help needed to support my feelings.



Do I have a support plan for my emotional wellbeing?



Yes



No



Am I happy with my Emotional Wellbeing support plan?



Yes



No



Do I need a support plan for my emotional wellbeing?



Yes



No



**General Health** supports make sure I am not sick or have any injuries. If there was anything wrong, I would visit the doctor.



Do I have a support plan for my general health?



Yes



No



Am I happy with my General Health support plan?



Yes



No



Do I need a support plan for my General Health?



Yes



No



**Physical and Intimate Care** is the care some people need when getting dressed, showering or using the toilet.



Do I have a support plan for my physical and intimate care?



Yes



No



Am I happy with my Physical and Intimate Care support plan?



Yes



No



Do I need a support plan for my Physical and Intimate Care?



Yes



No



**Safety** supports make sure I feel protected, looked after and not in danger.



Do I have a support plan for my safety?



Yes



No



Am I happy with my safety support plan?



Yes



No



Do I need a support plan for my safety?



Yes



No



**Environmental Wellbeing** is making sure the place where I live and the places I go everyday are good for me.



Do I have a support plan for my environmental wellbeing?



Yes



No



Am I happy with my Environmental Wellbeing support plan?



Yes



No



Do I need a support plan for my Environmental?



Yes



No





**Rights** are important to me. They are rules that tell me what I can do or have. They make sure everyone is treated the same and looked after properly.



Do I have a support plan for my rights?



Yes



No



Am I happy with my Rights support plan?



Yes



No



Do I need a support plan for my rights?



Yes



No



# My Life Meeting Agenda

(Example)



1. Attendance



2. Review of goals from last year



3. Plan goals for this year.



4. Things I like to talk about.



5. Things I don't like to talk about.



4. Plan for review.



# My Life Meeting Invite

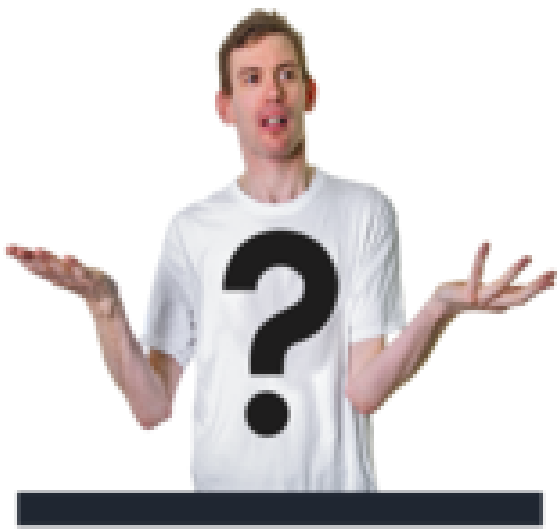
(Example)



Hello!  
You are invited to My Life Meeting.



The meeting is happening on \_\_/\_\_/\_\_ at \_\_am/pm.



The meeting will be held at \_\_\_\_\_.



\_\_\_\_\_ will also be at my meeting.



Please call \_\_\_\_\_ to let me know if you will be coming.

# Staff Notes

- This document should be considered by the key worker(s) of both day and residential prior to the meeting .
- The key worker(s) should support the person to be as involved as possible in all stages of the Person-Centred Planning Process for example :Information gathering, goal setting and planning to support the person to achieve their goals
- The person is always present unless they choose not to be. Key worker(s) should document the discussions had regarding this.
- Key worker(s) should record and have an awareness of steps being taken on how to achieve the goal.
- Identify actions required by staff team and colleagues to support the person's achievement of All About Me goals
- Ensuring all staff working with the person are aware of his/her All About Me goals and Support Plans.
- Key worker(s) should use the Goal Tracker form to document who is involved, when and where things are happening, what is needed to help ,barrier to achieving goals and steps taken to overcome barriers.
- Wherever possible, progress on goals should also be recorded in a way that is meaningful and understandable to the person e.g. a video, photos etc
- Goal Trackers should be reviewed and updated on a monthly basis ,with the service user.



Thank you to the My Life Together Group for their hard work and valuable contribution to making this information accessible.

