Unit 64: Support Care Plan Activities

Level: 2

Unit type: Optional (Group B2)

Credit value: 2

Guided learning hours: 13

Unit introduction

This unit is aimed at those working in a wide range of settings. It provides the learner with the knowledge and skills required to prepare and implement activities within a care plan and to contribute to the review of activities.

Learning outcomes and assessment criteria

To pass this unit, learners need to demonstrate that they can meet all the learning outcomes for the unit. The assessment criteria determine the standard required to achieve the unit.

Learning outcomes	Assessment criteria
1 Be able to prepare to implement care plan activities	1.1 Identify sources of information about the individual and specific care plan activities 1.2 Establish the individual's preferences about carrying out care-plan activities 1.3 Confirm with others own understanding of the support required for care plan activities
2 Be able to support care plan activities	2.1 Provide support for care plan activities in accordance with the care plan and with agreed ways of working 2.2 Encourage the active participation of an individual in care plan activities 2.3 Adapt actions to reflect the individual's needs or preferences during care plan activities
3 Be able to maintain records of care plan activities	3.1 Record information about implementation of care plan activities, in line with agreed ways of working 3.2 Record signs of discomfort, changes to an individual's needs or preferences, or other indications that care plan activities may need to be revised
4 Be able to contribute to reviewing activities in the care plan	4.1 Describe own role and roles of others in reviewing care plan activities 4.2 Seek feedback from the individual and others on how well specific care- plan activities meet the individual's needs and preferences 4.3 Contribute to review of how well specific care plan activities meet the individual's needs and preferences 4.4 Contribute to agreement on changes that may need to be made to the care plan

Unit content

What needs to be learned
Learning outcome 1: Be able to prepare to implement care plan activities
Care plan • A care plan may be known by other names, e.g. support plan, individual plan. It is the document where day-to-day requirements and preferences for care and support are detailed. **Individual** • An individual is someone requiring care or support. • Others may include: o the individual o family members o advocate o line manager o other professionals. **Sources of information about the individual and specific care plan activities** • Active use of person-centred approaches. • Reference to the individual's care plan. • Involving and communicating with individuals throughout the care planning implementation process. • Involving friends and family as appropriate. • Understanding preferences, wishes, choices, abilities and dislikes. • Recognise communication needs and adapt approaches as necessary. **Establishing the individual's preferences about carrying out care plan activities** • Encourage active participation. • Person-centred approaches. • Using preferred methods of communication. • Establishing consent. • Ability to state preferences. • Supporting independence. • Respect and dignity. • Acknowledging the religious, cultural and ethnic needs of individuals. • Focusing on positive outcomes and wellbeing. **Confirming own understanding of the support required for care plan activities**

What needs to be learned
• Confirming with others. • Following agreed ways of working. • Collaboration. • Using appropriate recording mechanisms. • Multidisciplinary approach. • Clarification of individual's needs, wishes and abilities.
Learning outcome 2: Be able to support care-plan activities
Active participation • Way of working that recognises an individual's right to participate in the activities and relationships of everyday life as independently as possible; the individual is regarded as an active partner in their own care or support, rather than a passive recipient. **Agreed ways of working** • Will include policies and procedures where these exist. **Support for care plan activities** • In accordance with the care plan and with agreed ways of working. **Active participation of an individual in care plan activities** • Interacting and communicating with individual before, during and after activity. • Involvement in agreement with the individual. • Addressing issues of concern. • Supporting individual throughout activity. **Adapting actions to reflect the individual's needs or preferences** • Monitoring behaviour changes. • Monitoring and observing individuals for signs of distress or anxiety. • Adapting actions according to agreed ways of working. • Following care plan. • Risk assessment as necessary. • Person-centred approaches in relation to individual's involvement and participation. • Seek advice and guidance for issues beyond own role.
Learning outcome 3: Be able to maintain records of care plan activities
Recording information about implementation of care plan activities • Keeping and maintaining accurate records. • Accurate recording, reporting and secure storing of information and data and any action required given concerns about accuracy, security and confidentiality.

What needs to be learned
• Handle information and data appropriately in line with national and local policies and appropriate legislation. • Technology and equipment used for data entry. **Recording that care plan activities may need to be revised** • Signs of discomfort. • Changes to an individual's needs or preferences. • Other indications. • Accuracy of recording. • Clarify needs and preferences with individual. • Inform those who need to know of changes or amendments to activities.
Learning outcome 4: Be able to contribute to reviewing activities in the care plan
Own role and roles of others in reviewing care plan activities • Providing daily support. • Safeguarding. • Monitoring and observation of activities. • Promoting independence, inclusion and active participation. • Supporting activities of daily living. • Implementing risk assessments and managing risk taking. • Promoting and implementing person-centred approaches. • Facilitating communication. • Record and monitor service provision. • Problem solving and decision making. • Working in partnership with individual and others. **Seeking feedback from the individual and others** • How well specific care plan activities meet the individual's needs and preferences. • Use of appropriate methods of communication. • Recording feedback. • Passing on issues of concern. • Advocacy support and involvement. **Contributing to review of specific care plan activities** • How well specific care plan activities meet the individual's needs and preferences. • Level of involvement in relation to own role and responsibilities.

What needs to be learned
• Involvement of others as appropriate. • Person-centred approaches to ensure individual's involvement in review. • Identifying priorities. **Contributing to agreement on changes that may need to be made to the care plan** • Involvement of individual. • Signposting. • Referral. • Identification of and access to necessary resources. • Target setting using SMART (specific, measurable, achievable, realistic, timely) targets. • Risk assessment, risk management and risk taking. • Agreed outcomes. • Focusing on positive outcomes and achievement.

Essential information for tutors and assessors

Essential resources

There are no special resources needed for this unit.

Assessment

This unit is internally assessed. To pass the unit, the evidence that learners present for assessment must demonstrate that they have met the required standard specified in the learning outcomes and assessment criteria.

This unit must be assessed in accordance with the assessment strategy (principles) in *Annexe A* of the associated qualification specification.
Learning outcomes 1, 2, 3 and 4 must be assessed in a real work environment.

The unit is assessed by a portfolio of evidence. Further information on the requirements for portfolios is included in *Section 4 Assessment requirements.*

Wherever possible, centres should adopt a holistic and integrated approach to assessing the skills units in the qualification. This gives the assessment process greater rigour, minimises repetition and saves time. The focus should be on assessment activities generated through naturally occurring evidence in the workplace rather than on specific tasks. Taken as a whole, the evidence must show that learners meet all learning outcomes and assessment criteria over a period of time. It should be clear in the assessment records where each learning outcome and assessment criterion has been covered and achieved.

Suggested resources

This section lists resource materials that can be used to support the delivery of the qualification.

Books

Hayes S and Llewellyn A – The Care Process: Assessment, Planning, Implementation and Evaluation in Health and Social Care (Reflect Press Ltd, 2010) ISBN 9781906052225
Lloyd M – A practical guide to care planning in health and social care (Open University Press, 2010) ISBN 9780335237326

Other publications

Department of Health – *Essence of Care 2010: benchmarks for the fundamental aspects of care* (Department of Health, 2010)

Websites

www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-and-support-plans/	NHS site providing guidance on care and support plans for anyone who needs care or cares for someone else
rcni.com/hosted-content/rcn/first-steps/care-plans	Royal College of Nursing Information about care plans and their use
www.scie.org.uk/person-centred- care/care-planning/what-to-expect	Social Care Institute for Excellence A quick guide for people using adult social care services
www.scie.org.uk/person-centred- care/care-planning/learning-disabilities	Social Care Institute for Excellence A quick guide for practitioners supporting people growing older with learning disabilities