Unit 4222-319 Facilitate person centred assessment, planning, implementation and review (HSC 3020)

Level: **3**
Credit value: **6**
UAN: **H/601/8049**

Unit aim
This unit is aimed at those working in a wide range of settings. It provides the learner with the knowledge and skills required to facilitate person-centred assessment, planning, implementation and review.

Learning outcomes
There are **six** learning outcomes to this unit. The learner will:
1. Understand the principles of person centred assessment and care planning
2. Be able to facilitate person centred assessment
3. Be able to contribute to the planning of care or support
4. Be able to support the implementation of care plans
5. Be able to monitor a care plans
6. Be able to facilitate a review of care plans and their implementation

Guided learning hours
It is recommended that **45** hours should be allocated for this unit, although patterns of delivery are likely to vary.

Details of the relationship between the unit and relevant national standards
This unit is linked to HSC 328 and HSC 329.

Support of the unit by a sector or other appropriate body
This unit is endorsed by Skills for Care & Development.

Assessment
Unit must be assessed in accordance with Skills for Care Development's QCF Assessment Principles

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Assessment Criteria

Outcome 1 Understand the principles of person centred assessment and care planning

The learner can:

1. explain the importance of a holistic approach to assessment and planning of care or support
2. describe ways of supporting the **individual** to lead the assessment and planning process
3. describe ways the assessment and planning process or documentation can be adapted to maximise an individual's ownership and control of it.

Outcome 2 Be able to facilitate person centred assessment

The learner can:

1. establish with the individual a partnership approach to the assessment process
2. establish with the individual how the process should be carried out and who else should be involved in the process
3. agree with the individual and **others** the intended outcomes of the assessment process and **care plan**
4. ensure that assessment takes account of the individual's strengths and aspirations as well as needs
5. work with the individual and others to identify support requirements and preferences.

Outcome 3 Be able to contribute to the planning of care or support

The learner can:

1. take account of **factors** that may influence the type and level of care or support to be provided
2. work with the individual and others to explore **options and resources** for delivery of the plan
3. contribute to agreement on how component parts of a plan will be delivered and by whom
4. record the plan in a suitable format.

Outcome 4 Be able to support the implementation of care plans

The learner can:

1. carry out assigned aspects of a care plan
2. support others to carry out aspects of a care plan for which they are responsible
3. adjust the plan in response to changing needs or circumstances.

Outcome 5 Be able to monitor a care plans

The learner can:

1. agree methods for monitoring the way a care plan is delivered
2. collate monitoring information from agreed sources
3. record changes that affect the delivery of the care plan.

Outcome 6 Be able to facilitate a review of care plans and their implementation

The learner can:

1. seek agreement with the individual and others about:
   - who should be involved in the review process
   - criteria to judge effectiveness of the care plan
2. seek feedback from the individual and others about how the plan is working
3. use feedback and monitoring/other information to evaluate whether the plan has achieved its objectives
4. work with the individual and others to agree any **revisions** to the plan
5. document the review process and revisions as required.

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Additional guidance

- The **individual** is the person requiring care or support. An advocate may act on behalf of an individual.
- A **care plan** may also be known by other names, such as a support plan, individual plan or care delivery plan. It is the document where day to day requirements and preferences for care and support are detailed.
- **Others** may include:
  - Carers
  - Friends and relatives
  - Professionals
  - Others who are important to the individual's well-being
- **Factors** may include:
  - Feasibility of aspirations
  - Beliefs, values and preferences of the individual
  - Risks associated with achieving outcomes
  - Availability of services and other support options
- **Options and resources** should consider:
  - Informal support
  - Formal support
  - Care or support services
  - Community facilities
  - Financial resources
  - Individual's personal networks
- **Revisions** may include:
  - Closing the plan if all objectives have been met
  - Reducing the level of support to reflect increased independence
  - Increasing the level of support to address unmet needs
  - Changing the type of support
  - Changing the method of delivering support