



Australian Government

Department of Education, Employment and Workplace Relations

CHCCM702A Implement goal directed care planning

Release: 1

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Modification History

Not Applicable

Unit Descriptor

Descriptor

This unit describes the knowledge and skills required to plan care for clients through provision of services and resources aimed at maximising and enhancing their independence and quality of life

Application of the Unit

Application

This unit may apply to work in a range of community sector contexts where high level care planning skills and knowledge are required

Licensing/Regulatory Information

Not Applicable

Pre-Requisites

Not Applicable

Employability Skills Information

Employability Skills

This unit contains Employability Skills

Elements and Performance Criteria Pre-Content

Elements define the essential outcomes of a unit of competency.

The Performance Criteria specify the level of performance required to demonstrate achievement of the Element. Terms in italics are elaborated in the Range Statement.

Elements and Performance Criteria

ELEMENT

PERFORMANCE CRITERIA

1. Undertake *care planning* to address identified client needs and goals
 - 1.1 Work with client to identify realistic and relevant goals as a basis for care planning
 - 1.2 Undertake *care planning* to address identified goals and in line with needs assessment and document in line with organisation requirements
 - 1.3 Undertake consultation with other organisation representatives to plan care in complex situations where multi-organisation involvement is required
 - 1.4 Ensure care plan recognises and supports person's strengths and abilities as well as addressing their needs
 - 1.5 Recognise and respect person's right to self-determination within legal parameters
 - 1.6 Plan care in consultation with the person, their carer/s and family, friends or others involved in advocacy or decision-making on their behalf
 - 1.7 Support person to make informed decisions about their care, reflecting understanding of their current situation, probable future situation and ensuing care needs
 - 1.8 Investigate range of options available to address client-identified needs and achieve their goals
 - 1.9 In conjunction with client, structure a range of services in a manner that supports informal care arrangements such as family support, and support of friends and/or neighbours
 - 1.10 Devise alternative strategies to meet identified client needs when specific services are not available
 - 1.11 Provide the person with cost details as required and work with them to ensure care plan is within their financial resources
 - 1.12 Identify occupational health and safety (OHS) risks and plan for their management
 - 1.13 Write care plan and clearly identify all work tasks and who is to perform them

ELEMENT

2. Implement care plan in conjunction with relevant others

PERFORMANCE CRITERIA

- 2.1 Seek and obtain person's consent before undertaking any referrals
- 2.2 Provide person with clear understanding of available services and choices, so they are an informed participant in all stages of care planning
- 2.3 Work in collaboration with appropriate professionals and organisations to ensure services are provided in a manner that maximises person's potential for achieving their goals and addresses identified needs
- 2.4 Ensure planning clearly articulates roles and responsibilities of each service provider, including coordination role/s
- 2.5 Maximise involvement of client and carer/s in care planning processes and decision-making
- 2.6 Ensure effective involvement of relevant health/community services professionals in care planning where clients have chronic or *complex needs*
- 2.7 Establish and maintain communication strategy and processes to ensure effective implementation of care plan
- 2.8 Ensure mechanisms are in place to support sharing of information between organisations and maintenance of updated information to all involved organisations
- 2.9 Support and develop person's ability to independently access alternative resources to ensure their needs are addressed in an appropriate manner

ELEMENT**PERFORMANCE CRITERIA****3. Monitor implementation of client care plan**

- 3.1 Regularly monitor planned services, support and resources against client-identified goals to ensure effective implementation of their care plan
- 3.2 Ensure appropriate level of rapport and communication with client is maintained as required to support disclosure of information regarding delivery of services and resources in line with care plan
- 3.3 Maintain collaborative relationships with clients, carers and other service providers to support people with complex needs
- 3.4 Promptly identify problems with implementation of care plan and make adjustment as necessary to best meet person's needs
- 3.5 Document and report any variations to care plan in line with organisation requirements and communication strategy

4. Undertake review of care plan

- 4.1 Respond appropriately to informal monitoring of health and well being of the person and/or their carer by volunteers, carers or family
- 4.2 Undertake regular and systematic reviews to ensure assessed needs of clients are being addressed effectively
- 4.3 Use regular reviews to re-prioritise client needs for service and to ensure equitable access based on ongoing appraisal of prioritised needs
- 4.4 Contribute to adjustments in care plan in response to changes in client or carer health; review of risk management/OHS needs; or as specified in person's care plan or as required by personal circumstances

ELEMENT**PERFORMANCE CRITERIA****5. Respond appropriately to diversity**

- 5.1 Ensure care planning for CALD and Aboriginal and Torres Strait Islander clients is culturally sensitive
- 5.2 Ensure appropriate interpreter support is provided in line with organisation protocols
- 5.3 Where appropriate, work in conjunction with ethno-specific and multicultural organisations and with Aboriginal and Torres Strait Islander communities and organisations
- 5.4 Recognise and support the role of these organisations in linking their communities into the service system
- 5.5 Where appropriate involve Aboriginal and Torres Strait Islander community and/or organisation representatives in the care planning process

6. Respond appropriately to people with different levels of need including those with complex needs

- 6.1 Facilitate access to assessment for people with different levels of need including those in *complex circumstances and identified as having high levels of need*
- 6.2 Maintain and promote *inter-organisation relationships and agreements* as appropriate to address client, family and carer needs
- 6.3 Ensure care planning builds on person's strengths and motivation to improve their quality of life

ELEMENT**PERFORMANCE CRITERIA****7. Evaluate client outcomes**

- 7.1 Undertake periodic evaluation of care planning based on analysis of outcomes
- 7.2 Obtain information from clients, carers, families and other service providers to determine progress and evaluate against identified goals in care plan
- 7.3 Take into account adjustments made to services and resources to better address person's ongoing situation and changing needs
- 7.4 Ensure evaluation includes determination of client satisfaction, comparison of costs against benefits received and assessment of quality and effectiveness of service delivery and case management components
- 7.5 Work with person to evaluate ongoing support needs to meet their goals, including review of parameters for disengagement, where applicable
- 7.6 Demonstrate accountability for adjustments to the care plan and associated financial outcomes
- 7.7 Identify opportunities for person to maintain or develop independence within any aspects of their overall care
- 7.8 Document and report quantifiable impacts experienced by person as a result of implementation of care plan and indicate how client-centred outcomes have been achieved

Required Skills and Knowledge

REQUIRED SKILLS AND KNOWLEDGE

This describes the essential skills and knowledge and their level required for this unit.

Essential knowledge:

The candidate must be able to demonstrate essential knowledge required to effectively do the task outlined in elements and performance criteria of this unit, manage the task and manage contingencies in the context of the identified work role

These include knowledge of:

- Literature on models and practices in goal-directed care planning
- The range of services, resources and holistic solutions available to clients with complex needs
- Components of service delivery system
- Gaps in the service system
- Characteristics and needs of identified client population
- Significance of the service setting, such as working in the client's home
- Organisation policies and practices relating to care planning
- Professional standards/code of ethics and relevant legislative requirements
- Government legislation, regulations, policies and standards
- Documentation requirements and practices
- Duty of care requirements when developing and implementing care plans
- Current research in area of practice

Essential skills:

It is critical that the candidate demonstrate the ability to:

- Work within professional standards and applicable government legislation, regulations, policies and standards
- Use data drawn from a range of client needs assessment information as a basis for planning care services to address client needs
- Review and apply outcomes data as a means to continually improve practice and make adjustments to care plan
- Practise in an ethical manner noted by professional discipline or defined ethical standards

REQUIRED SKILLS AND KNOWLEDGE

- Work within guidelines for currently identified best practices
- Minimise client dependency by developing their self management skills
- Examine issues related to sustainability of care to address client's level of need
- Demonstrate actions to support improvement/maintenance of quality of life for clients
- Navigate the service delivery system to meet client needs and support encouragement of client independence where possible
- Apply communication and leadership skills with providers to services and resources meet client needs
- Maintain client confidentiality when engaging stakeholders

In addition, the candidate must be able to effectively do the task outlined in elements and performance criteria of this unit, manage the task and manage contingencies in the context of the identified work role

These include the ability to:

- Demonstrate application of skills in:
 - consultation, liaison and negotiation
 - analysis of assessment and other data
 - report, case note and care plan writing
 - liaison with other organisations and service providers
 - facilitation
 - advocacy

Evidence Guide

EVIDENCE GUIDE

The evidence guide provides advice on assessment and must be read in conjunction with the Performance Criteria, Required Skills and Knowledge, the Range Statement and the Assessment Guidelines for this Training Package.

Critical aspects for assessment and evidence required to demonstrate this unit of competency:

- The individual being assessed must provide evidence of specified essential knowledge as well as skills
- This unit of competence will be most appropriately assessed in the workplace or in a simulated

EVIDENCE GUIDE

workplace and under the normal range of workplace conditions e.g. writing care plans based on case studies, writing case notes based on case studies

- Assessment may be conducted over one or more occasions and should include both the development and promotion of best practice

- Access and equity considerations:*
- All workers in community services should be aware of access, equity and human rights issues in relation to their own area of work
 - All workers should develop their ability to work in a culturally diverse environment
 - In recognition of particular issues facing Aboriginal and Torres Strait Islander communities, workers should be aware of cultural, historical and current issues impacting on Aboriginal and Torres Strait Islander people
 - Assessors and trainers must take into account relevant access and equity issues, in particular relating to factors impacting on Aboriginal and/or Torres Strait Islander clients and communities

- Context of and specific resources for assessment:*
- This unit can be assessed independently, however holistic assessment practice with other community services units of competency is encouraged
 - Resources required for assessment include access to:
 - an appropriate workplace where assessment can take place
 - simulation of realistic workplace setting

- Method of assessment:*
- Assessment may include observation, questioning and evidence gathered from the workplace setting
 - Examination of written examples of care plans and written examples of case notes

Range Statement

RANGE STATEMENT

The Range Statement relates to the unit of competency as a whole. It allows for different work environments and situations that may affect performance. Add any essential operating conditions that may be present with training and assessment depending on the work situation, needs of the candidate, accessibility of the item, and local industry and regional contexts.

Care planning may include, for example:

- Identifying range and type of specific services to be provided
- Planning details of each specific service to be provided, such as
 - domestic assistance
 - respite
 - nursing care
- Consideration of OHS and risk management issues and strategies to address these
- Referral strategies as required to address breadth of client needs
- Information about services, resources or activities the client may follow up independently, such as:
 - Health promotion
 - Local social or active living opportunities
 - Self management strategies and activities
 - Self-referral to other services

RANGE STATEMENT

Complex needs may refer to:

- Client needs requiring multiple service types with heightened needs for collaboration between service providers
- Clients with a range of needs that may not be met by available services and resources
- Clients who have family and carer needs that require additional service inputs
- People who have broad range of care needs related to chronic and/or multiple health issues and who require assistance to access the service system as well as a high level of ongoing advocacy

People in complex circumstances and identified as having high levels of need may refer, for example, to:

- Families with children with disabilities where a number of different organisations are providing support
- People with disabilities with a diverse range of needs arising from physical and behavioural causes
- People with disabilities requiring the development of appropriate responses for personal and/or respite care
- People with complex medical issues which may pose critical issues for assessment and care planning
- Older people with chronic illness and unstable health conditions requiring coordinated management across acute, sub acute and community health sectors
- Older people with dementia and/or other cognitive impairment
- Older people who are extremely socially isolated and withdrawn
- Circumstances involving difficult OHS issues for community sector workers
- People with mental health issues, whose functional limitations may fluctuate substantially over time
- People with psychiatric disabilities where inter-organisation agreements may be required to access specialist assessment expertise
- People with family and carer needs that require additional service inputs

RANGE STATEMENT

Inter-organisation relationships and agreements may relate to:

- Access to specialist expertise for secondary consultations , advice or assessment
- Extent and type of information provided on referral
- Joint assessment
- Case conferencing
- Care planning and ongoing support
- Use of specialist assessment tools
- Involvement in assessment of family members and other organisations providing services
- Receiving relevant information from health practitioners and/or support workers

Unit Sector(s)

Not Applicable