

Refocusing the Care Programme Approach

Care co-ordinator work-based assessment of competencies

(to be used following the care co-ordinator learning resource programme)

| | | |
|---------------------------------|-------|-----|
| Name of care co-ordinator: | | |
| Work Setting: | | |
| Assessment period (6 months) | From: | To: |
| Name of assessor: | | |

Guidance for care co-ordinators and assessors

This schedule outlines the competencies against which the care co-ordinator's practice will be assessed and includes the forms for recording progress.

The assessor

The selection of an assessor will be based mainly on relevant experience and training. These should be viewed as more significant than level of seniority or professional background. The decision should be a joint one made by the care co-ordinator and manager. The following criteria should be considered:

- amount of experience working as a care co-ordinator (suggest a minimum of three years)
- some experience of assessing and supervising others i.e. pre-registration students and/or qualified staff
- successful completion of a locally or nationally recognised mentor, programme

The evidence

It is the **care co-ordinator's responsibility** to provide evidence of the achievement of each competence to the assessor. The care co-ordinator is required to indicate on their assessment of competence record where the evidence supporting achievement of the competence is to be found.

- When the assessor is satisfied that the care co-ordinator has provided sufficient evidence to support achievement of a specific competence safely, effectively and consistently to the required standard 'ACHIEVED' should be recorded against that competence in the space provided.
- If no opportunity has been available for the student to demonstrate competence 'NO OPPORTUNITY' should be recorded against that competence.
- If the care co-ordinator has provided insufficient evidence to support achievement of a specific competence 'NOT ACHIEVED' should be recorded against that competence.
- The following types of evidence may be produced to indicate the achievement of a competence:
 1. **Direct observation (DO)** of the care co-ordinator whilst working alongside the assessor. For example, observing the care co-ordinator leading a review meeting within the CPA process
 2. **Question and answer session (QA)** to assess underpinning knowledge and decision-making. For example, asking the care co-ordinator to justify a decision made on the level of risk of an individual.
 3. **Reflective discussion (RD)** between the assessor and the care co-ordinator regarding their progress. For example, focussing on one of the competencies and discussing in relation to practice.
 4. **Written records (WR)** For example, care plans, notes, minutes, reports and other documents that are records of the care co-ordinator's actions
 5. **Testimonials/witness statements (WS)** from other staff, health care professionals, service users or carers. For example, a short statement from a carer confirming that they were involved in an assessment

Overview of the assessment requirements

- Care co-ordinators must be assessed on all competencies over the agreed time period (not to exceed 26 weeks).
- If a care co-ordinator fails to achieve all of the competencies then a second period of work-based assessment will be agreed by the manager, care co-ordinator and assessor in which the care co-ordinator will be expected to achieve the remaining competencies.

The assessment process

- Meeting 1** The care co-ordinator and assessor discuss the competencies, how they will be assessed and identify work-based opportunities that may be available to enable the care co-ordinator to achieve them
- Meeting 2** The care co-ordinator and the assessor arrange a meeting in the middle of the agreed timeframe to discuss progress. The meeting record is completed and signed.
- Meeting 3** The care co-ordinator and the assessor arrange a final assessment interview at the end of the agreed timeframe. The results of the assessment are entered on the Assessment of Competence Record. The assessor and care co-ordinator sign and date the form.

Confidentiality: The collection and management of evidence relating to individuals must be conducted sensitively with due attention to issues of confidentiality. Where appropriate, consent from individuals must be obtained.

Meeting 1

The aim of this meeting is for the care co-ordinator and the assessor to:

- agree the care co-ordinator's assessment timeframe.
- identify the work-based opportunities that are available to enable the care co-ordinator to achieve the competencies.

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|---|
| Work based opportunities that are available to enable achievement of competencies: |
| Agreed timeframe Start date: _____ Mid point meeting date: _____ Completion date: _____ |
| Comments and discussion: |
| Name of assessor (print): |
| Signature of Assessor: |
| Signature of Care co-ordinator: |

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Mid-point meeting

The aim of this meeting between the assessor and the care co-ordinator is to:

- acknowledge the progress made towards the achievement of competencies and any areas that require attention.
- review the initial goals and timeframe.

It is the care co-ordinator's responsibility to provide evidence of the progress made towards achievement of the competencies.

Review of progress and evidence to support this (to be completed by the care co-ordinator)

Comments and discussion (including any amendments to plan)

New actions

Name of assessor (print):

Signature of assessor:

Signature of care co-ordinator:

Final meeting

Name of care co-ordinator _____

Work place _____

The aim of this meeting is to:

- verify the care co-ordinator's evidence of achievement of the competencies
- review the care co-ordinator's performance and identify strengths and key areas of learning for future practice

It is the care co-ordinator's responsibility to provide evidence of achievement of the competencies.

Achievement of competencies: care co-ordinator's comments:

Achievement of competencies: assessor's comments:

Name of assessor (PRINT):

Signature of assessor:

Signature of care co-ordinator:

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Assessment record: 1. Comprehensive needs assessment

To be completed by the assessor with the care co-ordinator, following verification of the evidence provided by the care co-ordinator.
 Evidence types: DO=direct observation; QA=questions and answers; RD=reflective discussion; WR=written records; WS=witness statements

| Competencies | Evidence type | Achieved (Signature) | Not achieved (Signature) | No opportunity (Signature) |
|---|---------------|----------------------|--------------------------|----------------------------|
| CPA 1.1 Clarify your role within the assessment process | | | | |
| CPA 1.2 involve the person and significant others in assessment process | | | | |
| CPA 1.3 arrange advocacy for people who are unable to represent their own interests | | | | |
| CPA 1.4 carry out an assessment of physical, emotional and psychological needs | | | | |
| CPA 1.5 assess any immediate risk to the person or others | | | | |
| CPA 1.6 consult with, and refer to specialist advice and assessment if appropriate | | | | |
| CPA 1.7 with person and significant others, identify and agree actions and interventions | | | | |
| CPA 1.8 review assessment process and next steps with participants | | | | |
| CPA 1.9 record and provide information in line with legal and organisational requirements | | | | |

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Assessment record: 2. Risk assessment and management

To be completed by the assessor with the care co-ordinator, following verification of the evidence provided by the care co-ordinator.
Evidence types: DO=direct observation; QA=questions and answers; RD=reflective discussion; WR=written records; WS=witness statements

| Competencies | Evidence type | Achieved (Signature) | Not achieved (Signature) | No opportunity (Signature) |
|--|---------------|----------------------|--------------------------|----------------------------|
| In consultation with people, family/carers, and individuals and agencies involved in their care: | | | | |
| CPA 2.1 Support and encourage individuals to participate in the assessment, actions, processes, procedures and practices for dealing with the risk of danger, harm and abuse. | | | | |
| CPA 2.2 Assess and record the potential impact of harm, failure to protect and harm to self and others according to degree, likelihood and effect on individuals. | | | | |
| CPA 2.3 Prioritize identified needs and level of risk. | | | | |
| CPA 2.4 Arrange specialist assessments where required. | | | | |
| CPA 2.5 Consider and appraise the strengths and weaknesses of options to manage risk. | | | | |
| CPA 2.6 Consider and appraise the strengths and weaknesses of options to manage risk. | | | | |

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Assessment record: 2. Risk assessment and management cont....

To be completed by the assessor with the care co-ordinator, following verification of the evidence provided by the care co-ordinator.
 Evidence types: DO=direct observation; QA=questions and answers; RD=reflective discussion; WR=written records; WS=witness statements

| Competencies | Evidence type | Achieved (Signature) | Not achieved (Signature) | No opportunity (Signature) |
|---|---------------|----------------------|--------------------------|----------------------------|
| CPA 2.7 Acknowledge and record any disagreement concerning the source and level of risk. | | | | |
| CPA 2.8 Negotiate and agree a plan to manage risk. Identify and record instances where preferred options for action are not consistent with organizational priorities. | | | | |
| CPA 2.9 Share the risk management plan with the person, family / carers, and people/agencies involved in their care, as appropriate. | | | | |
| CPA 2.10 Take action to protect individuals considered to be in immediate danger. | | | | |
| CPA 2.11 Agree your role and responsibilities and those of others in reviewing the risk management plan, and the effectiveness of actions to deal with the risk of danger, harm and abuse. | | | | |
| CPA 2.7 Acknowledge and record any disagreement concerning the source and level of risk. | | | | |
| CPA 2.8 Negotiate and agree a plan to manage risk. Identify and record instances where preferred options for action are not consistent with organizational priorities. | | | | |

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Assessment record: 3. Crisis planning and management

To be completed by the assessor with the care co-ordinator, following verification of the evidence provided by the care co-ordinator.
Evidence types: DO=direct observation; QA=questions and answers; RD=reflective discussion; WR=written records; WS=witness statements

| Competencies | Evidence type | Achieved (Signature) | Not achieved (Signature) | No opportunity (Signature) |
|--|---------------|----------------------|--------------------------|----------------------------|
| CPA 3.1 Assess the risk of crisis situations occurring with individuals, families and carers. | | | | |
| CPA 3.2 Negotiate agreement to the risk management strategies with the individuals, carers, families, service providers, other agencies and practitioners | | | | |
| CPA 3.3 Negotiate agreement on the information which will need to be shared, and with whom, in accordance with agency and legislative requirements. | | | | |
| CPA 3.4 Ensure that the agreed actions are implemented as promptly as possible in accordance with the assessed urgency of the need | | | | |
| CPA 3.5 Review the outcomes of actions taken to address immediate needs. | | | | |
| CPA 3.6 Ensure that the results of the review are communicated clearly to all those who need to receive them. | | | | |
| CPA 3.1 Assess the risk of crisis situations occurring with individuals, families and carers. | | | | |

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Assessment record: 4. Assessing and responding to carers' needs

To be completed by the assessor with the care co-ordinator, following verification of the evidence provided by the care co-ordinator.
Evidence types: DO=direct observation; QA=questions and answers; RD=reflective discussion; WR=written records; WS=witness statements

| Competencies | Evidence type | Achieved (Signature) | Not achieved (Signature) | No opportunity (Signature) |
|--|---------------|----------------------|--------------------------|----------------------------|
| CPA 4.1 Develop relationships with carers in recognition of their role and expertise and enable them to communicate their needs and preferences. | | | | |
| CPA 4.2 Provide information about the carers' rights to have their needs assessed and the procedures for this. | | | | |
| CPA 4.3 Ensure that carers' needs are assessed in line with legislation and organisational policy | | | | |
| CPA 4.4 Ensure that carers have accessible information about resources, services, facilities and support groups that are available and appropriate to them. | | | | |
| CPA 4.5 Co-ordinate what support will be needed by carers to enable them to meet their own needs and preferences | | | | |
| CPA 4.6 Identify any risks to carers and individuals and how these should be managed. | | | | |
| CPA 4.7 Identify how carers' access to resources, services, facilities and support groups will be reviewed, when this will happen and who will be involved. | | | | |

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Assessment record: 4. Assessing and responding to carers' needs (cont)...

To be completed by the assessor with the care co-ordinator, following verification of the evidence provided by the care co-ordinator.
Evidence types: DO=direct observation; QA=questions and answers; RD=reflective discussion; WR=written records; WS=witness statements

| Competencies | Evidence type | Achieved (Signature) | Not achieved (Signature) | No opportunity (Signature) |
|--|---------------|----------------------|--------------------------|----------------------------|
| CPA 4.8 Take appropriate action to challenge discriminatory information and practice. | | | | |
| CPA 4.9 Record and report on actions, processes and outcomes in line with organizational policy. | | | | |
| 5. Care planning and review | | | | |
| CPA 5.1 Encourage individuals and their significant others to take a full and active part in the care planning and review process, consistent with the individual's wishes. | | | | |
| CPA 5.2 Clarify how information will be shared. | | | | |
| CPA 5.3 Encourage and support individuals and significant others to consider what recovery means to them, and what will enable them to recover. | | | | |
| CPA 5.4 Identify and take account of the views of other service providers, agencies and practitioners who are in a position to contribute to the person's care planning. | | | | |

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Assessment record: 5. Care planning and review cont.....

To be completed by the assessor with the care co-ordinator, following verification of the evidence provided by the care co-ordinator.
 Evidence types: DO=direct observation; QA=questions and answers; RD=reflective discussion; WR=written records; WS=witness statements

| Competencies | Evidence type | Achieved (Signature) | Not achieved (Signature) | No opportunity (Signature) |
|--|---------------|----------------------|--------------------------|----------------------------|
| CPA 5.6 With the person and significant others, discuss options and agree a care /recovery plan. | | | | |
| CPA 5.7 Agree the role of the person and significant others in achieving the aims and goals of the plan. | | | | |
| CPA 5.8 Establish with the person and significant others how the aims and goals of the person's care/recovery plan will be reviewed. | | | | |
| CPA 5.9 Monitor progress to ensure that the person is able to access the facilities, resources, and interventions agreed within the care/recovery plan. Take action where this is not achieved. | | | | |
| CPA 5.10 With the person and significant others, review the care/recovery plan. | | | | |
| CPA 5.11 Record and share as agreed the planning and review process | | | | |

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Assessment record: 6. Transfer and discharge

To be completed by the assessor with the care co-ordinator, following verification of the evidence provided by the care co-ordinator.
 Evidence types: DO=direct observation; QA=questions and answers; RD=reflective discussion; WR=written records; WS=witness statements

| Competencies | Evidence type | Achieved (Signature) | Not achieved (Signature) | No opportunity (Signature) |
|---|---------------|----------------------|--------------------------|----------------------------|
| CPA 6.1 Discuss with the person, and family/carers as appropriate, the options for transfer of care or discharge. Agree with the person and family/carers the goals for transfer of care or discharge. | | | | |
| CPA 6.2 Agree a transfer/discharge plan, including the support needs of the person upon transfer/discharge. | | | | |
| CPA 6.3 Agree with the person, family/carers and services involved the transfer/discharge arrangements. Implement transfer of care or discharge. | | | | |
| CPA 6.4 Monitor and review the effectiveness of the transfer/discharge arrangements. | | | | |
| CPA 6.5 Record and share transfer/discharge records in line with legal and organizational requirements. | | | | |

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