Communication for care planning Introduction to Module 3

The care plan is central to the quality of care for an individual. It must reflect individual needs and clearly outline care requirements in both general and specific terms. It is very important that this document is understood and actively implemented. It is also vital that the care plan is constantly updated and carers at all levels will be contributing to this by recording and reporting information on a daily basis. Good communication skills are important to gathering information for the care plan and to maintaining these records.

This module covers the following areas:

- understanding the care plan
- gathering information to support the care planning process
- recording information that will contribute to the care plan.

The summary activity for this module asks learners to complete some care plan documentation using a range of material. Although it is understood that many care workers will not be responsible for completing care plan documentation, this activity does provide an opportunity to show a good understanding of the process and to apply the skills practised in the module in their own workplace setting.

Social care – Module 3: Communication for care planning

Theme	Page ref.	NOS/ NVQ	Induction Standards	Foundation Standard 1	Literacy	Numeracy	Key Skills
Understanding care plan format	Sc 3:1–2	HSC21d; HSC25	2.2	2.5; 5.1; 5.2	Rw/E3.1; Rw/E3.3; Rw/L1.1		C1.2
Accessing and retrieving records	Sc 3:3–4	HSC21d; HSC224		2.5	Rt/L1.5; Rw/E3.4	N1/L1.1	C1.3
Understanding information on care plans	Sc 3:5–8	HSC21d			Rt/E3.1; Rt/L1.3; Rt/L1.5; Rt/L2.3; Wt/L2.6		C1.2; C2.2; C2.3
Entering straightforward information into a form	Sc 3:9–10	HSC21d; HSC25			Wt/E3.4; Rw/E2.1; Rw/L1.1	MSS1/E2.3	C1.2
Gathering and recording information for everyday records	Sc 3:11–16	HSC21d; HSC24; HSC25; HSC224; HSC233	1.3		SLc/L1.2; SLc/L2.2; SLd/L2.5; Rt/L1.3; Wt/L1.4; Wt/L1.2; Wt/L1.5; Wt/L2.2 Ww/L1.2		C1.2; C1.3; C2.1
Amending a care plan	Sc 3:17–18	HSC21d; HSC25; HSC224			Rt/L1.1; Rt/L1.3; Wt/L1.2; Wt/L1.4; Ww/L1.2		C1.3; C2.3

Skills checklist

A care plan is a resident's most important document. Understanding care plans and daily records and contributing to them is part of your job. You should be observant and sensitive to the needs of your residents so that what you say and write in your records is accurate.

You will need the following skills to understand and communicate all the essential information at work. Tick all the skills you have already and then look again at the checklist when you have used the materials

Skills for care planning	Now	Later
Understanding the way that care plans are written		
Knowing how and where to find the information you need		
Understanding specialist words used in care		
Knowing how to fill in forms		
Knowing how to ask the right sort of questions to get the information about a resident		
Knowing how to change parts of a care plan from the information gathered		

PAGES 3:1–3:2

Understanding care plan format

Occupational setting

Care plans and the information they contain are central to the system of care. Learners will need to be able to read and understand care plans, in order to carry out those plans effectively. They may not be involved in completing care plans, though information they gather will be used to complete them. Both entering information into and extracting information from care plan forms demands familiarity with the format of the forms and the vocabulary used in them. This theme develops the skills needed to read and understand the forms themselves and the kind of information required in each section. This skills development supports units HSC21d and HSC25.

Materials

Variety of forms from workplace

Care plan forms from Source material

Dictionary

Learning outcomes

1 To use headings and subheadings to locate information (focus page, Tasks 1 and 3)

2 To use reference material to find meanings of unfamiliar words (Task 2)

Suggested teaching activities

Introduction

- Discuss the Admission Assessment Sheet and its purpose. Do learners contribute to this form in any way? Do they need to read it?
- Think about the information required on a typical Admission Assessment Sheet. Write individual ideas on sticky notes. Try to organise the notes into groups or themes and give each theme a title, e.g. personal information, medical information, contacts. Conclude that information is easier to access if it is organised into smaller groups than if it is in a continuous list. Relate to headings and subheadings.

Focus page

- Using the form on the focus page or one from the workplace, analyse the information on it and how it is organised. How are headings recognised?
- Highlight any difficult words or phrases on the form (e.g. DOB, relationship, allergies, medication, urine, admission, anxieties, mental awareness, past occupation, dentures). Note that some words are included in the tasks.
- Some of these words have specific meanings, for example, 'relationship' here means whether you are a blood relation to the service user and the nature of this relationship (i.e. a suitable response would not be 'friendly'). Some of the terms are medical or technical, for example 'allergies', 'mobility'. This is a good opportunity to discuss why this information is required on forms and the significance of the information for planning care. Why is information needed about urine? What kind of information is needed?
- This is also a good opportunity to discuss issues of confidentiality and sensitivity. What do these terms mean in the workplace?
- Use a glossary or dictionary and general knowledge to ascertain meanings of these words.
- It is a good idea to get learners to develop a personal glossary – a small notebook, alphabetically indexed – in which to put words from the glossary and any others they need to remember.
- Practise explaining the meanings to a colleague to clarify understanding.

Curric. refs	NOS	Key skills
Rw/E3.1 Rw/E3.3 Rw/L1.1	HSC21d HSC25	C1.2c

Task 1

Use reference material or ask to find out the meaning of unfamiliar words and explain it to check understanding
Rw/L1.1

- Learners should realise that understanding the meanings of the words used on care forms is just as critical as understanding what someone else has written on the form.
- Learners need to realise that checking they have understood correctly is important.
- It is sensible to ask a colleague for help, though you may need to discuss circumstances where this might not be so helpful.
- Check learners are familiar with the use of a glossary or dictionary.
- Learners should do this task in pairs, coming up with meanings, then checking them in the glossary.
- It would be useful to spend some time discussing issues around each word. Why is it necessary to record information about mobility? What kind of information would you expect to see here?

If the learner has difficulty

- ESOL learners may have difficulty with many of these words as some have specific uses, for example admission. Some words may also be confusing in their vocational setting, for example 'continence/continent' can be easily muddled with 'continent', as in Europe. It is worth spending time ensuring that each of the information categories is properly understood.
- Some learners will not understand the term 'next of kin'. You may need to explain what this means, using examples from the learner's experience.
- Refer to activities in *Skills for Life* involving alphabetical order and using reference material.

Extension

- Repeat the exercise with further words from other documents.
- Look at other words related in meaning to the words selected here (e.g. diagnose, diagnostic, mobile, continent, incontinent).

Task 2

Sort sub-headings under headings
Rw/E3.1

- Refer to different types of form used in the workplace in which the location of information is speeded up by using headings and subheadings.
- Discuss the information to be placed under each subheading.

If the learner has difficulty

- In order to do this activity, learners need to understand the words as used and may need support to do this.
- Some learners may need support to sort these terms into categories (e.g. Why isn't information about allergies classed as personal information?) and a thorough understanding of what these terms do and do not mean is necessary.
- Provide further examples of documents in which headings and subheadings are used to sort information. Repeat the organisational exercise from the focus page.

Extension

- Find headings and subheadings in other documents such as NVQ portfolio, policies, procedures, health and safety information.
- Devise exercises to locate specific information in these documents using headings and subheadings.

Task 3

Locate places on forms where information is required and insert information
Ww/E3.3
Rw/E3.1

- Follow the procedure for filling in forms, as described on the focus page.
- The care plan is a legal document, so care must be exercised in completing information accurately.

If the learner has difficulty

- Check understanding of words such as diabetes.
- Check understanding of the relationship between subheadings and comments (e.g. the information about mental awareness).

- Encourage learners to complete the easier parts of the form first (e.g. telephone number), eliminating these from the search.
- Learners may have difficulty matching some of these comments to the subheadings (e.g. diagnosis). An understanding of the subheadings and the type of information gathered under them is critical; you may need to spend some time on this.

Extension

Using the Admission Assessment Sheet from the Source material, learners can enter information from a case study or about a resident with whom they are familiar.

Theme assessment

- Learners use headings and subheadings when locating information within an NVQ portfolio or a policy or procedure.
- Learners will demonstrate their understanding of headings and subheadings in care plans and other documents by knowing how to find specific information in the document and by adding information correctly to documents. This should be tested using real documents from the workplace.

Understanding care plan format

Focus

Forms are a quick way to see lots of information.
Get to know the form by reading it through.

Section headings tell you what each section is about and make it easier to find specific information.

Section headings should stand out. Look for:

- CAPITAL LETTERS
- **Bold letters**
- Big letters
- Underlining
- **ALL OF THESE**.

Subheadings show you where to put the detailed information.

Look up any **words** you do not understand. Can you explain the words to a friend or colleague?

REMEMBER!

You are dealing with confidential information and must treat it sensitively.

Admission Assessment Sheet

Personal Information

Title	First name *Ethel*	Last name *Jones*	DOB *05/06/1924*	Admission date *19/03/2005*
Address of client	*27 The Buildings* *Newtown, Northshire NS6 9KL*			Tel. no. *09823 765321*
Name and address of next of kin	*Mrs Mary French* *95 Oak Street, Newtown, Northshire NS1 2WS*		Relationship *Daughter*	Tel. no.

Medical History

Name and address of client's doctor	*Dr A Richards* *The Practice* *Newtown, Northshire NS9 8YG*			Tel. no. *09823 810200*
Diagnosis				
Allergies	*Nuts, Aspirin*			
Medication	*Paracetamol if pain killers needed*			
Assessed at *Newtown House*	Assessed by *Hilary Smith*	Blood pressure *142/85*	Weight *66 kg*	Urine *Glucose present*
Comments	*Be aware of possible need for Insulin in near future*			

Additional Information

Reason for admission	*Unable to cope with diet necessary to control diabetes*
Mobility	*Uses Zimmer frame*
Anxieties	*Is concerned about a pet cat*
Mental awareness	
Diet	
Continence	
Interests	*Plays bridge. Enjoys watching quiz programmes on TV*
Past occupation	*Legal secretary*
Religion	
Comments	

Equipment	Wheelchair *No*	Hearing aid *No*	Zimmer frame *Yes*	Dentures *Yes*

Understanding care plan format

Task

Understanding the forms in care plans means knowing how they are organised and what all the words in them mean.

Task 1

First check that you know all the technical words on the form. What do these words mean?

Diagnosis _____

Mobility _____

Continence _____

Next of kin _____

Task 2

Match the subheadings to the section headings on the form. One is done already. Make sure you understand whatever each of them means.

Title	Anxieties	~~Interests~~	Surname	Mobility
Religion	Allergies	Medication	Admission date	

Personal information

_____

_____

_____

Medical history

_____

_____

Additional information

Interests

_____

_____

_____

A **glossary** is a list of specialist words and their meanings. It may be more useful than a dictionary for finding the meanings of medical or technical words.

Keep a notebook with the spelling and meaning of the technical words that you may need to use.

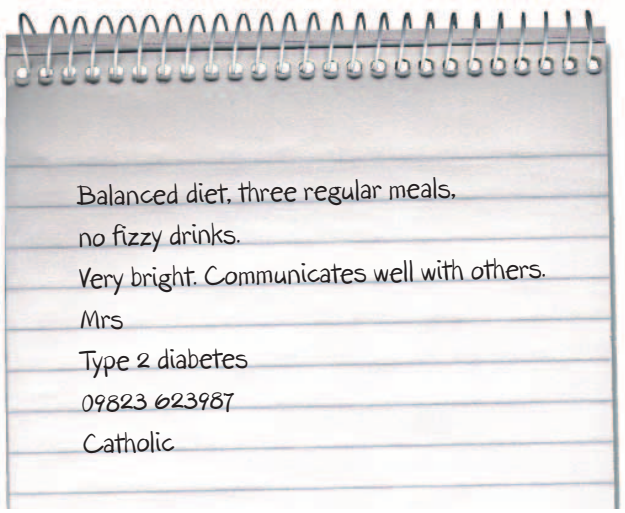
Organising topics under headings and subheadings makes it easier to find information on a page.

Task 3

Use the information on the notepad to fill in the rest of the form on the focus page.

1 Make sure you copy medical and technical terms correctly.

2 Make your writing as clear as possible. It is important information that other people will need to read and understand.



Using headings to find where to put information on forms.
Finding out the meanings of words on forms.

Rw/L1.1; Rw/E3.1

PAGES 3:3–3:4

Accessing and retrieving records

Carers need to be able to retrieve and return care plans and other information stored in filing systems. Techniques for locating information within a care plan are also required but are dealt with in more detail in Module 1 – Communicating in care and Module 2 – Information at work. This theme develops the skills of sorting and retrieving information in alphabetical order, as well as scanning skills for swift location of information. It contributes to units HSC21d and HSC224.

Materials

Access to information stored in different formats, as used in the workplace

Telephone directories and other materials in which information is stored alphabetically or numerically

Learning outcomes

1 To find and return records in an alphabetical filing system (focus page, Tasks 1 and 3)

2 To find and return records in a numerical filing system (focus page, Task 2)

3 To practise the skill of scanning to locate particular information in a care plan file (focus page, Task 4)

Suggested teaching activities

Introduction

- Discuss how records are organised in different workplaces and the problems that arise. What are the difficulties? Elicit identical names, names beginning with the same letters, Mc/Mac, De La etc. What is the best way to tackle these points? Discuss sorting by numerical order (e.g. on order forms).
- What involvement do learners have in finding and returning records? What would be the impact of not returning files to the correct place?

Focus page

- Check learners know or have strategies to sort into alphabetical order, to the level required here.
- Check learners understand how numbers are used in codes for filing. Cite the example of the NVQ portfolio.
- Check learners are familiar with the skill of scanning to locate information.
- Look at the information on the focus page and discuss its application in the learners' workplaces. Where are records kept? What sort of filing system is used?
- This theme gives you the opportunity to discuss issues of confidentiality. What does this mean? How confidential is confidential? Note that 'confidential' in the workplace does not necessarily mean that no-one else must know – there is a limit to who knows.
- Link this to the Data Protection Act. Learners could find out about this on the Internet. They need to understand how the Act impacts on records kept at work.

Curric. refs	NOS	Key skills
Rw/E3.4	HSC21d	C1.3a
Rt/L1.5	HSC224	
Nl/L1.1		

Task 1

Sort surnames into a filing system using first and second letter clues
Rw/E3.4

- Remind learners of real-life scenarios and reasons for accurate filing. This task is about sorting files into broad alphabetical groups, though they could also go on to sort into alphabetical order within these groups.
- Discuss difficult issues, e.g. last names beginning with Mc, Mac; people with the same name.

If the learner has difficulty

- Dyslexic learners have difficulty sorting into alphabetical order and will be supported by having the alphabet in front of them for this activity. The alphabetical groups used for this task, whilst being authentic, may add to the confusion (especially the split in the 'M' section). It is probably best to tackle each name in turn, using questions and answers, asking the learner to decide if this name falls into the alphabetical group.
- Write the names on cards for learners to sort manually.
- Some ESOL learners may also need support with alphabetical order.
- Provide the alphabet on a card or piece of paper, for reference; this can be a real support.

Extension

- Sort files from the workplace using first- and second-letter clues.
- Check in a telephone directory to see how names where there are potential difficulties are listed (e.g. Smith, MacTavish, O'Leary).

Task 2

Sort nine-digit numbers from lowest to highest
N1/L1.1

- Numbers often form part of coded filing systems.
- Learners should sort them in the same way as an alphabetical list, i.e. by first, second and subsequent digits.
- This is a deceptively simple task, made difficult by the visual discrimination skills required.

If the learner has difficulty

- Make sure the learner understands the principles of sorting numerically, as it is tempting to sort from right to left. Talk through this with an example from the page, pointing them to the first set of three digits (which decides the first aspect of the order) and deciding which is the largest / smallest number.
- Repeat the activity using numbers with fewer digits.
- Check learners' visual discrimination skills, particularly of numbers. Note: some dyslexic learners will find this task difficult as they have problems distinguishing the crowd of very similar numbers in a list. A guide card or ruler might help.
- Write the numbers on sticky notes for learners to put the numbers in order.

Extension

Repeat the activity combining letters and numbers to form a code.

Task 3

Arrange names in alphabetical order
Rw/E3.4

- Remind learners of instances of common names (e.g. Jones) or names of married couples when the surname would be identical and so names need to be sorted by initial.

If the learner has difficulty

- Write names on sticky notes or cards so that the learner can move them around until satisfied with the order.
- Reference to an alphabet would help with this task.

Extension

Give the learner another set of names to sort into alphabetical order, or to place correctly in a file.

Task 4

Scan a piece of text to locate the words 'file', 'files', filing'
Rt/L1.5

- Remind learners that it is not always necessary to read every word when searching for information, but to use scanning skills. This task practises these skills.
- Remind learners to think about looking for a familiar face in a crowd.
- Scanning skills are useful for finding information in longer texts and will be useful when researching for assignments.

If the learner has difficulty

- Good tracking skills (a visual skill) are required for this task. Some dyslexic learners will find this difficult and may miss out lines or not spot the words as they are distracted by actually reading the text.
- It might be useful to try scanning the text from the last line upwards.

- Encourage learners to use a ruler, card or finger to track each line rather than the whole text.

Extension

- Further scanning activities can be found in Module 2 – Information at work.
- Scanning skills can be used to locate service user's files and particular information in longer documents such as care plans (find the information about Mrs Worth's diet).

Theme assessment

- Ask learners to find specific files or cards in a filing system or to find names in a telephone directory.
- Ask learners to return files to a filing system.

Accessing and retrieving records

Focus

Are records on computer, in a card index or in a filing cabinet?

Every organisation has its own way of keeping records.

You should find out how the filing system in your workplace works.

Find out:

- where the records are kept
- how they are organised
- where you should return them to.

Ask someone who knows the system to show you how to use it.

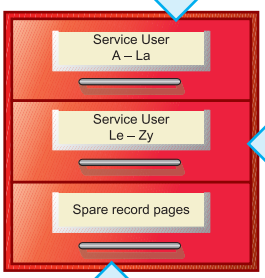
Are they numbered or in alphabetical order?

Not putting records back in the right place can cause a lot of extra work and may lead to important information being lost.

When you put a file away, look at the file in front as well as the file behind to check that it is in the right place.

To sort records that are numbered or coded:

- sort them so that the lowest number comes first and the highest last
- look for patterns in the numbers
- read the numbers in small batches
- read the numbers from left to right.



To sort records into alphabetical order:

- put the ones at the beginning of the alphabet first
- use the first letter of the surname to decide on the order
- if there are two first letters the same, look at the second letters
- if they are the same, look at the third letter, then the fourth and so on
- if there are two identical surnames use the initial letter of the first names.

There is no need to read every word when you are looking for information in the records. This is where the skill of **scanning** comes in useful.

CONFIDENTIALITY

The personal information on service users is always confidential.

To respect the privacy of residents and others, you should know what your responsibilities are.

Find out about the Data Protection Act 1998

Accessing and retrieving records

Task

Task 1

Write the names that you would put into each drawer of the filing cabinet.

Drake	Cryer	Miles	Adamson	Siddiqui	Earl
Mead	Gregory	Wardle	Taylor	Myles	Harper
McCourt	Ismail	Pindar			

A – Dy _____

Ea – Hy _____

I – Me _____

Mi – Ry _____

S – Zy _____

M', Mc, and Mac are usually all treated as Mac. The next letter in the name or the initial decides the position.

M'**C**aul
Mc**D**owell
Mac**g**owan

M'cintosh **A**
McIntosh **M**
Macintosh **R**

Task 2

Write these numbers in the correct order, smallest to largest.

EH/ 092/ *543*- 765
EH/ 012/ *843*- 765
EH/ 082/ *543*- 765
EH/ 012/ *643*- 765
EH/ 022/ *543*- 799
EH/ 032/ *543*- 765
EH/ 022/ *543*- 765
EH/ 032/ *545*- 465
EH/ 012/ *543*- 769

Look at long numbers in batches of three.

012345678
012 345 678

If it helps you to remember, repeat each batch aloud.

Task 3

Arrange these names into alphabetical order by surname.

HENRY ALLAN	SUSAN AMOS	ABDULLA O	AHMAD Dr G	ADDAMS W S
J ABRAHAMS	A T ABBOTT	ASHWANI D	ANDERSON E K	ANDERSON E H
ADAMS R S	AZIZ R T	J ABRAM	ADAMS A W	MILLICENT ALLEN

Task 4

How many times are the words 'file', 'files' or 'filing' mentioned in this piece of information? Scan the text and highlight the words.

Filing systems only work well if everybody follows the same method when they remove or replace files into the system. It is a good idea to leave a note if you need to take a file away. Return every file as soon as possible. Don't leave files lying around after you have finished with them. They contain confidential information that should only be seen by the people involved in the care of the service user. Make sure that you put every file back in the right place. Look at the file in front of it and the file behind it to see if it fits in where you are going to put it.

Aa Bb Cc Dd Ee Ff Gg Hh Ii Jj Kk Ll Mm Nn Oo Pp Qq Rr Ss Tt Uu Vv Ww Xx Yy Zz

Rw/E3.4; N1/L1.1; Rt/L1.5

PAGES 3:5–3:6

Understanding information on care plans (1)

Occupational setting

Learners and employees will be required to read and understand service users' care plans. These documents are critical records of the service user's care and contain a lot of confidential information. It is important that learners take account of confidentiality guidelines and are able to complete plans appropriately and accurately. This page supports development of skills in mandatory unit / element HSC21d. The theme develops the reading techniques that will allow learners to understand information accurately, with a reading strategy and questioning.

Materials

Copies of sample care plans from the workplace (taking account of confidentiality issues)

Policy document from the workplace

Learning outcomes

1 To use the 'PQ4R' reading technique to tackle longer pieces of text in service user records (focus page, Tasks 1 and 2)

Suggested teaching activities

Introduction

- This is a good opportunity to talk about the central role of care plans in social care, and learners' role in these. Discuss confidentiality, if not already considered.
- Discuss learners' involvement in reading care plans and any difficulties encountered in interpretation. Are they easy or difficult to understand? What might be the impact of not having a clear understanding of the information in care plans?
- Discuss how learners tackle reading tasks where there is a lot of text to read. You may find that there are several approaches, ranging from no particular strategy to someone who has been taught how to use a particular approach. Write up any issues and difficulties and discuss how they could be tackled.

Focus page

- Look at the example on the focus page and consider some of the issues arising: unfamiliar vocabulary, interpreting information that may not be very clearly expressed, lack of formatting. What can be done about each of these? It is useful to acknowledge that these are also issues for experienced readers (most people need to check meanings of words).
- Introduce and discuss the 'Preview, Question, Read, Reflect, Repeat, Review' (PQ4R) technique for reading. Test this using a piece of complex material such as a policy document. You could run this as a group activity:
  - All look at a text.
  - What is it about?
  - What do you expect to find in it?
  - Read the first paragraph – what is it about?
  - Think about the first paragraph, re-read it to make sure you understand it.
  - Explain what it is about in your own words.
  - Is it about what you thought it was about?
- Confirm that, if text is difficult to understand, using this reading technique can help. It is not necessary to use this technique for all reading however.

Curric. refs	NOS	Key skills
Rt/E3.1 Rt/L1.5	HSC21d	C1.2

Task 1

Look briefly at text to decide its purpose
Rt/E3.6

- Give learners a moment to glance at the text in order to answer the questions. Ask how they decided what the text is about. Expect to hear about key words (ask for the exact words), format and length of text.

- Discuss how this first quick glance at a text is used to decide whether to carry on reading (Is it what I'm looking for?) and how you will read it (I need to scan this text for information about Kenneth's hobbies so I can set up some activities for him).

If the learner has difficulty

- Dyslexic and ESOL learners may need more time than other learners to take in the message of a piece of text. Try breaking the text into chunks to help with comprehension.
- Learners whose reading skills are insecure may find this task difficult and get stuck in trying to read every word. Encourage them to practise glancing at texts, for instance in magazines or newspapers, and guessing what they are about.

Extension

Practise this skill in other areas of work where research is required (e.g. finding information for a project).

Task 2

Read text in detail, using reading strategies
Rt/L1.5
Rt/E3.1

- This task requires learners to read and extract meaning from a service user's record. Encourage them to use the PQ4R technique and to look up words (e.g. analgesic) in a glossary or dictionary if needed.
- Check responses carefully and look out for learners who complete this task very quickly – they may be guessing.
- Encourage learners to practise the PQ4R technique.

If the learner has difficulty

- Work through the questions systematically with the learner. Make sure they understand the question and any words in the text.
- ESOL learners may need assistance with the meaning of some terms (e.g. misses her company, ships in bottles, watch out for, side-effects).

Extension

- The PQ4R strategy is useful but needs to be practised in order to consolidate skills. Set similar questions on longer pieces of workplace text such as health and safety or policy information.
- Ensure learners remember to use these skills when researching for projects.

Understanding information on care plans (1)

Focus

Reading a resident's profile

If you have a complicated piece of information to read, tackle it a bit at a time.

Read a sentence.
Ask yourself what it says.
Put it in your own words.

Part 1.2 The Resident's Profile

Name *Dorothy Barker*

I am prepared to share, with people who will be assisting me, information about me including: previous work or social interests, hobbies, leisure pursuits, family background, culturall religious beliefs.

Signature of resident D. Barker

*Dorothy has never married. She worked as a **milliner** in a department store in Liverpool, then moved to London where she worked in ladies **lingerie** sales. Her underwear has to fit correctly. She is very particular about everything, especially personal hygiene. Her hair must be natural but tidy and tied up, preferably in a bun. She enjoys her food but is very slow as every mouthful has to be chewed 32 times before swallowing. She used to read a lot but this has been replaced by watching the TV as her ability to concentrate is not as good as it was. Takes a keen interest in **birds** garden.*

Continue on additional sheet

What is a milliner?

lingerie…
It has something to do with ladies and she's particular about her own underwear.

'Takes keen interest in birds garden?' Does she mean garden birds? I will have to ask her.

If it still does not make sense, ask about it.

You can get a brief idea about a text before you read it.
Where it is from: novel, newspaper or care plan.
What it looks like: handwritten, printed, bullet point.

As you are reading:
- ask yourself questions
- work out the meaning of new words from the context
- repeat something if it does not seem to make sense.

A technique for reading and understanding what you are reading is **PQ4R**:

Preview – Look at the text and try to decide what it is about.

Question – Ask yourself what you are expecting to find out as you read.

Read – Read a paragraph or section at a time.

Reflect – Think about what you have read.

Repeat – Repeat what you have read in your own words.

Review – Go back to the questions to see if they have been answered.

Understanding information on care plans (1)

Task

Use the PQ4R techniques on the focus page to identify the relevant information from this resident's profile.

Task 1

Look quickly at – or preview – this text and answer the questions. Do not read it yet.

1 What do you think this text is likely to be about?

2 What sorts of things are you expecting to find when you read it?

You can get an idea about a text from where it is and what it looks like.

Name *Kenneth Dawson*

I am prepared to share, with people who will be assisting me, information about me including: previous work or social interests, hobbies, leisure pursuits, family background, cultural/religious beliefs.

Signature of resident K J Dawson

Kenneth likes to be known as Chips. He has been called this all his life following his working life as a carpenter. His wife only called him Kenneth when she was angry with him. He misses her company since she died last month. He has some amazing ships in bottles in his room that he made when he was younger. His severe arthritis means that he cannot work with his hands any longer, but he has a series of exercises that he does to try to keep his joints more mobile. He says the physiotherapist at the hospital that he visits every three months told him what to do and it helps. He takes an analgesic when he is in pain. He also takes an anti-inflammatory that he cannot remember the name of – Methotrexate I think he said. Anyway we have to watch out for side-effects like headaches, rashes and stomach upsets. He tries not to eat oranges as they make the arthritis worse.

Task 2

Read the text using PQ4R. Use the information in the resident's profile to answer these questions.

1 Analgesic means: **a** arthritis tablet **b** pain killer **c** drug.

2 He has regular appointments at the hospital.
True/False/Maybe

3 His preferred name is Chips.
True/False/Maybe

4 If he is called Kenneth he thinks you are angry with him.
True/False/Maybe

5 He gets a lot of headaches, rashes and stomach upsets.
True/False/Maybe

6 Mobile means: **a** phone **b** moving **c** fixed.

PAGES 3:7–3:8

Understanding information on care plans (2)

Occupational setting

Learners and employees may be required to contribute to the completion of care plans, assessment records and other service user records. These documents are critical records, containing a lot of confidential and sensitive information. It is important that learners take account of confidentiality guidelines and are able to complete these plans appropriately and accurately. This theme develops skills in mandatory unit HSC21 and optional unit HSC25. Skills in this theme focus on selecting what is relevant to include in assessment records and framing this appropriately for transfer to the care plan.

Materials

Examples of completed assessment plans and care plans (taking account of confidentiality issues)

Workplace guidelines for completing documents

Learning outcomes

1 To select relevant information (focus page, Task 1)

2 To write information appropriately (focus page, Task 2)

Suggested teaching activities

Introduction

- Ask learners what is meant by 'relevant' – try to elicit 'appropriate', 'important', 'about the situation'. Discuss why records need to contain relevant information – illustrate with some examples from the workplace if possible.
- Discuss how different information is required in different records, for example information on diet is important for the kitchen as well as for the care plan, but different levels of detail will be required.

Focus page

- Discuss the different tone used in the Daily Living Needs Assessment sheet and the Care Plan – why is this? (The first is a record of a conversation and uses fairly informal language; the second is information to be given to other staff – it is almost a set of recommendations.)
- Look at the assessment information. Does the information answer the questions on the form? What important things about the service user can you tell from the information given?
- Look at the same information written into the Care Plan. Examine how each piece of information from the Assessment sheet is rephrased to form a 'Service to be provided' (e.g. 'does not like noise' becomes 'avoid noisy situations'). Work through some more examples from materials you bring to the session, or ask learners for examples of assessment information from their own experience.
- You may need to do some work on words such as 'encourage' and 'avoid' to ensure learners understand the positive action required by these terms.
- Confirm the need to treat service user information confidentially and sensitively and to use appropriate, professional language in records.

Curric. refs	NOS	Key skills
Rt/L1.3	HSC21d	C2.2
Rt/L2.3	HSC25	C2.3
Wt/L2.6		

Task 1

Select relevant information
Rt/L1.3

- Check learners understand the difference between Assessment Sheets and Care Plan documents.

- Learners read the information in the Assessment Form and decide what needs to be recorded in the care plan. You may need to talk about the different purposes of these documents, as well as the different tone. It might be useful to have the relevant sections of the care plan available, in order to see what is required on this form.
- It is a good idea for learners to do this task verbally, perhaps in pairs.
- The choices should be noted using a highlighter pen, or the items selected could be recorded on the board.

If the learner has difficulty

- Learners may have difficulty with some of the technical terms in the form and will need support for this. Check understanding with question-and-answer techniques.
- You may need to work with the learner on the different purposes of information in Assessment Sheets and Plans of Care. Refer to the different purposes expressed in the headings in this section of the Assessment Sheet.
- Go through each sentence/part of sentence and ask if this is important or relevant to the care plan.

Extension

- Look at other examples of similar information and select relevant information.
- Discuss why some of the information given here is *not* relevant for a care plan.

Task 2

Write information appropriately
Rt/L2.3
Wt/L2.6

- This task requires a reasonable level of vocational knowledge, as well as good reading and writing skills. A level of inference is required in reading. Learners will need support for this if their vocational knowledge is not in place or if their level of reading is not at Level 2.
- Explain to learners that 'Service to be provided' is about **what** to do. 'Objective' is about **why** to do it.
- You will need to explain this task carefully and take it in stages: the need to select relevant information from the Assessment Sheet; to rephrase points from the Assessment Sheet into 'Services to be provided' using appropriate language and a note form; framing 'Objectives' using the information in the Assessment Sheet.
- It would be useful to model the first example (about the walking frame) with learners.
- Take the task in stages (i.e. decide which are services; rephrase these points; decide on objectives; word these appropriately).
- Check responses carefully to ensure that learners have used appropriate language and that the information in the care plan is relevant and useful to colleagues. Would colleagues know what to do (Service to be provided) and why they were doing it (Objective)?

If the learner has difficulty

- Learners may have difficulty understanding the difference between 'Service to be provided' and 'Objective' – you could explain this in terms of the overall aim of what you are going to do (i.e. the reason for doing it) and the details of exactly what needs to be done. Use another example with which the learner is familiar (e.g. Objective (why): to relax; Service (what): book a holiday).
- Acknowledge that this is a difficult task and needs to be done carefully in stages. You will need to work with the learner at each stage in order to accomplish this task.
- Discuss any difficulties with use of language.

Extension

- Give the learner additional examples if possible.
- Use the assessment information in Task 1 to frame comments into Services to be provided and Objectives.

Theme assessment

- Practice in reading workplace information, allied to confirmation that learners' interpretation of this is accurate, is a good check of reading skills using the PQ4R technique. Further exercises testing the learners' comprehension of text is also useful. This could be done in the context of research for an assignment or when reading policy documents.
- Learners will need practice in extracting relevant information from Assessment sheets for putting into Plans of Care. This should be done with workplace examples. Stress the need for confidentiality and obtaining permission.

- Learners will need practice in rephrasing information for a different purpose (i.e. to move from the relatively informal notes in the assessment sheet to the formal record of the care plan, as Services to be provided and Objectives). This practice should be done using authentic workplace examples (considering confidentiality issues as above).

Understanding information on care plans (2)

Focus

Pick out relevant information

Find out what is needed in the Plan of Care.

Read all the information in the section of the Assessment.

Think about what you have read and put it in your own words.

Use your knowledge and experience of your job to help you to decide what is relevant, what you need to know about. Write details of your decisions in the Plan of Care.

Some things, like the glasses, are not really relevant.

Likes talking to others, so hearing well is important.

Has she got the volume set correctly?

Is it the right hearing aid for her?

If she really will not wear the hearing aid, then other things must be done to help her to communicate.

Part 2 The Daily Living Needs Assessment

2.2 Communication

2.2.1	Does the person use spectacles or hearing aids? Please specify: *No glasses but has a hearing aid that she refuses to use because it makes everything too loud and she does not like noise.*	YES / NO
2.2.2	Is the person registered as blind?	YES / NO
2.2.3	Is the person able to hold a conversation? Please indicate reasons why conversation or understanding might be impaired e.g. sensory, cognitive or physical impairment. *Enjoys a good natter. Finds hearing TV and other people difficult when not wearing hearing aid. Must have TV at maximum volume and people have to shout at her.*	YES / NO
2.2.4	Are there any aids required to assist with communication? Please specify, e.g. loop, picture boards, writing pad, sign language, finger signing, etc. *Hearing aid*	YES / NO

1 Finds hearing difficult when not wearing hearing aid.

2, 3 Makes everything too loud.

4 People have to shout at her.

5 Does not like noise.

Part 3 Plan of Care

3.2 Communication

Service to be provided	Objective
1 Encourage to wear hearing aid if possible.	*To allow her to communicate as well as possible with other residents, relatives and carers.*
2 Check volume is set correctly.	
3 Have hearing assessed.	
4 Speak clearly when hearing aid is not being worn.	
5 Avoid noisy situations.	

Understanding information on care plans (2)

Task

Task 1

These sentences are from an Assessment. Highlight the relevant points for putting in to the Plan of Care document.

REMEMBER!

You are only looking for the **relevant** points to be entered into the Plan of Care.

2.9 Food and meal times

2.9.1 Does the person require assistance with feeding? YES / NO

2.9.2 What are the person's preferred meal times and likes and dislikes of food? Please specify.
Will eat most meals. Does not like supper as it keeps her awake if she eats too soon before going to bed. Likes all food, but must not eat chocolate as it makes her very ill. She is sick and very unwell when she eats it. She thinks she must be allergic to it since her illness.

2.10 Dental and foot care

2.10.1 Does the person require assistance with dental and foot care? YES / NO
If yes, please specify e.g. if dentures used, person's use of dentist and chiropodist.
The chiropodist has visited her regularly at home and she would like to continue this now that she is living here. I suppose she has some sort of fear of dentists as she refuses to see the dentist.

2.11 Religious observance

2.11.1 Does the person require assistance with practising their religion? YES / NO
If yes, please specify.
She will join in the monthly service very infrequently. She used to attend All Saints but has lost her faith since her husband died so tragically and she has been so ill.

Task 2

Highlight the relevant points in this section of the Assessment. Use this information to decide the 'Service to be provided' in the Plan of Care. Write the overall 'Objective' of the service.

Check what you have written when you finish. Does it say what you want it to say?

3.3 Mobility and dexterity assessment

3.3.1 Does the person have any problem with mobility? YES / NO
If yes, please specify and also record any mobility aids used.
Walks with a frame and carer's assistance. Sometimes a wheelchair is necessary but she would do anything to avoid it as she is too proud of her independence to be seen being pushed around in a chair.

3.3 Mobility and dexterity – Plan of Care

Service to be provided	Objective

The 'Service to be provided' is **how** this should be done.

The 'Objective' is what the service **aims** to provide.

Rt/L1.3; Rt/L2.3; Wt/L2.6

PAGES 3:9–3:10

Entering straightforward information into a form

Occupational setting

As a care plan is a legal document, it is essential that all information entered into it is accurate. Understanding how the information should be entered and what words on forms mean is essential for accurate completion. Whilst learners may not be involved in completing care forms, they will be involved in gathering information for forms and need to be able to read them. An understanding of layout and content is an important stage in the development of skills required for accurate completion. This theme develops skills required for units HSC21d and HSC25.

Materials

Selection of simple forms from a care plan where simple information needs to be entered

Examples of inaccurate spelling and information for proofreading

Resident's Care Plan (Part 1 and Part 4) and Admission Assessment Sheet from Source material

Learning outcomes

1 To read and understand simple instructions on forms (focus page, Tasks 1–3)

2 To write dates accurately (Task 2) Note: further practice of this skill can be found in Module 4 – Figure it out

3 To read and understand words used on forms (focus page, Tasks 1 and 3)

Suggested teaching activities

Introduction

- Discuss the variety of forms that need to be filled in at home and at work and the features that they have in common, as well as the variety of ways of expressing the same thing (e.g. name, address, personal details).
- Discuss learners' involvement in Plans of Care. Do they have to fill them in? If not, do they contribute to information gathering? This is a useful opportunity to discuss Plans of Care and their purpose, as well as to confirm learners' responsibilities with reference to Plans of Care.

Focus page

- List as many ways of writing the following as possible: last name, first name, date of birth, delete, circle, sign, print. Discuss terms that are no longer used, e.g. Christian name (because not everyone is Christian). Look at the different ways that instructions are given on the form (e.g. delete, circle, cross out). What would be the impact if these were completed incorrectly?
- Introduce or remind as necessary about the use of a glossary, dictionary, prediction (i.e. working out from the context) and asking a colleague, as techniques for finding the meaning of words.
- Show learners examples of forms where poor handwriting has made information difficult to read. Discuss the implications of this.
- Discuss the use of capital (uppercase) letters (sometimes called 'print'). Why is this often required on forms? Is it easier to write this way?
- Practise techniques for copying accurately. Copy two to three letters at a time. Check back in a similar fashion. Mark where you have got to each time, perhaps using a small pencil mark. Practise copying medical terms, pharmaceutical names and unusual names.
- How are dates written in learners' workplaces? Look at the range of options. You may need to remind them that the American way of recording dates (sometimes used here) is to write the number of the month first, then the day, then the year (e.g. 9/11 is 11th September, not 9th November).
- Stress the importance of proofreading for spelling and accuracy. Why is it important? What could be the impact if something is spelled incorrectly? Provide examples of inaccurate spellings for analysis.

Curric. refs	NOS	Key skills
Rw/E2.1 Wt/E3.4 MSS1/E2.3 Rw/L1.1	HSC21d HSC25	C1.2

Task 1

Find the meaning of technical words
Rw/L1.1

- The meaning of words can be ascertained by using a glossary or dictionary, asking a colleague or using context.
- Compare the results of each strategy. Which is the quickest? Easiest? Most accurate?
- Ask learners to try each of these strategies to check the meaning is correct. A useful strategy is to reword the sentence or phrase that the word is in to check for sense.

If the learner has difficulty

- ESOL learners and others may need help to identify the meanings of some of these terms, although they occur on many forms. 'Principle' may be confused with 'principal', particularly by learners based in a college.
- Check alphabetic skills to ensure learners have the skills to look up words in the glossary. Ensure learners understand the glossary or dictionary definitions.
- Give further practice using the glossary.

Extension

- Compare dictionary and glossary definitions.
- Make a glossary for use by colleagues.

Task 2

Write the date
MSS1/E2.3

- Look carefully at the three conventions used here for writing the date. Which one is the easiest to understand? Which one is used in the workplace? Are there any other ways of writing the date? You should mention the American convention here, if not already discussed.
- Discuss the possibility of difficulties arising from using a range of different ways of writing the date. What might be the impact of confusion here?

If the learner has difficulty

- Refer the learner to *Skills for Life* numeracy material for further teaching and practice. In particular the numbering of months may be an issue.
- Learners with dyslexia may put numbers in the wrong sequence. They may not know the numbering of months. Careful checking is needed.

Extension

It is useful to practise writing dates from verbal prompts and to practise writing dates in different formats.

Task 3

Proofread care plan for errors
Wt/E3.4

- Encourage learners to read through the form carefully, noticing the instructions in particular.
- A methodical approach should be encouraged to spot the errors (see below).

If the learner has difficulty

- Some background knowledge is required for spotting errors (e.g. that a Sikh lady is unlikely to be of Chinese ethnic origin. You may need to discuss this).
- Many of the errors relate to incorrect reading or interpretation of the instructions. Remind learners to read instructions carefully.
- Go through the form with the learner, identifying the errors and eliciting correct answers.
- The errors are as follows.
  - The form is filled in using blue pen – it should be black.
  - The form is filled in using handwriting – it should be in capital letters.
  - Information has been crossed out where it should be ticked.
  - Information has been circled where it should be deleted.
  - The address is in the wrong place.
  - The telephone number is in the wrong place.
  - The age is wrong (see Module 4 (Figure it out) for how to calculate age).
  - The religion and principal language have been confused.
  - Ethnic origin is incorrectly ticked.
  - Information has been crossed out when it should have been circled.

Extension

Check through other completed forms for errors.

Theme assessment

- Complete a form from the Source material using the details of a colleague.
- Develop a checklist for completing forms. Use this to score completed forms.

Entering straightforward information into a form

Focus

A care plan is a legal document. Make sure that what you write is accurate.

The same information can be written on forms in many different ways. For example, First name could also be written as:

- given name
- forename.

Instructions about how to complete the form can be given in lots of different ways. For example:

- circle
- delete.

Heatherdean Care Home PLAN OF CARE

All information is to be treated as confidential

- Please write clearly
- Use black ink

Attach current photo of service user here

Service User

First name(s)	Date of birth
Last name	Age
Maiden name (if known)	Religion
Preferred name	Principal language
Gender (tick where appropriate) male ☐ female ☐	Is Interpreter needed? (Circle as appropriate) yes no
Marital status (Delete where applicable) Married/ single/ widowed/ divorced	Ethnic origin
Home address	Telephone number
GP Name	Address
Telephone day	Telephone night
Next of kin Name	Address
Telephone day	Telephone night
Relationship to service user	
Alternative contact emergency number	
Name	Telephone
Relationship to service user	

Service User Property/Valuables	Yes	No	Comments
Disclaimer form signed	☐	☐	
Property in safe	☐	☐	
Property given to relative	☐	☐	

Your workplace may have a policy about the way dates are written. Find out what it is and write dates in this way.

- 04/08/1934
- 4/8/34
- 4th August 1934

There may be words anywhere on the form that are new to you. You can:

- look them up
- ask what they mean.

Before you begin filling information in a form:

- read the form through
- find out the meaning of anything you do not understand
- check you have all the information you need.

When you are filling in a form, make sure:

- you follow the instructions on the form
- your writing can be understood by anybody reading the form
- you copy accurately.

Afterwards, read what you have written to check:

- all the information is in the proper places
- the information is accurate
- words are spelt correctly.

If you need to, write in pencil first, check it through, make changes and complete in pen. Or you could make a photocopy and practise filling it in.

Entering straightforward information into a form

Task

As the care plan for every resident is a legal document, it is important to know what to write, how to write it and where to write it.

Ask a friend or colleague. Use a glossary or dictionary.

Task 1

Find out the meanings of these words used on forms. Make a note of some words that you could use instead.

Principal language

Maiden name

Marital

Ethnic

Delete

applicable

appropriate

Task 2

Write the dates in three different ways. Some have already been completed.

Write dates in the same way they are written at your workplace.

1	02/02/1921	2nd February 1921	2.2.21
2	15/03/1934	_____	15.3.34
3	_____	27th April 1910	27.4.10
4	15/07/1929	_____	_____
5	_____	_____	13.6.41

Task 3

Check through this form; it has not been completed correctly. Draw a circle around each mistake that has been made.

You may need to check a form several times, looking for different things each time.

Heatherdean Care Home PLAN OF CARE

All information is to be treated as confidential

- Please write clearly
- Use black ink

Attach current photo of service user here

Service User

First name(s) Manjit	Date of birth September 7th 1934
Last name Dhillon	Age 80
Maiden name (if known) Not known	Religion English
Preferred name Manjit	Principal language Sikh
Gender (tick where appropriate) male ☐ female ☐	Is Interpreter needed? (Circle as appropriate) yes no
Marital status (Delete where applicable) Married/ single/ widowed/ divorced	Ethnic origin (tick where appropriate) White ☐ Asian ☐ Black ☐ Chinese ☑
Home address 0945 6788321	Telephone number 27 The Grove Kington KT6 9HG

Rw/L1.1; MSS1/E2.3; Wt/E3.4

PAGES 3:11–3:12

Gathering and recording information for everyday records (1)

Occupational setting

This page covers the communication skills required for gathering information from service users and provides development of the skills outlined in HSC21d and HSC224 of the standards. Skills development focuses on the use of active listening skills and appropriate questioning techniques. Much of this should be covered in group work, with learners using structured role-play activities as suggested.

Materials

Sets of prepared questions about, for example, diet, hobbies and interests, clothes preferences, for role-plays

Good Practice Guidelines relating to questioning service users from the workplace, if available

Learning outcomes

1 To decide what questions to ask to gather relevant information (focus page, Task 1)

2 To phrase questions appropriately, with an awareness of open and closed questions and confirmation (focus page, Task 2)

Suggested teaching activities

Introduction

- Discuss learners' involvement in gathering information from service users and the difficulties associated with getting accurate and useful information from them.
- Set up a role-play with a 'care worker' and 'service user', where the care worker has specific information to gather (e.g. a set of prepared questions relating to diet) and the service user finds it difficult to respond to the questions (for instance because she is confused or upset). You may need to role-play the service user if learners find this difficult. The learner should take the part of the care worker and ask the prepared questions.
- Discuss learners' experience of and strategies for dealing with this sort of situation, where the service user is confused.
- Discuss any Good Practice Guidelines available for obtaining information from service users or ask the group to think about what is good practice (e.g. a list of 'dos and don'ts').

Focus page

- Discuss open and closed questions – what they are, their impact on the information gathered and how to frame them. This could be done via a role-play, using all closed questions, then all open questions, with a discussion about the impact on quality of information gathered and the feelings of the person being questioned.
- Learners should use the set questions, if necessary, and may need to prepare open and closed questions beforehand.
- Discuss body language and its use in active listening. Set a role-play in which one person is talking about something (e.g. a problem with someone at work); the listener first withholds active listening (i.e. no eye contact, confirming comments, responses), then listens actively (i.e. eye contact, confirmatory gestures and verbal responses, rephrasing of comments). Discuss the impact of active listening on the listener and the quality of information gathered.

  Remember however that cultural differences can cause confusion. In some cultures, it is impolite to meet a direct gaze and eye contact is avoided.

  In others, the head can be shaken to imply 'OK', but it may come over as 'no'.

  Discuss any known cultural differences and the possible misunderstandings they may cause.
- Discuss some strategies for starting and encouraging a conversation and confirmation questions – this could result in a checklist or good practice guide for others.

- You may want to discuss strategies for what to do if there is a real problem in getting information from service users, e.g. translators, assessment for hearing impairment, using a friend as a mediator.

Curric. refs	NOS	Key skills
SLc/L1.2 SLc/L2.2 SLd/L2.5	HSC21d HSC224 HSC25 HSC24 HSC233	C2.1a

Task 1

Decide what questions to ask to gather relevant information
SLc/L1.2
SLc/L2.2

- Remind learners about the use of open questions for giving the service user space to talk about problems and closed questions when a yes/no response is required. Both types of question are needed for this form.
- Learners select appropriate questions from the suggestions on the page. This could be done in pairs. Encourage learners to practise the questions, with appropriate intonation.
- Discuss responses and why they were selected. A number of the suggested questions are inappropriate. Discuss why they are inappropriate (e.g. 'Are you deaf?' could be insulting and isn't the information you need here anyway).
- You may need to spend some time discussing why some questions are inappropriate. This may be a good opportunity to discuss diversity and also the need for sensitivity.

If the learner has difficulty

- Learners may need support with deciding about open and closed questions. If the answer could be yes or no, then it is a closed question.
- Confirm the learner's understanding of technical terms such as dexterity and mobility.

Extension

Develop a set of open and closed questions, with some suggested confirmation questions, for this and other sections of the workplace care plan.

Task 2

Phrase questions appropriately, with an awareness of open and closed questions and confirmation
SLc/L1.2
SLc/L2.2

- Remind learners about the use of open questions for giving the service user space to talk about problems and closed questions when a yes/no response is required. Both types are needed for this form.
- Learners could do this task in pairs and test the questions on each other.
- Share and discuss all questions; select the best ones for inclusion in a Good Practice Guide.
- You may need to remind learners about the need to be polite and sensitive when gathering personal information of this kind.

If the learner has difficulty

- Learners may have difficulty framing questions and you may need to model one or two to support understanding. Remind them about testing for closed questions with a yes/no response.
- Confirm the learner's understanding of technical terms such as religious observance.

Extension

Develop a set of open and closed questions, with some suggested confirmation questions, for this and other sections of the workplace care plan.

Gathering and recording information for everyday records (1)

Focus

Questions and answers

You can find out a lot about a person by asking appropriate questions, listening to the reply in detail and observing carefully.

Active listening is about:
- using your body language to encourage people to talk to you
- using your behaviour to let people know that you are concerned, supportive and interested
- allowing people the time and space to communicate their feelings and concerns.

Think about how to get information without asking questions.

Start a conversation:
- "Tell me about…"

Encourage people to continue talking:
- "That sounds as if it was fun …"

Be aware of the type of *question* you ask.
- ***Closed questions*** allow people to answer yes or no.
  "Are you worried about …?"
- ***Open questions*** do not allow a one-word response.
  "How do you feel about …?"
- ***Confirmation questions*** check that you have heard correctly.
  "Did I hear you say …"

Observing body language can give you a lot of information. Look at:
- expressions on the face
- the type of eye contact
- posture
- hands and gestures.

If you do not get the response you expect, think about the possible reasons:
- cultural differences
- impaired hearing.

Gathering and recording information for everyday records (1)

Task

Look at this part of a care plan, about daily living needs.

Task 1

Choose the best questions to get you the information you need for sections 2.2 and 2.3 of the form.

Questions

Are you able to get about by yourself?
Do you wear glasses?
Are you deaf?
What do you need to help you move around?
Are you overweight?
When do you need to wear your glasses/ use your hearing aid?
How are your mobility and dexterity?
Are you diabetic?
Have you got movement problems?
Tell me why you are on a diet.
Do you need a hearing aid all the time?
Do you wear a hearing aid?

Task 2

Make a note of the questions that you would ask the service user in order to get the information you need to fill in the rest of the sections. Which of these are open questions?

Part 2 Daily Living Needs Assessment

2.2 Communication

2.2.1	Does the person use spectacles or hearing aids? Please specify:	YES / NO

2.3 Mobility and dexterity

2.3.1	Does the person have any problem with mobility? If yes, please specify and also record any mobility aids used.	YES / NO

2.8 Diet and weight

2.8.1	Does the person have any problems with his/her diet or weight? If yes, please specify	YES / NO

2.9 Food and meal times

2.9.1	Does the person require assistance with feeding?	YES / NO
2.9.2	What are the person's preferred meal times and likes and dislikes of food?	

2.11 Religious observance

2.11.1	Does the person require assistance with practising his/her religion? If yes, please specify.	YES / NO

2.12 Daily living and social activities

2.12.1	What kind of interests and social activities is the person interested in?	

SLc/L1.2; SLc/L2.2

PAGES 3:13–3:14

Gathering and recording information for everyday records (2)

Occupational setting

Many learners and employees will be involved in some level of record keeping and it is important that they complete records accurately and appropriately, taking account of confidentiality, diversity and organisational requirements. This page will enable skills development for mandatory unit/element HSC21d. Skills development focuses on confidentiality, appropriateness of what is written and the need for the information to be helpful and informative.

Materials

Workplace policies on confidentiality and diversity

Workplace guidelines on completing documentation

Examples of completed workplace documentation

Text from Task 1 on OHT

Learning outcomes

1 To select relevant information for inclusion on documentation (focus page, Task 1)

2 To formulate this information for a specific purpose (focus page, Task 2)

3 To write information accurately and clearly (focus page, Task 3)

Suggested teaching activities

Introduction

- Discuss learners' involvement in completing work records and documentation. If experience in this area is limited, focus the discussion on reading existing documentation to examine how service user information is recorded.
- Elicit good practice from this review of a workplace document (i.e. the information needs to be expressed clearly and carefully, language needs to be professional and to take account of diversity and confidentiality). Confirm this with workplace guidelines, if there are any.
- Discuss the purpose of records in the management of the workplace and their legal significance. What is the impact of records being incorrect? Not taking account of diversity? Being unclear?

Focus page

- Using the example of bad practice on the focus page, consider the good practice suggestions around the page: the use of respectful language; keeping to the facts; avoiding putting opinion in records; giving information concisely but with sufficient detail to be genuinely helpful. Why is the example not good practice? Ask learners to rework the comments to reflect good practice.
- Look at the good practice suggestions on the page and examine why these are better than the bad practice examples.
- Begin to discuss issues around technical accuracy (spelling, punctuation and grammar) and handwriting. Expect learners to have some insecurities in this area.

Curric. refs	NOS	Key skills
Rt/L1.3	HSC224	C1.2
Wt/L1.4	HSC25	C1.3
Wt/L2.2	HSC21d	

Task 1

Select relevant information for inclusion on documentation

Rt/L1.3

- Learners can either do this unaided or you can work through the task with them, ideally on an OHT. Each sentence, or part of a sentence, needs to be evaluated separately to check whether it contains information relevant to the care plan. What is relevant for other staff to know? What information has an impact on the care plan?

- You may need to discuss what is meant by 'relevant' in this case.
- Highlight the sections of information selected.

If the learner has difficulty

- Learners may have difficulty selecting information for the care plan, for example they may select the follow-up appointment. Encourage them to consider the purpose of the care plan and therefore the type of information to be included – and the type of information that is not relevant.
- Check understanding of technical words (e.g. discharge, quadruped) and longer sentences. Break down long sentences into component phrases.

Extension

Look at other hospital or formal letters and select from them what should be included in the care plan.

Task 2

Write information accurately and clearly
Wt/L1.2
Wt/L1.4
Rt/L1.3

- The focus here is to recognise that the language used is inappropriate on several counts: in terms of style (it is too much like speech); appropriateness of comments (the writer's tone gives hints of inappropriate judgement of the service user); choice of language ('round the bend' is too colloquial). You will need to unpick these one by one to ensure that learners fully understand the problems.
- This presents a good opportunity to confirm what is good practice in these areas.
- Learners will then need to identify the important information required for the form and rephrase it appropriately. They could do this in pairs and share their responses.

If the learner has difficulty

- ESOL learners may have difficulty understanding some of the colloquial language in the text and will need help with this (e.g. patchy, round the bend).
- Learners having problems identifying the relevant information may need to be guided through the text sentence by sentence, using a question-and-answer technique.

Extension

- Further practice in this area would be sensible, with other examples to re-form.
- Learners could develop a checklist, with examples of good and not so good practice, for use by colleagues.

Task 3

Formulate information for a specific purpose
Wt/L2.2

- Learners need to take information from the hospital letter in Task 1 and formulate it as 'Objectives' and 'Service to be provided'. You may need to remind learners about these headings and what they include.
- The 'Services to be provided' are fairly obvious from the hospital letter, but need to be rephrased as instructions.
- Model the first piece of information and discuss the best way to phrase this for the care plan. To some extent, the Objectives are based on vocational knowledge, but it is useful for learners to think beyond the actual services to be provided and to consider the aim of the services – what they are trying to achieve. This may be best achieved in a group discussion.

If the learner has difficulty

- Differentiating the two types of information may be a problem. You will need to explain the two types carefully and then model the first piece of information, asking the questions 'Is this something that has to be done? Is this an aim for this activity?'
- Reformulating information is not easy and will need careful modelling to ensure that the learner has captured the essential information and is able to shape it for a different purpose.
- Check understanding of technical words such as 'mobility', 'dexterity', 'physiotherapist', 'quadruped'.

Extension

Give further practice, using other letters or information, to be formulated into services and objectives.

Gathering and recording information for everyday records (2)

Focus

Filling in records

The information you write should be accurate, clear and useful.

The residents need 24-hour care. The purpose for writing records is to give an up-to-date picture of the resident to the person who takes over from you. Records may also be passed to other agencies.

Think about your handwriting. Is it easy to read?

2.8 Diet and weight

2.8.1 Does the person have any problems with his/her diet or weight? YES / NO
If yes, please specify.
She is really, really overweight. She should have been put on a diet years ago.

2.8.2 Does the person have any dietary preferences? YES / NO
If yes, please specify.
I asked her what she likes to eat and she said she likes chocolate biscuits with her coffee, cake at tea time and bacon sandwiches for supper. I must have looked surprised because she whispered that she was supposed to be on a low-fat diet with a maximum of 1000 calories a day. That's more like it I thought. I don't want to do myself an injury moving you about.

2.9 Food and meal times

2.9.1 Does the person require assistance with feeding? YES / NO

2.9.2 What are the person's preferred meal times and likes and dislikes of food? Please specify.
Eats any time.

Do not use language that is disrespectful. Ask yourself whether what you have written could be read by the resident without offending him/her.

Do you know about the Access to Personal Files Act 1987?

Keep to the facts. Ask yourself what a colleague who reads the notes would need to know.

Do not give too little detail. Give enough information for someone else to know exactly what should be done.

2.8 Diet and weight

2.8.1 Does the person have any problems with his/her diet or weight? YES / NO
If yes, please specify.
Overweight. Current weight 93 kgs.

2.8.2 Does the person have any dietary preferences? YES / NO
If yes, please specify.
Low-fat diet with a maximum of 1000 calories a day. Enjoys chocolate, cake between meals.

2.9 Food and meal times

2.9.1 Does the person require assistance with feeding? YES / NO

2.9.2 What are the person's preferred meal times and likes and dislikes of food? Please specify.
Usual meal times. Encourage to eat healthy snacks.

These comments are helpful and based on the facts. They give enough information for the next person who reads it to continue with the care that the service user needs.

Gathering and recording information for everyday records (2)

Task

Make your records clear, relevant and accurate to make them useful.

Task 1

Read the extract from a hospital letter. Highlight the important information that should be entered into the Plan of Care.

Re: Norma Margaret Gill DOB 18/12/1926

Following her left knee replacement operation and discharge from hospital, Mrs Gill will be expected to follow the course of exercise as recommended by the physiotherapist (see attached).

She should walk regularly and attempt to increase the distance walked daily.

She should use the quadruped provided.

Please phone to make an appointment for four weeks' time to check on her progress.

Task 2

Rewrite these assessment notes in a way that is accurate, clear and useful.

2.7	Mental health and cognition
2.7.1	Does the person have any problems with mental health or cognition? (YES) / NO If yes, please specify. *After talking to her for about an hour I began to realise that her memory is patchy. One minute she said she had three children and the next two. First it's all girls and then a boy and a girl. Perhaps she could do with a proper check over to see whether she's right round the bend or just forgetful.*

The words that you use reflect your attitudes.

Think about words that should not be written about residents.

Task 3

Using the information selected from the hospital letter, write the statement for this part of the Plan of Care about services to be provided and objectives.

3.3 Mobility and dexterity – Plan of Care	
Service to be provided	Objective

Decide what to write in a report and the right words to use.

Rt/L1.3; Wt/L2.2; Wt/L1.4

PAGES 3:15–3:16

Gathering and recording information for everyday records (3)

Occupational setting

Many learners and employees will be involved in record keeping at some level and it is important that they do this accurately and appropriately, taking account of confidentiality and the need to avoid expressing opinion. Whilst technical accuracy (grammar, spelling, punctuation, etc.) is less vital, accuracy of information and clarity are obviously important. This page will allow skills development for mandatory unit/element HSC21d. Skills development focuses on confidentiality, format, clarity and accuracy.

Materials

Copy of laundry (or other) records from the workplace

Learning outcomes

1 To use format to record information clearly (focus page and Task 1)

2 To use note form to record information, where appropriate (focus page and Task 2)

3 To complete records with useful information (Task 3)

Suggested teaching activities

Introduction

- Discuss learners' involvement in completing similar work records. If experience in this area is limited, focus the discussion on reading existing records to examine how service user information is recorded.
- Elicit good practice from this review of a workplace record (i.e. the information needs to be expressed clearly and carefully; note form is appropriate; use format to assist clarity). Confirm this with workplace guidelines, if there are any.
- Records may be kept in a range of formats (e.g. tables, charts, graphs) or using systems such as index cards. Discuss learners' experience of these, ideally using examples from the workplace.
- Discuss the purpose of records in the management of the workplace and any legal significance.

Focus page

- Using the example of bad practice on the focus page, consider the good practice suggestions around the page: the use of format to assist clarity; keeping to the facts; avoiding putting opinion in records; giving information concisely, ideally in note form, but with sufficient detail to be genuinely helpful. Why is the bad practice not acceptable? Ask learners to re-work the comments to reflect good practice.
- You may need to explain the ditto mark (") used on the form to indicate a repeat of information.
- Discuss handwriting and note form. Ask learners to review each other's handwriting for legibility, to make sure that all are aware of the need to write clearly in a way that can be understood by all. Practise changing lengthy sentences from existing work records into note form.

Curric. refs	NOS	Key skills
Wt/L1.2	HSC21d	C1.3
Wt/L1.4		
Wt/L1.5		
Ww/L1.2		

Task 1

Use format to complete records

Wt/L1.5

- To make it easier for other people to read records, it is helpful to use format (i.e. bullets, numbers, letters) to record each point. Learners need to be clear about separating points. Work through and model the first point, if necessary.

- Compare responses with the model answer and discuss any differences. Confirm that the construction of the notes is up to the learner, as long as all points are recorded.
- Point out the tip – the mnemonic CARL helps you complete records.

If the learner has difficulty

- You may need to support ESOL and other learners to identify the separate points made. Chunk the sentences (each contains two or more parts) and ask the learner if this is a point for recording. The first sentence in particular is rather long and contains several important pieces of information.
- Underlining or highlighting points may help to separate them.

Extension

Give further practice using workplace records.

Task 2

Write records in note form
Wt/L1.2

- The first part of this task is to identify the points to record. This could be done by underlining or highlighting, or by reordering the points on a separate piece of paper.
- Learners then need to work on paraphrasing the points. You will need to model this with them, encouraging them to cut out words that are not necessary to support the point or aspects of the writing that are not relevant (e.g. they give an opinion). Encourage learners to read back their notes to ensure that all important points are included.
- It will be useful to compare their notes with the model answer. How are they different?

If the learner has difficulty

- The learner may have problems identifying the separate points here. One aspect of this activity is about identifying relevant and appropriate comments. Working through the text one sentence/part of sentence at a time will help this.
- Writing in note form may cause problems. Again, dealing with each point in turn and modelling will help. You could also try writing each point in full and deleting unnecessary words (e.g. 'Jane had ~~a really bad~~ argument with Bert ~~this afternoon over the~~ at tea table.)
- Some of the language in the original is colloquial (e.g. 'a good 4 hours') and will need to be discussed with ESOL learners.

Extension

Give further practice in writing notes, using existing workplace records.

Gathering and recording information for everyday records (3)

Focus

Updating records

You are accountable for what you write.

Make sure it is:

- **c**lear
- **a**ccurate – keep to the facts
- **r**elevant – not too short and not too long, include what is vital and miss out what is not significant
- **l**egible.

Think about who is going to read what you write:

- colleagues
- other professionals
- the service user.

RESIDENT'S CLOTHING/PERSONAL POSSESSIONS INVENTORY

Name of resident Marjorie Smith Date of admission 2/5/04

Date	Description of item	Held by home/resident
2/5/04	skirt	resident
"	skirt	"
"	Lovely brown jumper with bat-wing sleeves and a very pretty pink and blue design on the front. It's her favourite and I can understand why.	"
"	She has a double-breasted brown coat with a false-fur collar and false-fur cuffs.	"

Tables are arranged in **rows** and **columns** so that information can be found easily.

Make sure you put information in the right **row** or **column**.

Make sure you give enough **detail**. Marjorie has two skirts, but what are they like? Will they get muddled with someone else's skirts in the wash?

Stick to the **facts**. Your opinion is not important in this case.

Lovely brown jumper with bat-wing sleeves and a very pretty pink and blue design on the front. It's her favourite and I can understand why.

There is no need to write in complete sentences. **Notes** are enough, e.g.:

double-breasted brown coat; false-fur collar and cuffs

Make your writing legible. Someone else will have to read what you say!

If you need to make more than one point, you can use:

- bullet points …
- numbers 1. 2. 3.
- letters a) b) c)

to make the list clearer to read.

Gathering and recording information for everyday records (3)

Task

Task 1

Use bullet points, numbers or letters to separate the points in this report.

DATE 8/7/04 **TIME** 7pm

COMMENT

Victoria is looking forward to seeing her son tomorrow and wants to be woken early so that she can have a bath and go to the hairdresser in the morning before he comes. He is taking her out for lunch so we will need to cancel her lunch order.

SIGNATURE OJP Richards **RESIDENT'S NAME** Victoria Smith

Make sure what you write is:

- clear
- accurate
- relevant
- legible.

Task 2

Write these comments in note form. Make sure you include only the information that is necessary.

Cut out as many words as possible, so long as it still makes sense.

16/6/04 19.00

Brian continues to improve. Today he got out of bed with help and walked as far as the bathroom. Mind you he was exhausted by the time we got back to his room and he slept for a good 4 hours this afternoon.

B. Jones

26/11/04 07.00

Laura was awake all night worrying about her money. She is afraid she will not have enough to pay for all the care she needs. At 2 am she wanted to phone her bank manager to arrange everything. In the end I had to put the cot sides up on the bed to stop her falling out. She should be allowed to talk about it to somebody. I don't want another night like that one.

PH Rossiter

26/12/04 19.00

Jane had a really bad argument with Bert this afternoon over the tea table. None of us could find out what it was about but some very cruel things were said on both sides. He was shouting at her and she was yelling back. Will need to be discussed with them when they are both calmer. Maybe privately during the evening? Everybody was very subdued when it was over.

I. C.

PAGES 3:17–3:18

Amending a care plan

Occupational setting

This focus page and accompanying task page provide a summary activity for this module: to complete an Admission Assessment Sheet and make amendments to a care plan, both tasks that employees at Level 2 may be involved with. Learners need to understand their role in this important aspect of documentation in the workplace and to learn how to complete records appropriately. These pages allow the learner to confirm skills in gathering relevant information from a range of sources and complete documents accurately and appropriately. They support mandatory unit HSC21 and optional unit HSC25.

Materials

Admission Assessment Sheet from Source material
Review of Care Plan Form from Source material

Learning outcomes

1 To enter relevant data into a straightforward form (focus page, Task 1)
2 To select information to use to complete a care plan (focus page, Task 2)

Suggested teaching activities

Introduction

- Discuss learners' role in completing this type of documentation and any associated guidelines, and difficulties experienced.
- Revisit earlier learning to confirm the need for accuracy, appropriate language, useful information and clear expression and handwriting.

Focus page

- Task 1 is described on the focus page (Stage 1): learners need to read the case study on the task page and use the data to complete a copy of the Admission Assessment Sheet. Explain that this is the first stage. The service user needs to be re-assessed after a few weeks (Stage 2).
- There are some model questions on the focus page, designed to prompt the right kind of questions to help decide what to write in the Review of Care Plan Form. Discuss how these questions help and why it is a good idea to think up some questions before you start on this kind of task.
- Draw learners' attention to the tips on the focus page. These form a useful set of guidelines for staging the review process.

Curric. refs	NOS	Key skills
Rt/E3.1	HSC21d	C1.3
Ww/E3.3	HSC25	C2.3
Rt/L1.1	HSC224	
Rt/L1.3		
Wt/L1.2		
Wt/L1.4		

Task 1

Use given data to complete a form
Rt/E3.1
Ww/E3.3

- Learners need to read the case study on the task page and use the data to complete a copy of the Admission Assessment Sheet.
- Draw learners' attention to the tip, which provides a useful strategy to ensure that nothing is missed out.
- Learners may benefit from completing this task in pairs and sharing the results.

If the learner has difficulty

- Ensure the learner has used the strategy given in the tip.
- Some dyslexic learners will find it difficult to cope with the visual tracking demands of copying correctly from one source of information into another. Look out for information that is incorrectly placed, address items and telephone numbers in the wrong sequence and spellings that are copied incorrectly. A methodical and measured approach will help. Try also covering the areas of the form already completed with a sheet of

paper. Copying the form on to pastel-coloured paper may also help.

- ESOL learners and learners with insecure literacy skills may need support with address formats and technical language, such as 'continence'.

Extension

- Practise this skill using other information from the workplace.
- It is also useful to try the reverse process: writing a brief report based on information in a form.

Task 2

Complete a review form using information from a formal letter

Rt/L1.1
Rt/L1.3
Wt/L1.2
Wt/L1.4
Ww/L1.2

- Explain the task, confirming that learners will first have to read the hospital letter carefully and then decide what information is required under each of the headings in the Review of Care Plan Form. Refer learners back to the tips and questions on the focus page.
- Model the first one or two pieces of information then, ideally, ask learners to work on this in pairs. They should aim to achieve a good copy of the form. (Note: they may need two copies of the form.)
- Share responses and reasons for placing information.
- Look carefully at presentation: ask pairs to 'score' each other's work for spelling, punctuation and grammar, accuracy and handwriting.

If the learner has difficulty

- Explore any difficulties with the formal and technical language in the hospital letter (e.g. discharge, ophthalmologist).
- Work with learners to develop the information for the form, using questions to encourage them to think about choices.
- You may need to write the information they suggest on the form, in order to take away the burden of writing. However, learners will need to develop strategies to complete forms if this is to be part of their work activity.

Extension

Provide additional practice using workplace information.

Theme assessment

Devise a further case study as the basis for a similar activity, completing Admission Assessment Sheets and care plans. Learners could develop a checklist for assessing performance (Is the information clear? Appropriately expressed? Using professional language? Accurate? Is the handwriting clear enough to read easily? Are spelling and punctuation accurate?).

Amending a care plan

Focus

Stage 1

Mr Hinton is about to be taken into residential care. In Task 1 you will need to use the information supplied to fill in his details on the Admission Assessment Sheet from the Source material.

Stage 2

After several months in the residential home, Mr Hinton has returned following a brief spell in hospital after a stroke. A review of his care plan is necessary.

Tips

To make changes to a care plan you need to:

- observe the resident
- ask questions
- read the records
- get information from other sources.

Review of Care Plan Form

Review date _____

All areas of Care Plan to be reviewed with resident or representative where possible.

Area	Specify any changes to Care Plan	Continue objective New objective
Personal care and physical well-being		
Communication	Will the stroke affect communication? How? What action should be taken?	
Mobility and dexterity	Will the stroke affect movement? How? What action should be taken? Are any aids necessary?	
Personal safety and risk assessment	Are there any areas that require a new risk assessment? Does he need any new medication?	
Medical history Medication	Does he need any new medication?	
Mental health and cognition	Have there been any changes to his mood and understanding?	
Diet and weight	Does he need a different diet?	
Food and meal times	Any new developments?	
Dental and foot care	How are these affected?	
Religious observance		
Daily living and social activities	How will the stroke affect these?	

Amending a care plan

Task

Task 1

Read the information in the case study and fill in the Admission Assessment Sheet from the Source material.

Case study

Mr Hinton was born on January 27th 1910. His telephone number is 0934 572913. He is anxious about his finances but mentally alert. He has arthritis. He has a lovely niece called Vera Pierce with whom he lives at the moment, but she can no longer cope with his needs. He lives at The Cottage, King Street. Lowtown. Hardshire LT6 7ND and his GP is Dr Carol Weston, Town Practice, Lowtown. Hardshire LT5 9PF. She can be contacted on 0934 621863. Mr Hinton likes to be called Stan but his full name is Stanley John Hinton. He used to be a self-employed builder. He likes to listen to talking books and likes to keep up with the news on the radio and in the newspapers. He is fully continent. He has never been a church-goer but says he is C of E if anything.

Cross out the information as you use it.

Task 2

Read the new information about Stan in the letter from the hospital in the Source material. Use it to fill in Part 4 of the Care Plan from the Source material.

Ww/L1.2; Rt/L1.1; Wt/L1.4; Wt/L1.2; Rt/L1.3

Check it

1 Look at the Admission Assessment Sheet in the Source materials. Under which heading would you expect to find information about whether the resident needed sleeping tablets?

A Diagnosis

B Allergies

C Medication

D Mobility

Rt/L1.4

2 Which of these names should come first in an alphabetical list?

A Mrs J Wood

B Mr M Wood

C Wood, Fred

D Wood, John Albert

Rw/E3.4

3 Read the resident profile for Fred Smith. What might he not like to talk about?

A His left leg

B His right knee

C His eyesight

D His hearing

Rt/L2.2

Resident Profile

Name: Frederick John Smith

Fred is an ex-solider who lost his left leg in the Second World War. He likes to talk to others about his wartime pals but can be a bit sensitive about his disability. His mobility is generally good but he is experiencing some pain in his right knee and this is slowing him down a bit. He is keen on his food and particularly likes puddings such as sponge and custard. His weight needs to be watched though as this might affect his mobility. His eyesight is deteriorating – he has recently been diagnosed with macular degeneration. He needs to use a hearing aid and should be encouraged to use it for watching TV.

4 What does 'deteriorating' mean?

A Really bad

B Improving

C Getting worse

D Blind

Rw/L1.2

5 Which of these is <u>not</u> likely to affect his mobility?

A His right knee

B His hearing

C His left leg

D Increasing weight

Rt/L2.2

6 Under which of these headings on a form would you put the information that Miss Sharma had not been married before?

A Preferred name
B Principal language
C Ethnic origin
D Marital status

Rw/L1.3

7 Which of these is an open question?

A Did you work in a shop?
B Is your name Aziz?
C Do you like sitting by the window?
D Can you tell me about the job you used to do?

SLc/L2.2

8 Which of these statements is relevant to putting in a plan of care rather than a daily record sheet?

A Mr Colley has just come out of hospital after a cataract operation.
B His eyes will need to be checked tonight.
C He will need to be helped to the toilet.
D He should avoid watching TV for 24 hours

Wt/L2.1

Case Study

Bert is a lovely 92 year old who worked for many years as a plumber. He has developed serve arthritis which is affecting his hands and knees. This is being controlled with regime of physiotherapy and drug therapy. He is alert for most of the time but is showing evidence of deterioration in concentration.

9 Which sentence has information that should be entered in the care plan under the heading 'Mental health and cognition'?

A Bert is a lovely 92 year old who worked for many years as a plumber.
B He has developed serve arthritis which is affecting his hands and knees.
C This is being controlled with regime of physiotherapy and drug therapy.
D He is alert for most of the time but is showing evidence of deterioration in concentration

Rw/L2.1

10 Which sentence has information that should be entered in the care plan under the heading 'Medication'?

A Bert is a lovely 92 year old who worked for many years as a plumber.
B He has developed serve arthritis which is affecting his hands and knees.
C This is being controlled with regime of physiotherapy and drug therapy.
D He is alert for most of the time but is showing evidence of deterioration in concentration.

Rw/L2.1

Answers

PAGES 3:1–3:2

Understanding care plan format

Task 1

diagnosis name of an illness

mobility level of ability to move freely and easily

continence level of ability to control bladder and bowels

next of kin closest family member or relation, usually a parent or oldest child

Task 2

Personal information
Title
Surname
Admission date

Medical history
Allergies
Medication

Additional information
Interests
Mobility
Religion
Anxieties

Task 3

Title Mrs

Tel. no. 09823 623987

Diagnosis Type 2 diabetes

Mental awareness Very bright. Communicates well with others.

Diet Balanced diet, three regular meals, no fizzy drinks.

Religion Catholic

PAGES 3:3–3:4

Accessing and retrieving records

Task 1

A – Dy Adamson, Cryer, Drake

Ea – Hy Gregory, Harper, Earl

I – Me Ismail, McCourt, Mead

Mi – Ry Myles, Pindar, Miles

S – Zy Siddiqui, Wardle, Taylor

Task 2

EH/ 012/ *543*- 769
EH/ 012/ *643*- 765
EH/ 012/ *843*- 765
EH/ 022/ *543*- 765
EH/ 022/ *543*- 799
EH/ 032/ *543*- 765
EH/ 032/ *545*- 465
EH/ 082/ *543*- 765
EH/ 092/ *543*- 765

Task 3

A T ABBOTT
ABDULLA O
J ABRAHAMS
J ABRAM
ADAMS A W
ADAMS R S
ADDAMS W S
AHMAD Dr G
HENRY ALLAN
MILLICENT ALLEN
SUSAN AMOS
ANDERSON E H
ANDERSON E K
ASHWANI D
AZIZ R T

Task 4

The words 'file', 'files' or 'filing' are mentioned 8 times:

Filing systems only work well if everybody follows the same method when they remove or replace **files** into the system. It is a good idea to leave a note if you need to take a **file** away. Return every **file** as soon as possible. Don't leave **files** lying around after you have finished with them. They contain confidential information that should only be seen by the people involved in the care of the service user. Make sure that you put every **file** back in the right place. Look at the **file** in front of it and the **file** behind it to see if it fits in where you are going to put it.

PAGES 3:5–3:6

Understanding information on care plans (1)

Task 1

Your answers may be something like:

1 Information about a service user.

2 Past life, likes and dislikes, particular habits.

Task 2

1 Analgesic means **b** pain killer

2 He has regular appointments at the hospital.
(True)/False/Maybe

3 His preferred name is Chips. (True)/False/Maybe

4 If he is called Kenneth he will think you are angry with him. True/False/(Maybe)

5 He gets a lot of headaches, rashes and stomach-upsets. True/False/(Maybe)

6 Mobile means **b** moving

PAGES 3:7–3:8

Understanding information on care plans (2)

Task 1

You may have something like this:

2.9	**Food and meal times**	
2.9.1	Does the person require assistance with feeding?	YES / (NO)
2.9.2	What are the person's preferred meal times and likes and dislikes of food? Please specify. *Will eat most meals. Does not like supper as it keeps her awake if she eats too soon before going to bed. Likes all food, but must not eat chocolate as it makes her very ill. She is sick and very unwell when she eats it. She thinks she must be allergic to it since her illness.*	
2.10	**Dental and foot care**	
2.10.1	Does the person require assistance with dental and foot care? If yes, please specify e.g. if dentures used, person's use of dentist and chiropodist. *The chiropodist has visited her regularly at home and she would like to continue this now that she is living here. I suppose she has some sort of fear of dentists as she refuses to see the dentist.*	(YES) / NO
2.11	**Religious observance**	
2.11.1	Does the person require assistance with practising their religion? If yes, please specify. *She will join in the monthly service very infrequently. She used to attend All Saints but has lost her faith since her husband died so tragically and she has been so ill.*	(YES) / NO

Task 2

You might have written something like this:

Service to be provided

- *Allow to walk with frame and support from carer where possible.*
- *Help with transfers and move using relevant equipment for safety.*
- *Respect need for maximum independence.*

Objective

- *To allow the service user to have as much choice and independence as possible, taking into account the risks and the safety measures needed to achieve this.*

PAGES 3:9–3:10

Entering straightforward information into a form

Task 1

Principal language main

Maiden name woman's name before marriage

Marital married

Ethnic national, cultural, racial

Delete cross out

Applicable necessary

Appropriate correct

Task 2

2 15th March 1934

3 27/04/1910

4 15th July 1929 15.7.29

5 13/06/1941 13th June 1941

Task 3

Use the numbers to check what the mistakes are.

Heatherdean Care Home PLAN OF CARE

All information is to be treated as confidential

- Please write clearly
- Use black ink

Attach current photo of service user here

Service User

First name(s) Manjit	Date of birth September 7th 1934
Last name Dhillon	Age (80)
Maiden name (if known) Not known	Religion (English)
Preferred name Manjit	Principal language (Sikh)
Gender (tick where appropriate)	Is Interpreter needed? (Circle as appropriate)
(male ☐) female ☐	(yes) no
Marital status (Delete where applicable)	Ethnic origin (tick where appropriate)
(Married/ single/ widowed/ divorced)	White ☐ Asian ☐ Black ☐ Chinese (☑)
Home address (0945 6788321)	Telephone number (27 The Grove Kington KT6 9HG)

1 2 3 4 5 6 7 8 9

1 He has crossed out 'male' instead of ticking it.
2 He has circled 'widowed' instead of crossing out (deleting) the others.
3 He has put his telephone number here instead of his home address.
4 His age now would be nearer 70 than 80.
5 He has put his 'Principal language' here instead of his religion.
6 He has put his religion here instead of his 'Principal language'.
7 He has crossed out 'yes' instead of circling it.
8 He has ticked 'Chinese' instead of 'Asian'.
9 He has put his home address here instead of his telephone number.

PAGES 3:11–3:12

Gathering and recording information for everyday records (1)

Task 1

Part 2 Daily Living Needs Assessment

2.2 Communication

2.2.1 Does the person use spectacles or hearing aids? YES / NO
Do you wear glasses?
Do you use a hearing aid?

Please specify:
When do you need to wear your glasses / use your hearing aid?

2.3 Mobility and dexterity

2.3.1 Does the person have any problem with mobility? YES / NO
Are you able to get about by yourself?

If yes, please specify and also record any mobility aids used.
What do you need to help you move around?

Task 2

You may have noted something like this

2.8 Diet and weight

2.8.1 Does the person have any problems with his/her diet or weight? YES / NO
If yes, please specify
Are you on a special diet? Tell me about why you are on a diet.

2.9 Food and meal times

2.9.1 Does the person require assistance with feeding? YES / NO
Do you need any help at mealtimes?

2.9.2 What are the person's preferred meal times and likes and dislikes of food?
When do you like to have your main meal of the day?
Tell me about your favourite food.

2.11 Religious observance

2.11.1 Does the person require assistance with practising his/her religion? YES / NO
Do you go to church (or other place of worship) regularly?

If yes, please specify.
Which church do you go to?

2.12 Daily living and social activities

2.12.1 What kind of interests and social activities is the person interested in?
How do you like to spend your spare time?

PAGES 3:13–3:14

Gathering and recording information for everyday records (2)

Task 1

Correct answers are highlighted in bold:

Re: Norma Margaret Gill DOB 18/12/1926

Following her left knee replacement operation and discharge from hospital, Mrs Gill will be expected to **follow the course of exercise as recommended by the physiotherapist** (see attached).

She should **walk regularly** and attempt to **increase the distance walked daily**.

She should **use the quadruped** provided.

Please phone to make an appointment for four weeks' time to check on her progress.

Task 2

2.7	Mental health and cognition	
2.7.1	Does the person have any problemswith mental health or cognition? If yes, please specify. *Her memory is not reliable.* *Suggest a formal check.*	YES / NO

Task 3

3.3 Mobility and dexterity – Plan of Care		
	Service to be provided	Objective
	Mrs Gill will be assisted and encouraged to: *1. follow the course of exercise as recommended by the physiotherapist* *2. walk regularly* *3. increase the distance walked daily* *4. use the quadruped to support herself whilst walking.*	*1. To achieve as much mobility as possible using the exercise plan provided by the physio.* *2. To walk as far as possible, using the quadruped as support.*

PAGES 3:15–3:16

Gathering and recording information for everyday records (3)

Task 1

You might have written the information in one of these ways.

8/7/04
7pm
Victoria is looking forward to seeing her son tomorrow and wants to:
1. be woken early
2. have a bath
3. go to the hairdresser in the morning
4. cancel her lunch order
OJPRichards

8/7/04
7pm
Victoria is looking forward to seeing her son tomorrow and wants to:
a) be woken early
b) have a bath
c) go to the hairdresser in the morning
d) cancel her lunch order
OJPRichards

Task 2

You may have written something like this:

16/6/04
7.00
1. Brian continues to improve
2. Got out of bed with help
3. Walked to bathroom
4. Slept for 4 hours this afternoon
B. Jones

26/11/04
07.00
1. Laura awake all night worrying about money
2. At 2 am wanted to phone bank manager
3. Put up cot sides
4. Arrange for her to talk about her finances
PH Rossiter

26/12/04
19.00
a) Jane had argument with Bert at tea table
b) Both of them were involved.
c) Discuss reasons when calmer. This evening?
I.C.

PAGES 3:17–3:18

Amending a care plan

Task 1

Your completed Admission Assessment Sheet should include the following information:

Personal information

Mr Stanley John Hinton *27/01/04*
The Cottage *0934 572913*
King Street
Lowtown
Hardshire
LT6 7ND

Vera Pierce *Niece 0934 572913*
The Cottage
King Street
Lowtown
Hardshire
LT6 7ND

Medical history

Dr Carol Weston *0934 621863*
Town Practice
Lowtown
Hardshire
LT5 9PF

Diagnosis *Arthritis*

Additional information

Reason for admission	*Niece can no longer cope with his needs*
Continence	*Fully continent*
Interests	*Talking books, News on the radio, Reading newspapers*
Past occupation	*Self-employed builder*
Religion	*C of E*
Equipment	*Wheelchair Hearing aid Zimmer frame Dentures*

Task 2

Specify any changes to Care Plan

Personal care and physical well-being
Needs help to control his bowels and bladder.

Communication

1. *Difficulties with speeking and slurred speech.*

   Three appointments a week over the next three months with speech therapist in the Stroke Unit. Start as soon as possible.

   Please take account of gestures and facial expressions distorted.

   Speak slowly and clearly.

   Make eye contact.

   Check understanding

   Use gestures, drawing and writing if necessary.

2. *Has complained of blurred vision. Hospital suggest visit to an ophthalmologist as soon as possible.*

Mobility and dexterity

Able to swallow.
Movements restricted in right arm and leg.
Hospital suggests a foot support and the use of a tripod.
Physiotherapist has devised series of exercises for him to follow.

Medical history/Medication

$\frac{1}{4}$ aspirin every 12 hours.
Daily multi-vitamin and mineral supplement.

Mental health and cognition

Watch for signs of anxiety and depression.

Diet and weight

Diet:

- *High in fruit and vegetables*
- *Low fat*
- *No salt*

Food and meal times

Wake for meals at regular times.

Check it

1 C
2 C
3 A
4 C
5 B
6 D
7 D
8 A
9 D
10 C