



## REGISTERED NATIONAL STANDARD

### UNIT OF COMPETENCY

<b>Title:</b>	<b>Provide individualised support</b>  <i>Note:</i> <i>This unit has been adapted from the Commonwealth of Australia (2021) approved Unit of competency encoded CHCCCS015 bearing the same title but contextualised for the purposes of aged care in Tonga</i>		
<b>TQF Level:</b>	3	<b>Credits:</b>	10
<b>Version:</b>	1		
<b>National standard code:</b>	NS061-03		
<b>Associated qualification (and code):</b>	National Certificate in Aged Care Level 3 (QR-03-NQ-014-02-0915-22-01)		
<b>Approval date:</b>	10 June 2022	<b>Review date:</b>	10 June 2027
<b>Purpose:</b>	<p>This unit has been developed to give learners the skills and knowledge required to organise, provide and monitor support services within the limits established by an individualised support plan for a client.</p> <p>Persons credited with this unit will be able to:</p> <ol style="list-style-type: none"> <li>1. Plan the support work that is needed for a client in accordance to their individualised care plan;</li> <li>2. Interpret individualised care plans;</li> <li>3. Provide support services to clients;</li> <li>4. Monitor support services provided to clients;</li> <li>5. Complete reporting and documentation requirements after providing support to clients.</li> </ol>		

<b>Learning Outcome 1 (LO1)</b>	<b>Plan for support needs</b>
<b>Performance standards</b>	<p>1.1 Describe the purpose of an individualised care plan.</p> <p>1.2 Describe the kinds of information which needs to be on an individualised care plan;  <i>[Range may include but not limited to: personal contact information, next of kin, emergency contact, any allergies, illness/conditions, short background of client, all support preferences for personal care arrangements, toileting, grooming preferences, food and eating requirements, cultural and spiritual needs, manual handling requirements, likes and dislikes, other allied health workers offering support, medication requirements]</i></p> <p>1.3 Interpret individualised care plan and clarify one’s own role and role of others in preparation for completing the client’s care;</p> <p>1.4 Confirm individualised plan details with the client and family/carers when appropriate;</p> <p>1.5 Prepare for support activities and preferences following organisation policies, protocols and procedures.</p>
<b>Learning Outcome 2 (LO2)</b>	<b>Provide support services while respecting individual differences and ensuring client maximum dignity.</b>
<b>Performance Standards</b>	<p>2.1 Conduct exchanges with the person in a manner that develops and maintains trust;</p> <p>2.2 Assemble equipment as required according to established procedures and/or the Individualised care plan  <i>[Range equipment may include but not limited to: items required for personal care task such as wheelchairs, shower chairs, lifting equipment, walking frame, bathroom products – i.e., towels, face cloth, change of clothes, continence aid, toiletries, hearing aids]</i></p> <p>2.3 Allow maximum privacy for a client when necessary while providing personal care activities.  <i>[Range may include but not limited to: ensuring client’s private parts of their body are covered during manual transfers to maintain dignity at all times, allowing for client privacy when they are using the toilet, closing curtains so no one can see them change or being assisted with personal care]</i></p> <p>2.4 Ensure maximum client dignity while providing personal care activities.</p>

	<p><i>[Range may include but not limited to encourage independence to complete own personal care tasks where able, offer reassurance and encouragement. Listen to client to understand their choices. Give client privacy when they are getting changed, this will also maintain their dignity]</i></p> <p>2.5 Seek assistance when it is not possible to provide appropriate support;</p> <p><i>[Range may include but not limited to: using assistance from a second support worker when appropriate, including carer to assist when supporting client, report any tasks that require assistance to supervisor rather than completing unsafely]</i></p>
<p><b>Learning Outcome 3 (LO3)</b></p>	<p><b>Monitor support activities</b></p>
<p><b>Performance standards</b></p>	<p>3.1 Seek feedback from client about own service delivery;</p> <p>3.2 Reflect on one's own ability to provide any required care;</p> <p>3.3 Involve the client in discussions about how support services are meeting their needs and any requirement for change;</p> <p>3.4 Identify aspects of the individualised care plan that may need review and discuss with supervisor;</p> <p><i>[Range may include but not limited to: Changes in a client's abilities, changes in client's health, Client's lifestyle may change, living arrangements may change, Problems with the person's ability to cope, Mobility decreases, Carer may no longer be able to assist client]</i></p> <p>3.5 Participate in discussions with the client and supervisor to confirm any changes made to their plan meet their new requirements for support.</p>
<p><b>Learning Outcome 4 (LO4)</b></p>	<p><b>Complete reporting and documentation after providing support</b></p>
<p><b>Performance standards</b></p>	<p>4.1 Identify any reporting requirements after caring for a client;</p> <p>4.2 Describe guidelines that need to be considered when completing medical/progress notes within Industry;</p> <p>4.3 Identify situations of potential or actual risk within scope of own role and report to supervisor as required;</p> <p><i>[Range of situations may include but not limited to: tasks required for the client that are not within one's scope of practice, reporting changes in health of client, adhering to manual handling rules when assisting clients and the need for 2 support workers,</i></p>

	<p><i>requiring additional training for a procedure/task you are unsure of, aggressive client]</i></p> <p>4.4 Identify and report signs of additional or unmet needs of the client;</p> <p>4.5 Complete and maintain documentation according to organisation policy and protocols.</p>
<b>Pre-requisites</b>	N/A
<b>Co-requisites</b>	<p>NS063-04 Provide personal support needs to clients within the aged care sector</p> <p>[Refer to 'Assessment requirements' section, #2 context of assessment]</p>
<b>Underpinning skill and knowledge</b>	<p>The following skills and knowledge underpin this unit standard:</p> <p>a) <i>Individualised care plan</i>: When a person is initially referred to an organization, a plan is developed in consultation with the client and family members/carers which will guide service providers with the support and services needed.</p> <p>b) <i>Individualised care plan development</i>. The planning process involves four steps, which are completed with close consultation and input from the person being supported:</p> <ol style="list-style-type: none"> <li>1. Assessment – identifying the strengths and requirements of the individual through comprehensive assessment;</li> <li>2. Planning – identifying the goals to be achieved, planning actions, strategies or solutions;</li> <li>3. Implementation – putting the actions, strategies into practice and carefully monitoring the plan's effectiveness while making observations of any changes in the person's wellbeing. This step involves reporting and documentation requirements;</li> <li>4. Evaluation – reflecting on and evaluating how effectively the goals were achieved, and revisiting the plan in line with any changes or preferences of the client.</li> </ol> <p>c) <i>Preparing for support activities and preferences</i> may include:</p> <ol style="list-style-type: none"> <li>1. Using clear communication to gain the consent of a client to attend to an activity or task;</li> <li>2. Maintaining client's privacy and ensuring their safety;</li> <li>3. Prepare any resources which may include <i>personal protective equipment (PPE)</i>, or client's personal items or equipment, etc.;</li> </ol>

*d) Reasons for reviewing individualised care plans:*

1. Circumstances change with time. Reviewing a plan ensures it reflects current circumstances. Circumstances refer to factors such as knowledge (especially of diseases and of human health), resources, people, etc.);
2. Needs of client change over time. If a plan is not reviewed regularly then it will not reflect what needs a client actually has;

*e) Examples of changes in a client's circumstances that may prompt a review:*

- Changes in a client's abilities (e.g. ability to move from place to place (mobility), ability to cope, etc.);
- Changes in client's health;
- Client's lifestyle may change;
- Client's living arrangements may change;
- Client has improved in their skills and no longer requires as much assistance.
- Carer may no longer be able to assist client;

*f) Guidelines for writing medical/progress notes:*

- Write just the facts
- Don't write "I" write Staff – it is not about you
- Use quotation marks to indicate what was actually said
- Write time and date for every addition
- Always draw a line to the end of your addition
- Always sign your name, print your name above
- Write in Black or Blue Pen only
- Ensure you maintain the privacy of each client
- Only write what you have seen or done – never write what someone else has told you
- Do not diagnose as you are not a doctor

## Assessment requirements

### Suggested methods of assessment:

A range of assessment methods should be used to assess students' knowledge and application of skills, include but not restricted to the following:

1. Direct observation of students during role-play, demonstration, and work placement.
2. Written questions;
3. One-on-one verbal questions;
4. Written report;
5. Review of work placement reports – signed off by assessor/workplace supervisor; and
6. Portfolio.

### Context of assessment

1. LO1 can be assessed entirely in the classroom;
2. Work placement is part of the overall *National Certificate in Aged Care Level 3* qualification. It is therefore recommended that LO2 and LO3 are assessed during work placement using integrative assessment in conjunction with the unit *NS063-04 Provide personal support needs to clients within the aged care sector*.
3. Assessment used during work placement is expected to be via observation of support activities with clients; Support activities include assisting clients with personal care activities, such as showering, grooming, dressing, oral hygiene that are required by the client. All of these activities must be listed on the client's individualised care plan;

A candidate of assessment must provide evidence to demonstrate his/her achievement of the Learning outcomes and performance standards;

<p><b>Resource requirements</b></p>	<ol style="list-style-type: none"> <li>1. Classroom, classroom furniture, white/blackboard, tables or benches, chairs, student notice boards, whiteboard markers, butchers paper / coloured card or spare paper and pens for group activities.</li> <li>2. Simulation room including bed, mannequin, showering and bathing equipment.</li> <li>3. Shower facilities, shower chair, wheelchair, towels, clothes for mannequin,</li> <li>4. Mock care plans to be used for role-plays.</li> </ol>
<p><b>Moderation arrangements</b></p>	<ol style="list-style-type: none"> <li>1. Provider Institutions are responsible for moderation arrangements to ensure consistency of assessments.</li> <li>2. Moderation process must be approved by TNQAB.</li> <li>3. Moderations forms are available from TNQAB.</li> </ol>
<p><b>Requirements to complete this unit</b></p>	<p>There are four learning outcomes consisting of a total of 20 performance standards to measure competence.</p> <p>To demonstrate competence in this unit, a candidate of assessment:</p> <ol style="list-style-type: none"> <li>1. Must achieve every learning outcome to fulfil the requirements of the unit standard;</li> <li>2. Is eligible to 3 attempts on their assessments. Should the first attempt be unsatisfactory, reassessments must be completed within 14 days of their first attempt.</li> </ol>
<p><b>Important notes and definitions</b></p>	<p><u>Notes:</u></p> <ol style="list-style-type: none"> <li>1. Reasonable adjustment can be made to the assessment tasks to ensure equity in assessment. If a student is identified to have a particular need reasonable adjustment may be considered.</li> <li>2. If clients do not have individualised care plans in place for students to follow during work placement, then PS 3.4 can be assessed via role-plays and scenarios written by the training provider.</li> </ol> <p><u>Definitions:</u></p> <ol style="list-style-type: none"> <li>1. <i>Confidentiality</i>: Keeping information private. All services are required to follow privacy laws.</li> <li>2. <i>Individualised care plan</i> (or Care plan): A plan developed in consultation with an older person and their significant others; clearly setting out the support and services required by the client. Usually lists who is responsible for different</li> </ol>

	<p>support required.</p> <ol style="list-style-type: none"> <li>3. <i>Integrative assessment</i>: is a type of assessment design in which students' learning from multiple learning units or modules are assessed in the same assessment task/activity. In such assessment approach, students are better able to make connections between knowledge and learning that span multiple units and topics.</li> <li>4. <i>Privacy</i>: Maintaining confidentiality in private matters as required through law.</li> <li>5. <i>Progress notes</i>: Ongoing records of the older person's day-to-day progress highlighting changes in support and services.</li> <li>6. <i>Scope of practice</i>: Refers to the activities that a person is allowed to do as part of their job role. A support worker must work within their 'scope of practice' and not attend to activities that are not within their job role/or they have not been trained to do.</li> </ol>
<p><b>Public comments on unit</b></p>	<p>Please contact TNQAB National Qualifications Unit (email <a href="mailto:EnquireNQ@tnqab.to">EnquireNQ@tnqab.to</a> or Telephone 28136) if you like to discuss or suggest changes to the details of this unit.</p>