A

# CHS84 Develop and agree care management plans with individuals diagnosed with long term conditions

## OVERVIEW

This standard is about developing and agreeing evidence-based holistic care management plans for individuals diagnosed with long term conditions. The care management plan would focus on supporting individuals to adapt their lifestyle, taking account of needs resulting from their long term condition – and would also take account of individuals' treatment plans. Care management plans may be developed in a primary or secondary care setting.Users of this standard will need to ensure that practice reflects up to date information and policies.Version No 1

## KNOWLEDGE AND UNDERSTANDING

You will need to know and understand:

1. how to adapt communication styles in ways which are appropriate to different people (e.g. culture, language or special needs)
2. how to establish an understanding of an individual's values, beliefs and interests
3. the importance of establishing rapport, and how to do so
4. how to ask questions, listen carefully and summarise back
5. methods of communicating stressful information to individuals
6. the range of diverse cultures prevalent in the community
7. the religious beliefs of different cultures
8. the effects of different cultures and religions on care management
9. the principle of confidentiality and what information may be given to whom
10. the importance of involving individuals in discussions, and how to do so
11. the importance of encouraging individuals to ask questions, and how to do so
12. the principles of evidence-based practice, and how to apply them
13. anatomy and physiology of the human body
14. the principles of informed consent, and how to obtain informed consent from individuals
15. how to develop clear care plans with individuals with long term conditions
16. the importance of identifying individuals' needs, and how to do so
17. the importance of identifying relevant interventions for the individual, and who can provide them
18. how factors in people's lifestyles (eg physical activity, smoking, diet, alcohol consumption, religious beliefs) can affect their care management plan
19. how the care plan will be managed

20. pharmacological therapies for treating individuals with long term conditions and how to determine appropriate therapies
21. methods of taking different medications
22. the effects, side-effects and potential interactions of different medications
23. the effects, side-effects and potential interactions of medication for long term conditions on other health conditions
24. causes and factors that determine long term conditions and their different stages
25. the short-, medium- and long-term effects of long term conditions on the individual's physical, psychological, mental and biological states and functions
26. the local protocols of contacting members of the MDT
27. the MDT member responsible for each aspect of the individual's care plan, and how to contact them
28. the range of services available locally and nationally for people who need information and support in making and maintain changes in their behaviour, and how to access these services
29. the range of services provided by the local GP and other professionals, and how to access these services
30. what to do if a need is identified but cannot be met by a service provider
31. the range of social care services available, and how to access them
32. palliative care and end of life care services available locally, and how to access them.

## PERFORMANCE CRITERIA

You must be able to do the following:

1. explain clearly own role and its scope, your responsibilities and accountability
2. explain the process and importance of developing a care management plan, including
    1. the information that may be collected while working with them and who might have access to it and who will not, and
    2. the benefits and risks of different ways of meeting their needs and alternative approaches
3. obtain the individual's consent to the development of the care management plan
4. encourage the individual to involve other people during the development of care management plan, where appropriate
5. discuss and agree with the individual
    1. the needs to be addressed
    2. appropriate aims (eg short, medium and long term) for the care management plan and stages within it
    3. who could contribute to meeting different needs
    4. when possible interventions may take place
    5. the location and timing of particular interventions
    6. how the plan as a whole will be managed and reported, and
    7. risks in delivering the lifestyle plan and how these will be managed
6. explain to the individual the medications prescribed, their effects and benefits, methods and frequency of taking them, and the importance of adhering to their regime
7. establish and agree monitoring methods, including a self-monitoring regime with the individual

8. encourage the individual to monitor their own symptoms and provide the individual with a hand-held record for recording their progress
9. support people effectively throughout, promoting their wishes and beliefs, addressing their concerns and encouraging them to promote their own health and well being
10. provide opportunities for the individual to ask questions and increase their understanding of their symptoms, the progress of the disease and their treatment plan
11. discuss any issues which the individual may have
12. agree a date to review the care management plan with the individual, their family and the Multi-Disciplinary Team
13. make clear, full and concise notes of the care management plan, agreements, monitoring methods and review date on the individual's records.

## ADDITIONAL INFORMATION

This National Occupational Standard was developed by Skills for Health.This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):Dimension: HWB6 Assessment and treatment planningThis standard has replaced CHD_GB1 and HCS I16