Learning Guide

Personal plans for complex needs

28987 Contribute to personal plans for people with complex needs in a health or wellbeing setting

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<th>Name:</th>
<th>Workplace:</th>
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Level 4 8 credits
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Introduction

It is important for you to contribute to the assessment of people’s complex needs, and to the development, implementation, review and update of their personal plans to meet those needs.

How to use your learning guide

This guide supports your learning and prepares you for the unit standard assessment. The activities and scenarios should be used as a general guide for learning.

This guide relates to the following unit standard:

- 28987 Contribute to personal plans for people with complex needs in a health or wellbeing setting (level 4, 8 credits).

This guide is yours to keep. Make it your own by writing notes that help you remember things, or where you need to find more information.

Follow the tips in the notes column.

You may use highlight pens to mark important information and ideas, and think about how this information applies to your work.

You might find it helpful to talk to colleagues or your supervisor.

Finish this learning guide before you start the assessment.

What you will learn

This topic will help you to understand:

- how to assess a person’s complex needs using different methods and tools.
- the relationship between assessing a person’s needs and their personal plan.
- how you might contribute to the development, implementation and review/update of personal plans in your workplace.

More info

If you have a trainer, they should give you all the forms that you need for this topic.
Personal plans for people with complex needs

A person with multiple chronic conditions or limited ability to perform basic daily functions due to physical, mental or psychosocial challenges is referred to as having complex needs.

Part of your role is to contribute to their personal plan. This includes supporting the assessment of their complex needs, contributing to the development the plan, supporting the implementation of the plan and reviewing/updating the plan in line with your organisation’s policies and procedures. This personal plan is an important part of assisting a person with complex needs to achieve their health and wellbeing goals.

In the next section, we will look at exactly how you are required to contribute. But first, read the short descriptions below of each stage of the personal plan process. It is important to remember that as a support worker you will need to know and work within your role and responsibilities and know your boundaries in contributing to a personal plan for a person with complex needs. You will be learning more about these stages as you work through this learning guide.

Assessing complex needs

A personal plan is developed by first assessing a person’s particular needs. This assessment process gathers information about a person’s health status which, in turn, helps to identify the support that they need. A plan can then be made detailing how these support needs are to be met.

This learning guide explains how you might be required to contribute to assessing a person’s needs in your workplace and describes the assessment tools used in that process.

A person with complex needs may have many different health professionals involved in their care and support, such as doctors, physiotherapists, speech language therapists, dieticians, occupational therapists, health assistants or support workers.

Developing a personal plan

The multidisciplinary team (MDT) will help build a personal plan that meets the needs of the person, their family/whānau and the team in order to meet specific goals. This plan will support the needs of the person on a holistic level. It may be part of your role to help develop a part of the person’s plan.
Implementing a personal plan

To help develop the personal plan you need to understand your role as the support worker who implements it. You need to have a clear understanding of how you contribute to putting a person’s personal plan in place once it has been developed. You need to understand what the policies and procedures for your particular workplace say about what is required. You will also consider some other general guidelines that are useful.

Reviewing and updating a personal plan

Personal plans for people with complex needs may need to be reviewed quite often. You will learn about how and when personal plans are reviewed and what needs to happen after a review. You will then have an opportunity to reflect on your role and responsibilities in terms of reviewing and updating personal plans in your organisation.

At the end of this learning guide you will be given a scenario that you can use to practise what you have learned.

Key words

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<td>the process of gathering information about a person's health status, identifying the support they may need and deciding how this support may be delivered</td>
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<td>tools that may be used to carry out an assessment of a person's needs</td>
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<td>personal plan</td>
<td>a written document that outlines the ways in which your organisation will support the needs of a person or group</td>
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<tr>
<td>implement</td>
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Your contribution to personal plans

Part of your role is to contribute to personal plans for people with complex needs in a health or wellbeing setting. Let’s look at what this really means.

“If everyone had something to contribute, there would be enough.”

Tina Fey

What does it mean to contribute?

In a general sense, to contribute means to give to something – time, knowledge, skills, money, etc. – that helps in some way to achieve a common goal or cause.

For the purposes of this learning guide, you contribute by giving your assistance to a wider personal plan process. This means you will never be developing, implementing, reviewing or updating personal plans on your own. By using the knowledge and skills you learn in this learning guide and within your own workplace, you will help others and work as part of a team to achieve these tasks.

How will you contribute in your workplace?

Exactly how you contribute towards the personal plan process of people with complex needs in your workplace will depend on:

- the people you support.
- the setting you work in (residential care or home and community).
- any contracts that may exist.
- your organisation’s policies and procedures.
- your own role and responsibilities.

Typical examples of tasks you might assist with include collecting data, observing people, interviewing people, collecting feedback and so on.

You are not allowed to complete assessments or develop, implement, review or update personal plans on your own.

In assisting with the personal plan process, you must keep your organisation’s policies and procedures, and your own role and responsibilities, in mind.
Your contribution

You may be required to contribute to the assessment process by:

• collecting data.
• interviewing the person and their family/whānau.
• making observations of the person.

All these different types of information can help to identify a person’s support needs.

Data collection

Collecting data about a person contributes to understanding their health status by providing objective, measureable information. Data may be gathered from existing health records or by speaking with, examining, observing and/or monitoring the person. The information can then be recorded and any changes over time can be monitored.

Some examples of data that may be collected include:

• blood pressure.
• heart rate.
• weight.
• skin integrity.
• pain levels.
• temperature.
• medication.
• quality of life score.

These are just some examples of the kind of data that you might be asked to collect. Depending on your role, responsibilities and workplace policies and procedures, you may or may not be permitted to gather some types of information.

Key words

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<th>objective</th>
<th>being fair when making decisions concerning other people and not making judgements based on biases, prejudices or personal opinions</th>
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<td>things you notice when you watch a person</td>
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Interviews

An interview in this context is where a person is spoken to, consulted with and asked questions about the status of a health condition. This approach can help to gain important information that may not be collected or measured in other ways. For example, questions about a person’s satisfaction with life may give clues as to their state of mind, while asking about their concerns about the future may give insights into the person’s ability to think abstractly.

Speaking with a person as part of the assessment provides not only information about the person’s preferences, but also gives insights about them as a person. In this way, interviewing the person is an important step towards a person-centred approach to support. This means placing them at the centre by encouraging their participation, listening to their needs and seeing them as a unique individual.

Interviews may be formally structured meetings or could be less formal, such as having a conversation with the person. Interviews often happen face to face, but can also be carried out over the telephone and by other methods.

Remember

Separate interviews with the person’s family/whānau may also provide additional information about areas of concern not identified in other ways.

Refer to your organisation’s policies and procedures to understand how, when and by whom interviews may be conducted for this purpose in your workplace.

Observations

Observations can provide valuable information about the person’s mobility and ability to function in daily life. Observational data may be gathered through standardised mobility tests or less formalised observations.

As someone who sees the person most often, a support worker is usually well placed to provide observational information.
Question

How will you contribute to the personal plan process of people with complex needs in your workplace?

Check your understanding with your supervisor.

Talk

Speak with your supervisor to check that your understanding of how you will contribute to the personal plan process in your workplace is correct.
Assessing a person’s complex needs

Accurately assessing a person’s condition, situation and needs is critical to providing them with the support that maximises their ability to function. When carrying out an assessment in your workplace, the aim is to gain an understanding of the person’s:

- general health status.
- mental health status.
- assistance required for daily life.
- level of support they receive from family and/or friends.
- future outlook.
- family/whānau concerns.

There are different tools you may be required to use when assessing a person’s complex needs. Like the assessment process itself, the tools used will depend on the nature of your workplace and your organisation’s policies and procedures.

One assessment tool you may be familiar with is InterRAI. All organisations providing aged care are legally bound to use InterRAI as an assessment tool.

InterRAI

What is InterRAI?

InterRAI stands for International Resident Assessment Instrument. InterRAI is a comprehensive clinical assessment tool used by registered nurses who have gone through the necessary training.

Information and data are entered into the tool and then used to assess a person’s functioning and find opportunities for improvement and/or risks to the person’s health. The result gives a score of the person’s dependency, complexity of needs, possible risks and opportunities. This score then forms the basis of their personal plan.

InterRAI has a number of assessments that are used in various settings. For example the Home Care (HC) assessment, Assisted Living (AL) assessment, Palliative Care (PC) assessment to name a few. All of these are used differently in their different settings.
Your role

As a support worker you will **never** use InterRAI on your own. The reason for this is that part of the assessment requires clinical judgement, which is not a part of your role. You will, however, assist the registered nurse by collecting data and information needed for the assessment or by observing changes that may prompt reassessment.

If you are working in a home and community setting supporting a person who lives with a condition or multiple conditions with more stable circumstances, you may be involved in entering information as part of review. We cover review later in this learning guide. However, you will still not be making any judgements. How far you are involved in review will depend on your role and responsibilities and the policies and procedures in your workplace.

In some workplaces, all the registered nurses are trained to use InterRAI. Larger organisations may only have a certain number of registered nurses trained to use InterRAI. This means that when you assist by collecting information for assessment you may not be working directly with the registered nurse who enters the information.

Other assessment tools

Your workplace may use some other assessment tools as well. These could include tools used to assess a person’s risk of falling, level of nutrition, skin breakdown, need for restraint and so on.

Below is an example of a continence assessment tool.

Continence assessment tool

**Purpose of assessment**

To assess continence issues for a person with complex needs, including:

- toileting ability, cognitive skills and mobility.
- bladder and bowel patterns.
- nutrition (fluid and diet).
- skin care (around the appropriate areas).
- medical conditions that may cause incontinence.
- the person’s perspective.

Any continence-related needs that are identified during the assessment will be documented and dealt with appropriately as part of the person’s personal plan.
Process of assessment
A checklist is completed that has a series of questions to be checked and also includes appropriate care options. Once the assessment is completed, options for appropriate care are identified – for example, showing the person how to empty their catheter bag.

Legislative requirements
No medications can be changed without the input of the registered nurse, continence nurse or general practitioner. All tasks must be completed in ways that meet the Code of Rights.

Reassessment requirements
Reassessment could be needed if:
• the person’s needs change and they suddenly require assistance when toileting.
• the person requires a change in medication or their pain levels change.
• the person’s bowel or bladder habits change considerably.
• the person improves.

Recording and reporting requirements
A copy of the assessment checklist is required to be kept with the person’s personal plan. A copy is also kept in their personal file with the registered nurse.
Any changes in condition and/or medication and significant changes in toileting habits have to be reported.

Support person’s assessment role and responsibilities
My role and responsibilities are to interview the person in order to complete certain sections of the assessment checklist myself. I need to get the registered nurse to complete some other sections with the person. I also check the 3-day bladder chart and 7-day bowel chart and give the details to the registered nurse if necessary.
**Question**

How will you contribute to assessing a person’s complex needs in your workplace?

**Remember** to keep in mind your organisation’s policies and procedures and your own role and responsibilities.

**Check** your understanding with your supervisor.

**Talk**

Speak with your supervisor to make sure that your understanding of how you will contribute in your workplace is correct.
Questions

What assessment tools might you be required to use in your role?
Do some research and identify an assessment tool that you are familiar with or have used in your organisation.
The tool used is:

Use your organisation policies procedures to answer the questions.
• What is the purpose of the assessment?

• What is the process used for the assessment?

• How does the assessment relate to the personal plan?

• What are the legislative requirements (if any)?

• What changes in a person’s condition/circumstances may require reassessment?

• What are the recording and reporting requirements?

• What are your role and responsibilities in the assessment process?

Talk

Discuss the findings from your research with your supervisor to check accuracy.
Developing a personal plan

The information collected during assessment is used to plan how a person’s support needs will be met. All this information is put together in the form of a person’s written personal plan.

Your contribution

As with an assessment, your contribution in this planning and development stage will depend on your particular workplace, its policies and procedures and your own role and responsibilities.

Question

How will you contribute to planning and developing a personal plan for a person with complex needs in your workplace?

Remember to keep in mind your organisation’s policies and procedures and your own role and responsibilities.

Check your understanding with your supervisor.

Talk

Speak with your supervisor to make sure that your understanding of how you will contribute in your workplace is correct.
Implementing a personal plan

Once a personal plan for someone with complex needs has been developed, it is usually ‘signed off’ by the appropriate person(s) as determined by your organisation’s policies and procedures. The person responsible for signing off the personal plan in different situations might include the person themselves, their family/whānau and their doctor.

Then the plan is ready to be implemented. This means that the things in the plan must be put in place and carried out appropriately.

As with other aspects of the personal plan process, how you contribute during the implementation stage is determined by:

• the contents of the plan.
• the policies and procedures set by your workplace.
• your own role and responsibilities.

During the implementation

When carrying out the tasks required of a personal plan, you need to consider a number of important things. These include:

• safe care and practice – being aware of and taking appropriate steps to identify, isolate, minimise or eliminate hazards and protecting the safety of everyone, including yourself, in the workplace.
• risk management – understanding your role and responsibilities in following any risk management strategy and reacting to prevent risky situations. For example, making sure you are carrying out routine clinical observations and tasks correctly, following any particular processes and checklists that you are required to use.
• responding to changes in a person’s condition or symptoms and documenting these changes. This includes knowing what to do when you observe these changes, how these changes need to be recorded, to whom they will be recorded and what actions should be taken.

Key words

| implement | to put in place or carry out |

Do it

Do your own research on what happens next in your workplace once the personal plan has been developed.

Who is responsible for signing off the personal plan?

More info

Some of these things are discussed in the following learning guides:

• 27458 Support a person with goals (level 3)
• 28545 Personal plan requirements (level 2)
Question

Check out your workplace policies and procedures. What do they say about your role and responsibilities in the areas of:

- safe care and practice?
- risk management?
- routine tasks?
- responding to changes and documenting them?

Discuss your thoughts with your supervisor.

Providing information to the person

Another important part of implementing a personal plan for a person with complex needs is to provide them with appropriate information about their care and treatment.

Code of Rights

Providing information is not only a courtesy, but a central part of the Code of Rights.

Providing information to the person is a central part of Rights 5 and 6 of the Code of Rights. These can be summarised as:

- the right to effective communication (Right 5).
- the right to be fully informed (Right 6).

These two rights make Right 7 possible by allowing information to pass to the person so that they can participate in an informed conversation about their care:

- the right to make an informed choice and give informed consent (Right 7).

These three rights are vital to the first right of the code:

- the right to be treated with respect (Right 1).

Key words

| Code of Rights | a set of rights for the people who use a healthcare service |

More info

See also the learning guide for US 28542 Professional and ethical behaviour (level 3) for more information.
General guidelines

Your workplace policies and procedures will direct you, but here are some general guidelines for giving information.

- Provide information that is consistent with your role and level of responsibility.
- Provide all the information you can so that the person is fully informed. If you don’t know something, find the information.
- Provide the information that the person wants.
- Provide information that can be understood by the person. This may include giving the information in manageable chunks rather than all at once.
- Speak clearly, calmly and in a gentle matter-of-fact way, keeping sentences short and simple and focusing on one idea at a time. Avoid ‘talking down’ to the person.
- Choose the right time and environment to speak to the person. Avoid times or places where there are distractions or where the person’s right to privacy is affected.
- Be prepared to listen. The person may have questions and fears they want to voice – you need to listen carefully so as to understand what they are saying. Don’t interrupt or try to fill in the silence, as a period of quiet may mean that they are thinking about their response.
- Show empathy and consider what it might be like to not be in total control of yourself and your environment.

Key words

| empathy            | thinking about how you might feel if you were in the other person's situation |
Your contribution

Question

How will you contribute to implementing the personal plan of someone with complex needs in your workplace?

Remember to keep in mind your organisation’s policies and procedures and your own role and responsibilities.

Check your understanding with your supervisor.

Talk

Speak with your supervisor to make sure that your understanding of how you will contribute in your workplace is correct.
Reviewing and updating a personal plan

Regular reviews

A personal plan should be reviewed regularly to make sure it is still effective and accurate. How often depends on the organisation and the person being supported. An organisation with clients whose conditions are generally stable may review personal plans only once a year. The personal plans for people with complex needs are likely to be reviewed much more often than this.

Depending on your workplace and your own particular role and responsibilities, you may be required to contribute to a review by:

- identifying changes in the person’s condition or complex needs.
- collecting data.
- interviewing the person and their family/whānau.
- making observations of the person.
- reassessing a person’s complex needs using an assessment tool (or tools).
- gathering feedback from other multidisciplinary team members.

Immediate reviews

An immediate review of a person’s personal plan may be required if:

- there are obvious changes in their condition or complex needs.
- their complex needs have been reassessed using an assessment tool, data collection, interviewing, observations and/or a person’s feedback.

Updating the plan after review

When a personal plan has been reviewed, it must be updated to make sure that everyone in the multidisciplinary team caring for the person can provide the correct care and support.

Minor changes to the personal plan may mean that the plan is changed, while more extensive changes may result in the plan being completely rewritten.

More info

Refer back to the part on ‘Assessing a person’s complex needs’ in this learning guide to jog your memory about these tasks.
Your contribution

As mentioned in the section about the InterRAI assessment tool, your involvement during review will vary. If you are working in a home and community setting supporting a person who lives with a condition or multiple conditions with more stable circumstances, your role may be more involved and you may have more responsibility and input into review. However, you will still not be expected to make any judgements. Your involvement in review will depend on your role and responsibilities and the policies and procedures in your workplace.

Question

How will you contribute to each of the following in your workplace:

- **reviewing** the personal plan of someone with complex needs?

- **updating** the personal plan of someone with complex needs?

Remember to keep in mind your organisation’s policies and procedures and your own role and responsibilities.

Check your understanding with your supervisor.
Scenario

Changes in Barbara’s complex needs

Barbara is an 80-year-old widow who lives alone and independently. She has an active social life and goes out nearly every day to meet friends or play bridge. Lately Barbara has been experiencing headaches and dizziness, and has had two falls within her home. While neither of these resulted in any injury, you have noticed that since the falls Barbara is now missing social engagements – something she would never have done before they happened. You wonder if Barbara’s symptoms of dizziness, headaches and feeling unsteady on her feet have caused her to have a fear of falling.

Talking with Barbara discloses that she does feel some anxiety about going out of the house in case she has a fall that could result in losing her independence. Fewer opportunities to go out has meant that she now shops ‘more simply’ and has a second glass of white wine in the evening to compensate for her more solitary life.

Barbara’s past medical history includes hypertension, type 2 diabetes, osteoarthritis, left total hip replacement and surgery for cataracts. You take Barbara’s blood pressure and carry out a random capillary blood glucose test. The results of these tests are 190/95 mmHg and 9.9 mmol/L respectively.

When you talk to Barbara about her diet you learn that she has been eating more fried food and cakes that she can get from the dairy just along the road, rather than take a bus to the supermarket. Barbara also tells you that she never has more than two glasses of white wine. When you ask what glass she uses, Barbara shows you a large tumbler (approximately 300 ml) that she fills to the top (‘it saves me getting up so often’). You quickly calculate that this would mean approximately 600 ml per day, or nearly a bottle of wine per day. Your discussions with Barbara also reveal that she has some confusion about her medication. You are worried about Barbara and report your concerns.

Follow up tests reveal that Barbara has a HbA1c of 8.5% – this is above the target level for diabetics (7.5%). This puts Barbara at increased risk for heart, kidney and eye damage. Further examination reveals that Barbara suffers from postural hypotension (or orthostatic hypotension), a form of low blood pressure that occurs when a person suddenly stands up. Furthermore, you find that Barbara has not been taking her medication as prescribed, so that there is no accurate record of how she has been taking her medication.
Write

What are the important facts about Barbara that you would highlight in a meeting to review her personal plan?

What broad types of support would you like to see Barbara receive?

Make brief notes about what you would say to Barbara about these changes in her support.
## Glossary

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