SFHCMC5
Build a partnership between the team, patients and carers

Overview

This standard is about developing approaches to patient care in which patients and carers are active, respected participants. It responds to the aspirations of many patients who wish to take as much control as possible of their condition and treatment, and their need for continuity and consistency in the way they are treated and consulted by practitioners. For practitioners, it also reflects evidence that shows improvement in patients' health and wellbeing when they have a significant part to play in their own care. The standard covers identifying roles case by case and implementing them though care plans.

This standard is relevant to those who provide proactive and co-ordinated Case Management. Here, Case Management means identifying and risk stratifying vulnerable, high-risk people with complex multiple long term conditions. Case Management should take place within the philosophy of enabling and promoting self care, self management and independence.

Users of this standard will need to ensure that practice reflects up to date information and policies.

SFHCMC5

Build a partnership between the team, patients and carers

Performance criteria

You must be able to:

P1 identify potential areas of involvement in which patients and carers can participate and take more control of their care

P2 identify and utilise any existing organisational resources for developing patient involvement and participation

P3 provide patient information at times jointly agreed so that the patient feels supported and involved (e.g. during the progression of their disease, end of life)

P4 evaluate the possibilities of patient involvement case by case when planning care plans or pathways

P5 identify and discuss with patients and carers any behaviour that indicates an unstated need for involvement in their own care

P6 identify the degree to which patient and carer wish to become `experts'

P7 respect an individual patient's decision not to be involved.

P8 ensure that the care plan and the involvement in decision making is consistent with the level of autonomy and participation requested by the individual patient and carer

P9 utilise staff and other resources available to best effect within the constraints created by the patient's and carer's roles

P10 establish lines of communication among the multidisciplinary team and the patient to support the partnership approach and ensure that the patient and carer are equal partners in any conversation

P11 establish and evaluate feedback and response mechanisms between the patient and carer and the team

P12 create opportunities for patients and carers who do not volunteer proposals about their care, to have a chance to explore these issues in an unpressured environment

P13 evaluate the extent to which the environment is a safe one in which views can be voiced without fear of judgment or resulting pressure

P14 ensure that a member of the team actions agreed decisions.

P15 ensure that the patient and their carer understand what skills they will have to learn

P16 bring into the process those members of the multidisciplinary team and community staff who have information or explanations to impart or who need themselves to understand the patient's and carer's roles

P17 facilitate, where possible, an open, interactive process where the pace and subject matter of the activity is led by the patient

P18 search for and address misunderstandings or misconceptions of fact

P19 make available follow-up support in differing formats (eg printed material, web

P20 resolve with other members of the multidisciplinary team any problems arising from the responsibility taken on by the patient and carer

P21 check that the patient and their carer can carry out the care safely on

their own

P22 ensure that patients are familiar with the procedure to follow if equipment or services fail

P23 agree on early follow-ups and establish a pattern of review

SFHCMC5

Build a partnership between the team, patients and carers

Knowledge and understanding

You need to know and understand:

K1 how to ask open-ended questions, listen carefully and summarise back
K2 methods of communicating sensitive information to individuals
K3 the importance of providing individuals with opportunities to ask questions and increase their understanding
K4 how to adapt communication styles in ways which are appropriate to different people (e.g. culture, language, or special needs)
K5 the importance of identifying how the individual wishes to be addressed and communicated with, and how to do so
K6 how to identify and respond to the concerns which patients may have regarding their disease and the way in which it affects their lives
K7 the effects of dependence and independence on the patient, carers and the provision of the service
K8 how to obtain from patients a valid picture of their goals, aspirations, feelings and expectations
K9 how to make decisions from the multiple perspectives of a team
K10 information that should be available in the plan of care, what it means and what to do if it does not seem to be there
K11 recording of agreements, plan of care and other communications to be accessed by all members of the multidisciplinary team (eg recorded electronically)
K12 the importance of treating individuals fairly, and how to do so
K13 the effects of culture, religious beliefs, age and disability on individual communication styles
K14 the different features services must have to meet people's gender, culture, language or other needs
K15 the progression of the long term conditions and the interplay between them
K16 the nature of a long term condition and the medical, nursing and social care needed
K17 evidence of the relationship between patients' lifestyles and their wellbeing
K18 effect of nutrition on a patient's health
K19 conditions and co-morbidities that influence the patient's plan
K20 evidence of successful involvement by patients in managing their condition and co-morbidities
K21 medication management, its function and its effects on the co-morbidities
K22 relationship between the co-morbidities, nutrition, medication and measures of the patient's health (e.g. blood pressure, anaemia) and procedures for managing these
K23 the roles and availability of members of the multidisciplinary team
K24 the contribution that different professions can make to the evaluation and planning of patient care

K25	guidelines and constraints of the organisation on the support to patients taking responsibility for their care and treatment

SFHCMC5

Build a partnership between the team, patients and carers

Additional Information

External Links

This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):

Dimension: HWB4: Enablement to address health and wellbeing needs

SFHCMC5

Build a partnership between the team, patients and carers

Developed by	Skills for Health
Version number	1
Date approved	June 2010
Indicative review date	June 2012
Validity	Current
Status	Original
Originating organisation	Skills for Health
Original URN	CM C5
Relevant occupations	Health, Public Services and Care; Nursing and Subjects and Vocations Allie; Health Professionals; Healthcare and Related Personal Services
Suite	Long Term Conditions - Case Management
Key words	case management, community matrons, long term conditions