SFHCME1
Help individuals with long term conditions to change their behaviour to reduce the risk of complications and improve their quality of life

Overview

This standard covers working with individuals with long term conditions to enable them to change their behaviour to improve their quality of life and reduce the risk of longer term complications through changes to diet, lifestyle and physical activity. This change may concern a specific aspect of behaviour that is one element in a total care plan. The role of the healthcare professional in this standard is to work collaboratively with the individual, and to identify goals and plans for change through discussion and agreement. 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.

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Performance criteria

You must be able to:

P1 communicate with individuals in a manner that is appropriate to them and which encourages an open exchange of views and information

P2 encourage individuals to:
- P2.1 identify practical changes in behaviour that could improve their health
- P2.2 recognise the benefits of changing their behaviour and the alternatives available to them
- P2.3 value themselves positively and recognise their ability to change

P3 explore:
- P3.1 the motivation of the individual regarding changing their behaviour
- P3.2 obstacles they may face in attempting to change their behaviour
- P3.3 how the obstacles can be addressed
- P3.4 constructively the support available to help them change behaviour

P4 identify with individuals a range of strategies for changing their behaviour, which are consistent with:
- P4.1 their condition and personal circumstances
- P4.2 the risks associated with their behaviour
- P4.3 evidence of how to achieve behaviour change
- P4.4 local or national public health initiatives

P5 where individuals agree to develop a plan to change their behaviour, help them to identify:
- P5.1 realistic short and long term goals for changing their behaviour
- P5.2 a realistic plan for achieving the goals
- P5.3 when and how the plan will be reviewed

P6 provide information on facilities or support that will be of help to individuals in changing their behaviour

P7 make an accurate record of the plan which can be followed by other members of the care team, the individual and carer

P8 encourage individuals to value their attempts and achievements in changing their behaviour, and provide positive support and reinforcement when they have achieved less than they expected

P9 review with individuals:
- P9.1 how they can maintain their new behaviour
- P9.2 how they can deal with any problems they are encountering
- P9.3 whether they are making effective use of the support available to them
- P9.4 whether the plan should be adjusted in the light of progress to date

P10 agree arrangements for supporting individuals that are consistent with:
- P10.1 the agreed plan for change

P10.2 their need for support
P10.3 the resources available for their support

P11 encourage individuals to seek further support from you and from other people when they are in need of it

P12 update the record of the plan and progress with it in a form which can be followed by other members of the care team, the individual and carer

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Knowledge and understanding

You need to know and understand:

K1 the relevant clinical guidelines/NSF
K2 expert advice from a specialist adviser
K3 causes of the relevant disease
K4 signs and symptoms of the relevant disease
K5 normal and abnormal biochemical values
K6 how to monitor conditions
K7 typical progressive patterns of the long term condition
K8 the importance and effects of patient education and self management
K9 the psychological impact of the long term condition, at diagnosis and in the long term
K10 how to gather information from patients about their health
K11 how to work in partnership with patients and carers
K12 the social, cultural and economic background
K13 the patient/carer group
K14 the impact of nutrition and physical exercise
K15 the effects of smoking, alcohol and illicit drugs
K16 the effects of, and how to manage, inter current illness
K17 how to manage the long term condition
K18 the medications used to manage the long term condition
K19 the long term complications of long term conditions disease eg. diabetes and when they are likely to occur
K20 how to monitor long term conditions
K21 when to recognise when to seek the advice of a specialist in relation to specific disease management
K22 the law and good practice guidelines on consent
K23 the staff member's role in the healthcare team
K24 and the role of others
K25 local guidelines in relation to the long term condition
K26 local referral pathways
K27 local systems for recording patient information
K28 quality assurance systems
K29 the process of notification for legal and insurance purposes
K30 sources of practitioner and patient information the relevant long term condition
K31 contact details of local and national support groups
K32 how individuals can access local facilities for exercise and physical activity, education and community activities
K33 principles of cognitive behavioural therapy and how to apply them
K34 principles of motivational interviewing

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Additional Information

External Links

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

Dimension: HWB6 Assessment and treatment planning

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