Non-Examined Assessment

Band 2 Exemplar Learner Response

NCFE CACHE Level 1/2 Technical Award in Health and Social Care (603/7013/0)

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Contents

Introduction

The following are sample learner responses for each task within an assignment alongside examiner commentary for each assignment. They show how learners might respond and can help assessors in making their overall marking decisions.

Learner responses

Each learner response should demonstrate *what* a **mark band two / third band** response looks like alongside any evidence that is required to be completed. All responses use content from the mark schemes and align with the standards in the mark band descriptors and indicative content.

Assessor commentary

The assessor commentary demonstrates *why* the responses given throughout the assignment meet the criteria for the mark band they have been awarded. The assessor commentary will be linked to, and supported by, the descriptors in the mark scheme.

Task 1 – Care planning report – Assess and implement		
Band	**Marks**	**Descriptors**
4	10–12	**AO3 – Excellent** analysis and evaluation of the case study and individual profile to assess and identify John's care needs and support required that is **comprehensive** and **highly relevant**. **AO2 – Excellent** application of knowledge and understanding of care planning, care needs and support that is applied to meet the individual needs of John that is **comprehensive** and **highly detailed** and **highly relevant** to the case study and task. **AO1 – Excellent** recall of knowledge and understanding of care planning that is **comprehensive**.
3	7–9	**AO3 – Good** analysis and evaluation of the case study and individual profile to assess and identify John's care needs and the support required that is **detailed** and **mostly relevant**. **AO2 – Good** application of knowledge and understanding of care planning, care needs and support that is applied to meet the individual needs of John that is **detailed** and **mostly relevant** to the case study and task. **AO1 – Good** recall of knowledge and understanding of planning cycle that is **mostly detailed**.
2	4–6	**AO3 – Reasonable** analysis and evaluation of the case study and individual profile to assess and identify John's care needs and support required that has **some detail** and **some relevance**, though this may be **underdeveloped**. **AO2 – Reasonable** application of knowledge and understanding of care planning, care needs and support that is applied to meet the individual needs of John that has **some detail**, although this may be **underdeveloped** with **some relevance** to the case study and task. **AO1 – Reasonable** recall of knowledge and understanding of care planning that has **some detail.**
1	1–3	**AO3 – Limited** analysis and evaluation of the case study and individual profile to assess and identify John's care needs and support required. **AO2 – Limited** application of knowledge and understanding of care planning, care needs and support to meet the individual needs of John that has **minimal detail** and are **mostly superficial**. With **minimal relevance** to the case study and task. **AO1 – Limited** recall of knowledge and understanding of the planning cycle that have **minimal detail**.
0	0	No rewardable material.

Case study

John is 68 years old. He lives on his own since his wife died 2 years ago.

Four months ago, John suffered a stroke. He has spent time in residential care to recuperate and is due to return home next week. The stroke has left John with difficulties with his mobility, co-ordination and speech.

John and his son have met with the social worker, and it has been agreed that for John to safely return home, he will need support from a care assistant from home care services. They will provide care and support 3 times a day to meet John's needs and support his independence.

John's son will visit once a day and a neighbour will be able to get John's shopping.

Using the case study and the two resources complete tasks 1–5.

Task 1: care planning – assess and implement

Evidence:

Written report and care plan can be either word processed or handwritten.

John aged 68 years old lives at home following discharge from residential care. John is living with the effects of a stroke. John has lots of holistic care needs.

John can use a knife and fork but is slow. If he doesn't eat/drink enough, he might become dehydrated. When eating John can get food around his mouth and needs someone to prepare food. John's left side body strength is not good, and his fine motor skills and upper body strength have been changed by the stroke. John can only walk for a short time. When in the flat John will find filling / lifting a kettle or washing pots, getting dressed too hard to do. He is a bit stuck because he needs help with looking after himself.

John can't shop for food; he wouldn't be able walk to the shop on his own as it would be too far, and he can't talk clearly to a shop assistant and might end up not getting the things he needs or be able to carry them back from the shop. Even if his neighbour does the shopping, he will find opening packets too hard.

John finds caring for himself difficult because of the stroke. He has left sided weakness and reduced fine motor skills / control. He needs to keep clean so that he can feel good about himself and not get poorly but he couldn't get into a bath and wash himself or probably manage to turn on the tap. He couldn't use a shower or bowl and flannel to wash as he wouldn't be able to manage. He finds brushing teeth and putting on moisturising cream difficult, as he can't open the lid and squeeze the tube.

John wants to do as much as he can to care for himself. John wants to smoke, and he doesn't seem bothered about the effects of smoking. When being cared for John should have dignity and be respected. Before the stroke he enjoyed going to the pub playing cards and dominoes.

John is more likely to fall because he is unsteady on his feet. He does use a walking frame, but it is hard to hold the walking frame and do things at the same time. John needs to be safe so that he doesn't become injured for example break his hip, but John still needs exercise to stop him getting sore from sitting down.

Assessor comments

Here for example, the learner has shown how John's weak fine motor skills impact on his care needs. There is an accurate link but full details of the impact are not addressed.

It is clear that John's left side body strength is impacting on his ability to do tasks independently but the link is not fully described or explored and stops short of a good level of analysis.

This shows the learner has started to connect John's needs to the impact on his daily life but the connection isn't fully made or included.

John's physical needs and the effects of a stroke on physical needs such as upper body/left side weakness are relevant however, these are repetitive throughout the response. The effects of the stroke on John's social / emotional need are less obvious within the response.

The response includes a reasonable range of care needs, for example food and drink, mobility, hygiene / personal care, safety, dignity, social interaction as reflected by Maslow and included in the content / specification.
However, not all of John's individualised care needs are reflected and some are omitted. Links to how needs are met building towards self-actualisation are not reflected.

Before the stroke John has taken part in social activities and made friends with his neighbours. He still needs to keep relationships with others otherwise he might get mental health problems. The stroke has made it hard for John to talk to others even though he understands what others are talking about he finds talking too hard and this stops him from joining in conversations..

Here the response shows that the learner has made the connection between not being able to clearly verbally communicate and John's daily life, however, this is not fully explored or developed.

Care plan

Need	How to meet John's needs	Who will meet the need	Equipment	Outcome for John
Healthy food and drink	• meal at home service every day • provide prepared healthy drinks / food that are easy to heat, cut and self-feed so he can be independent • make hot drinks and put in insulted lidded cup • provide water in easy-to-use bottle • face wipes accessible.	Care assistant. Neighbour Son.	Microwave Prepared food chopped into manageable pieces. Adapted cutlery / drinking bottle Insulated cup Face wipes	Independently have food and drink when required. Stops dehydration. Face stays clean. Makes him feel comfortable
Personal care with dignity	• help John to wash his body, clean teeth and change clothes but let him choose clothes and do as much as he can for himself, John should be given privacy • use communication picture to help tell others what he wants • provide electric toothbrush • help John use moisturiser.	Care assistant. John	Water, soap, towel and clean clothes Electric toothbrush Chair in the bathroom Communication picture sheet. Walker	Prevents infection and makes John feel comfortable. Encourages John to care for himself.
Safety	• encourage John to stop smoking • cut up food into small pieces as too difficult to do alone • remove items that John could trip on in the flat • make sure medication is taken.	Care assistant	N/A	Helps John to be healthy Reduces the chance of choking Reduces the chance of John falling
Love / care/ activities	• provide chances for his friends to visit him at home.	Care assistant Son	Walker	Stops mental health issues.
Mobility	• encourage John to move as much as he can • add a daily walk outside • encourage use of walking frame • encourage daily chair-based exercises suggested by the physiotherapist.	Care assistant Son Physiotherapist	Walking frame	John can move around safety Stops pressure sores.

Assessor comments

The format / headings of the care plan reflect elements of professional care plan.

Not all elements of John's needs are transferred into the care plan. This shows a reasonable attempt to apply ways to support John's care needs. However, there are elements that could be included and explained.

Vocational knowledge is shown, which is reflected in selection of appropriate personal care aids. However, the learner could have included further items such as PPE, or alternative mobility aids.

The outcomes show an understanding of how meeting John's care needs will result in improved holistic outcomes for John. These are accurate yet underdeveloped in range.

Here for example, elements of person-centred care are included where the response indicates that John should be given a choice of clothes to wear.

Vocational knowledge could have been reflected here. The learner could have suggested further relevant professionals or services, for example stop smoking services such as a stop smoking advisor.

The outcome for love / care / activities is reasonable. However, it could be detailed to explain how mental health issues could be stopped, which would move the learner response from 'reasonable' to 'good'.

This response is an example that shows the learner has identified what John's needs are, which show a reasonable application of knowledge. However, this could have been developed to include when he should be encouraged / how he would be encouraged. A what, when, how description would move the response from 'reasonable' to 'good'.

Task 2: health and safety – procedures

Evidence:

Written procedure, which is either word processed or handwritten.

Safe working practices in relation to the use of PPE.
PPE should be used when carrying out practitioner roles which puts the practitioner in contact with:

- blood
- bodily fluids
- soiled intimate care products
- contact with a person with an infectious disease
- handling/preparing food
- cleaning a potentially contaminated area.

PPE protects the person working in health and social care and the child or person using the health and social care service.

First, the health and social care practitioner must decide whether PPE is needed, and then which type of PPE they should use. There are different types of PPE e.g. gloves, masks, apron, gown. There are also different situations when PPE should be worn for example, when cleaning a bathroom area, a mask with gloves and apron should be worn but if cleaning a food preparation area only gloves and an apron is needed, If the practitioner doesn't know if PPE is required or which type is required, they should ask their manager.

All PPE must be used correctly.
All used / contaminated PPE / equipment should be put in the yellow bin for clinical waste. Items such as used nappies / incontinence or sanitary products should go in sanitary bins or non-hazardous waste bags and not in yellow bins / clinical waste.

Before using PPE check that it is not damaged.
Before putting on PPE practitioners should wash their hands.
Each piece of PPE should be new/fresh for each procedure / person / child involved. PPE should be on hand for emergency situations e.g. sudden nosebleed

Assessor comments

Reasons for using PPE in a health and social care setting are accurate and clearly identified.

Principles for effective PPE use are applied in this example.

Reasonable knowledge of checking PPE before use is shown, however, to move from 'reasonable' knowledge to 'good' knowledge the learner would need to include greater depth including how and what aspect should be checked.

Again here is an example of where the response falls short of a 'good' level of analysis and evaluation. If how practitioners would wash their hands was added the learner would demonstrate a 'good' understanding rather than a 'reasonable' one.

This response is partially accurate, to be fully accurate the step should indicate how each item of PPE should be used to accurately reflect safe practice / procedure.

Procedure for safe use and disposal of PPE.

Step 1	Decide what PPE to use.
Step 2	Wash hands thoroughly using soap
Step 3	Put an apron on first, then a mask, then eye protection (if needed) and then gloves
Step 4	When putting on a mask make sure if goes over the nose and mouth. There should be no gaps.
Step 5	When putting on gloves, choose the correct size to cover the hand and wrist.
Step 6	Removing PPE. First take off gloves, remove apron, take off eye protection, then remove the mask. Put all items in the correct bin/bag.
Step 7	Wash hands thoroughly with soap for at least 20 seconds.
Step 8	Dry hands thoroughly.

Assessor comments

Throughout the PPE procedure the learner shows 'reasonable' knowledge. The response includes what is required but the application of this practice is not fully explored/developed. Details of how each component of the routine would be carried out would move the response from 'reasonable' to 'good'

Methods for safe removal of PPE shows some relevance and some detail but is not fully explored or connected to a reason or benefit..

To develop and move from 'reasonable' to 'good' a stepped up approach reflecting the what, where, how content would help demonstrate further understanding.

Task 3 (a): planning an activity

Evidence:

Activity plan, which is either word processed or handwritten.

Time	Activity	How activity will support John's development	What the practitioner / family member will do during the activity	Resources needed
08.00	**Getting ready for the day** John to choose his clothes, get dressed, go to the toilet, have a shave, clean teeth and wash.	It will help John's independence. John will use his arms/body to get dressed this will help him get stronger. He will feel good about himself.	Care assistant, to help fill up the sink and help with shaving. John should be given privacy. The care assistant should ask John for his opinions, e.g. which body wash to use.	Chair to sit at sink. Long handled sponge Towel Soap / bodywash PPE for care assistant
08.45	**Get breakfast ready / eat breakfast** **Have medication**	Having breakfast will help John stay healthy. He will use some physical skills. Taking medication will help to stop another stroke.	Care assistant will get John's breakfast ready by cutting up fruit. John should be helped to put bread in the toaster and spread butter. The kettle is heavy so the care assistant should use the kettle, so John doesn't get burnt but get John to put the tea bag and milk in the cup, John will need help to take medication from the box. The care assistant must write down the medication given and get John's tea ready for later.	Walking frame Perching stool Adapted equipment like bread board with spikes and easy grip knives. Medication
9:45	**Toileting/ handwashing**	John will be clean and comfortable.	Care assistant will help John to use the toilet.	Walker Perching stool

Assessor comments

The format and layout of the plan reflects a daily plan that is relevant to the HSC sector.

The care plan contains a reasonable range of care needs such as food and drink, personal care and more. These are accurate and reflect a day that would suit John. However, when activities are provided the full holistic benefits are not identified for example, after the physio session, John is given a drink but the need for rest isn't fully reflected.

The response identifies a potential H&S risk here and later in the plan issues of H&S are linked to handwashing and taking medication/recording. However, this isn't applied consistently throughout the plan or developed to show how John will be safeguarded as part of the daily activities.

Time	Activity	How activity will support John's development	What the practitioner / family member will do during the activity	Resources needed
10.00	**John to be collected from his flat and taken to an Age UK day centre**	John will be transported to the centre. Getting out will boost his mood. John will enjoy seeing places when sitting on the bus and trying to talk to the volunteer	Age UK bus will take John. There will be a volunteer on the bus to help get John into his seat. They will talk to him too.	Personal items for going out. Walking frame.
10.20	**Arrive at the centre** **Drink**	He will enjoy the feeling of being out of the house.	Day centre staff to provide tea. There will be volunteers and care assistants to help John and talk to him.	
11.00	**Free choice activities** **John can do arts and craft, play cards or look at books in the library.**	John will have chance to develop his fine motor skills and communicate with others during the activity. His day will be fun.	Volunteers will help John when he is doing an activity. If John needs the toilet he can have help.	Activity materials e.g. paint
12:30	**Go to the toilet and clean hands**	John will feel comfortable	Volunteers will help John to use the toilet and wash his hands so he doesn't have dirty hands when eating.	Handrails Perching stool Easy to use soap dispenser. Walking frame

Assessor comments

Here is an example of John's needs. However, these are identified in isolation. The response could be developed into 'good' if the learner connects needs together to show how one need relates to another. Overall the plan shows an reasonable understanding of holistic needs.

There are a range of activities that are suitable for John aged 68 and they also reflect the activities he has previously chosen and likes to do. The description of activities is 'reasonable', it could show stronger detail to explain how the activity will support John's current stage of development. For example, John will develop fine motor skills is stated but there is no explanation of how the activity will do this making it underdeveloped and simplistic.

Time	Activity	How activity will support John's development	What the practitioner / family member will do during the activity	Resources needed
12.30	**Lunch time John can choose to eat cottage pie and veg or pasta and sauce. He will be offered sponge and custard or yogurt and fruit for pudding.**	Eating will help John to use his fine motor skills. This will make sure John has energy. He will be sociable. Having a choice for food will help him feel in control of his day.	Day centre assistants to provide lunch and cutlery to help John to eat his food. Wipes and an apron will help keep John clean. If John needs the toilet he can be helped to go.	Adapted cutlery Plate guard - to support John cutting his food and it not falling off his plate Wipes Apron
13.30	**Group singing or walk around the garden**	John will be given a choice. Both activities will encourage intellectual skills and boost his self-esteem when he can do stuff. Being outside will help his mental health.	Day centre staff to lead singing or walk John Peers from the day centre	Song books and music
14.00	**Physiotherapy session**	Helping John to improve his walking and co-ordination.	Physiotherapist. John	Walking frame
14:30	**Drink with a cup of tea / coffee or cold drink and biscuit**	He will have a drink to keep him hydrated.	Volunteers / care assistants will find John a comfy seat.	Chair to rest in Television Cup for drink
15:00	**Games time either dominoes or bingo game. John can choose.**	This will stimulate John's brain and problem solving,	Volunteers / care assistants will help John with the dominoes if he struggles to pick them up. John will be able to go to the toilet when he needs to go.	

Assessor comments

The learner knows that help is needed showing a 'reasonable' understanding of John's needs but the detail and explanation is sometimes underdeveloped.

To demonstrate a 'good' understanding of family / practitioners role the learner should add what the practitioner would do, how they would do this and why. This is started in parts of the plan but not consistent.

Evidence of understanding of equipment that could support John that shows some relevance. However, there is equipment missing, which would be beneficial to John such as providing a plate guard – to support John cutting his food and it not falling off his plate. Therefore the content shows a 'reasonable' recall of taught knowledge.

Some detail of links made to John's preferences / activities he enjoys throughout. However, links could be developed further to include the significance of each activity. Maybe John's son could support John to visit the pub in the evening building on John's interests and further supporting John's need for stimulation and socialisation.

Time	Activity	How activity will support John's development	What the practitioner / family member will do during the activity	Resources needed
16.00	**Home time**		Ring and ride bus service	
16.20	**John arrives home, watch TV.**	John will have the opportunity to 'recharge his battery'		Chair to rest in TV
17.30	**John to prepare a sandwich and drink for his tea.**	Helping John to be independent and not be hungry. He will feel proud.	John The care assistant who came in the morning will have made a flask and cut up some food ready for John to make a simple sandwich. This will be left ready for John.	Perching stool for the kitchen so John can sit down while making his sandwich.
18:30	**John's son to visit John at home**	Social interaction with his son. He will gain confidence to use his language skills. He can have help from his son if he needs to use the toilet. John's son brings John's grandson, and they all have the chance to talk	John John's son / grandson	
19.30	**Getting ready for bed.** **Medication**	This will ensure that John has received help to undress and get ready for bed	John. John's son to help with getting ready and toileting / hygiene tasks. John's son should make sure that John has his medication and writes down that he has given him the tablet.	

Assessor comments

The learner has not completed what will happen in this part of the day. Therefore the plan is not fully completed.

The day ends early and there aren't details of what happens after 7:30pm. Will John be expected to stay in bed from 7:30pm – 8am? Therefore only a 'reasonable' awareness of John's needs and life stage are shown.

Task 3 (b): planning an activity – risk assessment

Evidence:

Risk assessment, which is either word processed or handwritten.

Garden walk

Red = high risk
Amber = medium risk
Green = low risk

Hazard	Who might get harmed and how	Keeping everyone safe	Action needed
Trips and falls. Stones or rubbish on the ground. These could be sharp and could cut John or others if they fall on them.	Service users, practitioners or volunteers could slip and fall and break a bone or cut themselves if rubbish is sharp	Remove items if seen. Make sure everyone who has them uses their walking aids.	Litter pick or check for stones before going out so that there are no trip hazards for John and others.
Uneven ground, slabs could be cracked or stick up and crutches could get caught causing John or someone to fall over. If it has been raining slipping might be more likely.	Service users, practitioners or volunteers could trip or slip on uneven ground and hurt themselves. They could also get upset if hurt.	Make sure everyone wears suitable footwear and uses the walking aids they use.	Make sure uneven ground like paths are fixed. The caretaker should make sure the area is safe. Don't take service users out if it has been raining.
Tripping over garden equipment eg. watering can, hose pipe.	Service users, practitioners or volunteers could fall over things like a hose pipe or spade that has been left out. They could bump their head or break a bone. They will also feel sad.	Practitioners pick up things if they are in the way	Make sure the gardener puts equipment away. Check the area.

Assessor comments

The format of the risk assessment, including colour codes demonstrates a 'reasonable' understanding of a risk assessment that could be used for this activity. Relevant aspects of risk are recalled but not fully developed with what, when, how content. The hazards show what the potential harm / risk is and gives details of how they could cause harm physically and emotionally.

The response is generic across everyone who could be at risk, there is minimal understanding demonstrated to show that service users are potentially more at risk due to vulnerabilities of age, health and mobility.

Awareness shown of risks linked to mobility.

Hazard	Who might get harmed and how	Keeping everyone safe	Action needed
Poisonous plants.	Service user, practitioners or volunteers. If touched the person could have a sore rash and get ill causing them to be sick. This isn't good for anyone especially people who are older or unwell already.	Encourage handwashing after walk. If you don't know if the plant is poisonous, tell everyone not to touch plants.	Find out if there are poisonous plants so that they can be removed and issues avoided.

The response shows some relevance / a 'reasonable' range of risks however, there are more that could have been considered such as the sun (sunburn, dehydration) pond (drowning), insects (bites, stings).

Controls are underdeveloped. The response would move from 'reasonable' to 'good' if more detail was applied. For example, who would 'make sure everyone who has them uses their walking aids', how and when would this be communicated?

This increased detail would demonstrate greater application to practice for example, it could link to the care value base.

This is accurate, however, with some further explanations is required to show why this is important and the relevance of the action.

Task 4: care planning – review

Evidence:

- a written report – with the recommended changes and why – which can be word processed or handwritten
- an updated care plan, which can be word processed or handwritten.

Review of social workers report findings

John's mobility has improved, this is good. John doesn't need to use his walking frame anymore. John can walk with one crutch and can walk further than before. He still has muscle weakness, but this is getting better. He should keep doing his exercises from the physiotherapist. He should keep taking medication.

His fine motor skills are getting better but are not 100% back to normal. He still needs help with personal care and doing fiddly things.

John can eat small amounts of food but is still slow. Cutting up food is tricky for him.

John can talk better now. He doesn't need to use communication picture sheet as often. He still needs to see the speech and language therapist though.

He enjoys being with other people, this something John likes and wants to do more of.

John is still smoking which isn't good for him.

Assessor comments

Some aspects of Maslow's hierarchy of needs are reflected in the information provided.

The response summarises a reasonable level of analysis demonstrating some of John's progress / how well John's needs have been met. However, not all achievements and developments have been drawn out from the SW report. For example, omission of John reading again, he is less frustrated, he is still using gestures (which infers that communicating with others is still challenging) and comments from his discharge from the physio are referenced. This shows the learner has some skills to analyse and has been able to pick out some relevant pieces of information but not to a 'good' level.

Changes needed to care plan

- ★ John is not using a walker now so doesn't need this in the plan he has more strength now
- ★ he could have a shower now he needs less support with mobility
- ★ he could have different equipment that might help him to care for himself now he is stronger
- ★ he doesn't use the communication picture sheet as much because he is able to talk clearer
- ★ help to stop smoking should be sorted out
- ★ he needs to meet his friends and do more social things so that his mental health stays healthy
- ★ still needs help with personal care so that he can keep clean and healthy and looks ok when he goes out.

Assessor comments

Justifications for why the care plan might need to change have been attempted and reasons are fair. Although a greater level of detail to the justifications would have demonstrated greater understanding. Sentences are 'clipped' and not fully explained. For example, 'he doesn't use a communication picture sheet as much because he is able to talk clearer' could have been developed to say that John can express his needs more clearly and can communicate what he would like to do with care assistants and his family.

Adding having a shower, meeting friends more often / going out shows that the learner is thinking about how John could progress further and become more independent in caring for himself. This demonstrates knowledge of John's ongoing care needs. This comment also shows that John is being moved towards practice that reflects good care practice and includes care values. Inclusion of these elements show some detail and relevance to John and his care needs / development and progress.

Information below has been added to the care plan:

- John can have a shower maybe once a week with a bit of help now his physical mobility has improved. He could have a long handle sponge to help wash (shower chair, crutch)
- communication picture cards should be available but will be used less often. Speech and language therapy would help John
- encourage John to stop smoking, this should be a priority following social worker report. Stop smoking advisor could help John. He could have patches or advice from the GP as well which will help him stop and be healthier
- Provide trips out to see his friends and do social activities
- go out for a short daily walk maybe in the garden at first
- add a daily walk outside. Maybe John's son could help
- encourage use of crutch.

Assessor comments

A reasonable knowledge is demonstrated to show where John's development is at four weeks after being back at home. The suggested improvements identify the improvements that would further enhance John's life experience and meet his holistic needs. These are 'reasonable', if substantiated with reasons why and the benefits this response would move to 'good'.

Need	How to meet John's needs	Who will meet the need	Equipment	Outcome for John
Healthy food and drink	• meal at home service every day • provide prepared healthy drinks / food that are easy to heat, cut and self-feed so he can be independent • make hot drinks and put in insulted lidded cup • provide water in easy-to-use bottle • face wipes accessible.	Care assistant. Neighbour Son.	Microwave Prepared food chopped into manageable pieces. Adapted cutlery / drinking bottle Insulated cup Face wipes	Independently have food and drink when required. Stops dehydration. Face stays clean. Makes him feel comfortable
Personal care with dignity	• help John to wash his body, clean teeth and change clothes but let him choose clothes and do as much as he can for himself, John should be given privacy. • John can have a shower with a bit of help his physical mobility has improved • use communication picture to help tell others what he wants. Communication picture cards should be available but will be used less often. • provide electric toothbrush • help John use moisturiser.	Care assistant. John	Water, soap, towel and clean clothes He could have a long handle sponge to help wash Electric toothbrush Chair in the bathroom Communication picture sheet. ~~Walker~~ Crutch Shower chair	Prevents infection and makes John feel comfortable. Encourages John to care for himself.
Safety	• encourage John to stop smoking this should be a priority • cut up food into small pieces as too difficult to do alone • remove items that John could trip on in the flat.	Care assistant	N/A	Helps John to be healthy Reduces the chance of choking Reduces the chance of John falling
Love/care/ activities	• provide chances for his friends to visit him at home • provide regular trips out to see his friends and do social activities • go out for a short daily walk.	Care assistant Son	Walker Crutch	Stops mental health issues. Increases mobility and skills
Mobility	• encourage John to move as much as he can, add a daily walk outside • encourage use of crutch ~~walking frame~~ • encourage daily chair-based exercises suggested by the physiotherapist.	Care assistant Son Physiotherapist	Walking frame	John can move around safety Stops pressure sores.

Task 5: evaluation of your care plan

Evidence:

An evaluation. which is either word processed or handwritten.

How well the care plan records and outlines John's care and support

The care plan includes John's care needs e.g. how John will get food / drink / the help he needs e.g. to shave. This means that John will be safe and well cared for making it a good care plan. The first care plan must have worked because John has improved, he has done his exercises, and this has made him stronger. If someone reads the plan, they will know what to do. If the care assistant didn't help John he couldn't care for himself and would not be able to live at home.

The new care plan has changed because John has got better with strength and walking, and the care plan. This makes it a person-centred care plan because it shows what he needs now and is up to date e.g. shows he is strong enough to have a shower. Now John is less stressed he should stop smoking.

The care plan shows the equipment John needs so he can care for himself, and the care assistants know what to do. Care assistants could be different each day, and the care plan will help care assistants know their job. This will help John feel better too if care assistants care in the same way and has helped John be independent and stay at home.

How well the care plan meets John's holistic needs and development

I think the plan is person-centred. The plan included care, compassion, communication and commitment, these are important Cs in health and social care. The plan also shows care values. I wrote the care plan after reading reports, so it is up to date.

Compassion is shown as John is kept safe, he has food and is helped by a care assistant and his family. He isn't left alone and has chances to see other people. Any risks of John hurting himself are thought about and ways to help him like giving him a flask instead of using a kettle are in the care plan. John has lots of chances to do things that he can for himself this shows he is being helped to be independent which is important even if you are unwell and older.

Assessor comments

This content shows the learner has provided an example of the care needs included in the plan. This shows relevant recall. The learner could have expanded and reflected the holistic nature of needs rather than individual needs.

The learner has recognised the important part that care assistant input has made in helping John care for himself and in helping him to live at home.

The learner has been able to link John's current development and needs stated in the SW report and make a conclusion to why such progress has occurred, which shows reasonable analysis.

Strengths of the care plan are noted, which helps demonstrate the learner has evaluated the care plan. The learner recognises the value of care planning relating to working and communicating with others.

The learner has linked to HSC good practice and reflected on the 6 Cs / person-centred practice as a method of assessing the plans effectiveness. This shows evaluation, however, the content of the evaluation could be more detailed and improved.

He has food each day either by a meal at home service or food got ready for him. This shows he will not be hungry. This shows that everyone is committed to John's care and wants him to get better. He has chances to see other people and be kept clean.

Ways that John can communicate are in the care plan this is another of the C's. John could also do with speech therapy to help his speech; this is in the new plan.

John is encouraged to go out of the house; this is good and will mean he gets fresh air and sees his friends and make sure he doesn't get down in his mental health. In the past John has enjoyed being sociable so this is in the care plan because it is important to John and what he wants to do.

Assessor comments

Examples are given with some detail and relevance. These are not fully developed / explained in regard to John's full care needs.

Risks are considered but with some detail. Further ways that John's safety needs could be met are omitted. How might he be protected from unwelcome visitors or 'scams'.

Methods of communicating between those who care for John are not addressed in the plan or commented on in the report. Reflecting on this could have given the learner additional ideas for how the care plan could be improved, reflecting an understanding of the care planning cycle and partnership working would have demonstrated greater knowledge of HSC practice.