Portfolio Document: Care Coordination (Primary Care)

Name:

Practice:

Workplace supervisor/mentor:

Learning Facilitator (LF):

***It is your responsibility to keep your Portfolio Document with you at all times in practice, in order to review your progress with your* workplace supervisor/mentor.**

Welcome to your Portfolio Document (PD)

Purpose of the Portfolio

This Portfolio Document (PD) is designed to support and guide you in building a portfolio of evidence that demonstrates your capabilities as a care coordinator. It serves as an important tool for learning and development in your role.

It is expected that the care coordinator will have completed a PCI-accredited, 2-day care coordination training program, which covers the training content required for the competencies.

The process of completing this portfolio enables the care coordinator to demonstrate the practical application of the training content. This is achieved through critical reflection and action-based learning within their role.

Care coordinator responsibilities.

Restricted Access to Confidential Information: As a care coordinator, you will have access to sensitive information that must be treated with the utmost discretion and care.

Prohibition on Identifying Patients or Service Users: The Personal Development (PD) documentation should never contain information that could lead to the identification of patients, service users, or carers. This prohibition includes names, addresses, specific medical conditions, or any other unique identifiers.

Restrictions on Disclosure and Use of Information: Information about patients, service users, or carers must not be disclosed to any unauthorised person. This restriction applies to verbal discussions, written communications, and electronic data sharing alike.

Prohibition on Removing or Misusing Information: Removing, photocopying, or using confidential information outside the workplace is strictly prohibited. This policy is designed to prevent unauthorised or accidental sharing of sensitive data.

Practice based learning facilitator responsibilities.

This role is an essential enabler within the care coordinators place of work, sharing, guiding, and providing support to build confidence through reflective evidence-based practice. The practice-based facilitator will meet regularly with the care coordinator throughout the 6-month period to review their progress against the competencies and, where necessary support them to access opportunities to demonstrate their capabilities against each competency.

The role should be aware of any disability or needs that require reasonable adjustments and allow for this to ensure the care coordinator achieves the maximum benefit from the learning experience. The role is to help the care coordinator to make progress by providing information, guidance and facilitating opportunities for learning and demonstration of practice.

When the designated practice-based learning facilitator is not available, support must be delegated within the team with appropriate feedback processes in place. All members of the team will contribute to the care coordinator's experience and will provide support during their learning experience, identifying learning opportunities and by providing feedback on the care coordinator's performance.

Key role of the Practice Based Facilitator

1. **Identify learning opportunities:** The role will identify relevant learning opportunities and creating learning and development plans with the care coordinator.
2. **Assessing the care coordinator:** When assessing the competencies, consider sources of evidence that encompass knowledge, skills, attitudes, and the views of those receiving care. Comments should acknowledge those exceptional care coordinators who are exceeding expectations for their stage in practice or who have particularly commendable attitudes, behaviours, knowledge, or skills.
   If the care coordinator is not meeting the required standards this should be highlighted as a development need as soon as possible to ensure that appropriate support is in place and an action plan should be formulated.
3. **Assessment of overall performance**: you are responsible for assessing the achievement of all the required learning outcomes and professional attitudes and behaviours for the care coordinator at the end of year one of the programme. This should be documented in the PD.

Learning and Development Schedule

The provided Learning and Development Schedule serves as a customisable template designed to facilitate the planning and implementation of your learning and development as a care coordinator. This example schedule outlines a structured framework of key themes and milestones intended to enhance skills, knowledge, and competencies over a specified period. You are encouraged to use this sample as a foundational guide, adapting and tailoring it to suit your specific learning objectives, preferences, and needs. By doing so, you can create a personalised roadmap that effectively supports your journey towards achieving your development goals.

See next page for example schedule.

Learning and development Schedule				April	May	Jun
WS 1: Overview						
WS 2: Domain 1 Personalised Care						
WS 3: Domain 2 Communication						
WS 4: Domain 3 Relationships						
WS 5: Domain 4 Reflection and continuous learning						
WS 6: Developing case studies and action plan progress						
WS 7: 2: Domain 1 Personalised Care						
WS 8: Domain 2 Communication						
WS 9: Domain 3 Relationships						
WS 10: Domain 4 Reflection and continuous learning						
WS 11: Developing your case studies and action plan progress						
WS 12: Final meeting						

Practice Based Assessment Document Competencies

As a Care Coordinator, you are expected to maintain high standards of conduct at all times in your workplace and other care settings, embodying the core values and responsibilities essential to your role. This requirement goes beyond just technical skills, highlighting the significance of ethical practices, effective communication, and a compassionate approach towards patients and colleagues.

To meet these standards, you must ensure that all assessment criteria outlined in your portfolio programme are thoroughly completed and successfully achieved by the dates set out by your practice-based learning facilitator. The criteria aim to cover a comprehensive range of competencies. Successfully meeting these criteria demonstrates your ability to perform your duties competently and your commitment to ongoing professional development and excellence in care delivery.

The practice-based assessment document is vital in this process, providing an easy and transparent way to review and/or audit your progress at a glance. Structured to facilitate a clear understanding of your achievements and areas needing further development, this document is an invaluable tool for you and your supervisors.

If you find yourself unable to demonstrate the practical application of a specific competency, you are given the opportunity to engage in critical reflection on this shortfall with your supervisor. Such discussions are crucial as they allow you to critically analyse your performance, understand the underlying issues, and develop strategies for improvement. Documenting these reflections in the assessor signature box highlights your engagement with the learning process and your proactive approach towards addressing and overcoming your limitations.

Assessment Criteria	The following table allows the tracking of Care Coordination Competencies and should be completed by the Practice Based Facilitator, assessing achievement of each competency. This provides an easy and clear overview to review and/or audit progress at a glance.		
Personalised Care: *Personalised care is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs and demands. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcomes. Personalised care is about considering what matters to people, their values, family situations, social circumstances, and lifestyles; seeing the person as an individual and working together to develop appropriate solutions.*	**Evidence** *Practical application of the training content;* *critical reflection/ action-based learning/ further topic specific training/ 9 values worksheet*	**Assessors Signature** *Comments/ rationale*	**Date Achieved**
Comprehend that effective personalised care and support planning requires several discussions.	Case study 1; Write here about how that patient contact demonstrates these skills		
Taking into account, what matters to people as well as their expressed needs			
Emotional support involving family and friends			
Provide coordination that is timely, appropriate, and effective.			

Align Resources with Patient and Population Needs: Within the care setting, assess the needs of patients and populations and allocate health care resources according to those needs. At the population level, this includes developing system-level approaches to meet the needs of particular patient populations. At the patient level, it includes assessing the needs of individual patients to determine whether they might benefit from the system-level approach.			
Care Coordinator treats individuals with dignity, respecting individual's beliefs culture, values and preferences.			
Communication Skills: *"The ability to quickly establish rapport with patients and their family members in an empathetic and sensitive manner. Making sure communication takes place in a way that meets the patients information and decision making needs.*	**Evidence** *Practical application of the training content;* *critical reflection/ action-based learning/ further topic specific training/ 9 values worksheet*	**Assessors Signature** *Comments/ rationale*	**Date Achieved**
Frequent communication: Frequent communication helps to build relationships through the familiarity that grows from repeated interaction.			
Timely communication: Communication can be frequent and still be of poor quality. For one thing, it can lack timeliness. In coordinating highly interdependent work, timing can be critical.			
Accurate communication: The effective coordination of work depends not only on frequent and timely communication, but also on accurate communication.			

Problem solving communication: Task interdependencies often result in problems that require joint problem solving. Hence, effective coordination requires that participants engage in problem solving.			
Interpersonal Communication: *The give-and-take of ideas, preferences, goals, and experiences through personal interactions. Examples include face-to-face interactions, telephone conversations, email, and letters.*			
Information Transfer: The flow of information, such as medical history, medication lists, test results, and other data, from one participant in a patient's care to another.			
Link to Community Resources: Provide information on the availability of and, if necessary, coordinate services with additional resources available in the community that may help support patients' health and wellness or meet their care goals. Community resources are any service or program outside the care system that may support a patient's health and wellness.			
Enabling and signposting to digital health and wellbeing: Provide information on the availability of and, if necessary, coordinate services with additional resources available in the community that may help support patients' health and wellness or meet their care goals. Community resources are any service or program outside the care system that may support a patient's health and wellness.			
Teamwork focused on Coordination: Integration among separate care entities participating in a particular patient's care (whether health care			

professionals, care teams, or other care organisations) into a cohesive and functioning whole capable of addressing patient needs.			
Handling data and information: Accurate and accessible information and data underpins effective care navigation. Failures in communication between organisations, sectors and patients/carers can lead to disjointed and poor care. Individuals who work to provide effective care navigation need to be able to appropriately use relevant electronic records, databases to access, input, store and retrieve information. Data is also important for service evaluation improvement.			
Relationship Skills: *The ability to quickly establish rapport with patients and their family members in an empathetic and sensitive manner. Making sure communication takes place in a way that meets the patients information and decision making needs.*	**Evidence** *Practical application of the training content;* *critical reflection/ action-based learning/ further topic specific training/ 9 values worksheet*	**Assessors Signature** *Comments/ rationale*	**Date Achieved**
Facilitate transitions: Facilitate specific transitions, which occur when information about or accountability for some aspect of a patient's care is transferred between two or more care entities or is maintained over time by one entity. Facilitation may be achieved through activities designed to ensure timely and complete transmission of information or accountability.			

Create a Proactive Plan of Care, a personalised care and support plan : Establish and maintain a plan of care, jointly created and managed by the patient/family and health care team, which outlines the things that matter to the patient, their current and longstanding needs and goals for care and/or identifies coordination gaps. The plan is designed to fill gaps in coordination, establish patient goals that focus on what the patient wants to change or achieve in relation to their needs and, in some cases, set goals for the patient's providers. Ideally, the care plan anticipates routine needs and tracks current progress toward patient goals.			
Monitor, Follow Up, and Respond to Change: Jointly with the patient/family, assess progress toward care and coordination goals outlined in the PCSP. Monitor for successes and failures in care and coordination. Refine the personalised care and support plan as needed to accommodate new information or circumstances and to address any failures. Provide necessary follow up care to patients.			
Support Self- Management Goals: Tailor education and support to align with patients' capacity for and preferences about involvement in their own care. Education and support include information, training, or coaching provided to patients or their informal caregivers to promote patient			

understanding of and ability to carry out self-care tasks, including support for navigating their care transitions, self-efficacy, and behaviour change.			
Building and sustaining professional relationships: Relationships underpin effective inter-boundary working and are skills people in navigation roles need to develop. The ability to engage and sustain key working relationships is fundamental to work with patients, their family and with multidisciplinary team members.			
Establish Accountability or Negotiate Responsibility: Make clear the responsibility of participants in a patient's care for a particular aspect of that care. The accountable entity (whether a health care professional, care team, or social care organisation) will be expected to answer for failures in the aspect(s) of care for which it is accountable. Specify who is primarily responsible for key care and coordination activities, the extent of that responsibility, and when that responsibility will be transferred to other care participants.			
Continuous Learning: The ability to demonstrate reflective practice, based on the best available evidence and to assess and continually improve the services delivered as an individual provider and as a member of an interprofessional team.	**Evidence** *Practical application of the training content;* *critical reflection/ action-based learning/ further topic specific training/ 9 values worksheet*	**Assessors Signature** *Comments/ rationale*	**Date Achieved**
Digital Health IT-enabled Coordination: Using tools, such as electronic medical records, patient portals, or databases, to communicate information about patients and their care between health care			

entities (health care professionals, care teams, or health care organisations) or to maintain information over time.			
Participate in practice-based learning and improvement activities that involve investigation and evaluation of patient experiences, evidence, and resources.			
Identify evidence to inform practice and integrated care.			
Apply new technical and information/knowledge to practical use on the job			
Regularly engage in interdisciplinary training for staff.			
Regularly engage in continuing professional development.			
Implement and routinely monitor patient safety standards.			
Professionalism: These are rooted in the ethical, moral and legal aspects of care and support, grounded in the principles of patient-centred care. Commitment to develop expertise, self-awareness, limitations of scope of practice and working with integrity are some important features			

Essential Resources toolkit

Welcome to your resources toolkit, crafted to support your continued learning as a care coordinator. Within this set, you'll find a variety of resources tailored to help you map out your path, demonstrate your competencies, and reflect on your professional growth. These tools are designed to be versatile, catering to the diverse aspects of your role—from planning and goal setting to documenting interactions and fostering collaborations.

Each document and tool in this collection serves as a stepping stone toward showcasing your abilities and achievements. Whether you're reflecting on your experiences, charting your progress, or planning future developments, these resources are here to guide you. They provide a structured approach to capturing the essence of your role, the challenges you face, the solutions you devise, and the outcomes you achieve.

You're encouraged to engage with these tools actively, using them to highlight your expertise in care coordination, your commitment to professional development, and your dedication to improving patient care. By integrating these resources into your daily practice, you'll not only enhance your own skills but also contribute to the broader goals of your team and the care community at large.

Remember, these tools are just the beginning. They're meant to be adapted and expanded upon, allowing you to personalise your development journey. As you grow in your role, you may find new ways to document your progress, reflect on your experiences, and showcase your competencies. This toolkit is designed to evolve with you, supporting you every step of the way as you advance in your career as a care coordinator.

Key Values of Person-Centred Care Worksheet

Personalised care simply means that patients have more control and choice when it comes to the way their care is planned and delivered, considering individual needs, preferences, and circumstances. Use this worksheet to reflect on the 9 key values;

1 . What does the value mean?

2. How you would you put the value into practice in your role?

Person Centred Value	What is it?	Why is it important to care coordination
Individuality		
Rights		

Choice		
Privacy		

Independence		
Dignity		
Respect		

Partnership		

Study 1	Overview of coordination needs	Coordination that has taken place	Outcomes, reflections, and learning

Study 2	Overview of coordination needs	Coordination that has taken place	Outcomes, reflections, and learning

Study 3	Overview of coordination needs	Coordination that has taken place	Outcomes, reflections and learning

Action Plan

Tasks set during workshop sessions and 1:1 practice-based facilitator reviews to enable competency sign off. For example;

Area of Focus	Actions to be taken	Help to get there	Success measurement	Date to be complete/reviewed

PD: Initial Discussion with Practice Based Supervisor

Learning and development needs	
Learning opportunities to support achievement of competencies	
Care Coordinator and supervisor to negotiate and agree a learning plan	
Care Coordinator signature:	**Date:**

Practice based facilitator signature:	**Date:**
Additional Signature (if applicable):	**Date:**

PD: Final Review

Care Coordinator self-assessment/reflection on progress Reflect on your overall progression over 6 months, referring to your individual strengths, professional values and behaviours and any future learning and development requirements/ aspirations.
Supervisor comments Discuss with the care coordinator their self-assessment and comment on their progress using the assessment descriptors below, detailing evidence used to come to your decision

Checklist for assessed documents:	**tick**	**Name** **Initial**	**C/C** **Initial**
The Practice based facilitator final interview			
The Practice based facilitator has signed the Practice based criteria achieved by the care coordinator in this area (where applicable)			
The care coordinator and Practice based facilitator have completed all the required interview records and development plans			
Care Coordinators signature:		Date:	
Practice based facilitator signature:		Date:	
Additional signature (if applicable):		Date:	

Record of working with other healthcare professionals/inter professional working and developing local relationships

Record reflections on your learning with other staff

Date	Who and why	Reflections on your learning and importance of the relationship
Practice based facilitator comments: Practice based facilitator signature: Date:		

Date	Who and why	Reflections on your learning and importance of the relationship
Practice based facilitator comments: Practice based facilitator signature: Date:		

Ongoing feedback from key people

This can be completed by any individual involved in the care coordinators learning e.g.

Date/time	Your role	Input the care coordinator has had

Ongoing feedback from staff in practice

This can be completed by any individual involved in the care coordinators learning e.g.

Date/time	Your role	Input the care coordinator has had

Patient/Service users Feedback Form

Obtain consent from patients/service users/family who should feel able to decline to participate

We would like to hear your views about the way the care coordinator has helped you

- Your feedback will help the care coordinator's learning
- The feedback will not affect the quality of your care

Tick if you are: The patient/service user ☐ Carer/relative ☐					
How happy were you with the way the care coordinator:	Very happy 	Happy 	I am unsure 	Unhappy 	Very unhappy 
Understood your individual needs?					
Explained the importance of choice?					
talked to you?					
showed you respect?					
understood the way you felt?					
What did the care coordinator do well?					
What could the care coordinator have done differently?					

Practice based facilitator signature: date: Care Coordinator's signature: date:

Acknowledgments:

We acknowledge the support and collaboration of the Personalised Care Centre at Birmingham City University in the development of this toolkit. The Centre, recognised for its contributions to care research and development, has played a key role in the creation of these resources. Their commitment to enhancing personalised care within the health and social care sectors has been essential.

We thank Tom Lawrence and his team, the creators behind this toolkit. Their expertise and contributions have been essential in shaping these resources. For more insight into their work, please visit the Personalised Care Centre website at https://www.bcu.ac.uk/health-sciences/research/centre-for-social-care-health-and-related-research/research-clusters/personalised-care-centre.