

# Assessment Record



**Student** 118966 - Jaspreet Kaur  
**Intake** 2021 VIC CA C4AS MASTER - VIC 2021\_Certificate IV in Ageing Support  
**Assessment** CHCCCS006 - 2; Assessment Workbook - Facilitate Individual Service Planning and Delivery  
**Revision** 2  
**Attempt #** 3

**Status** Submitted

**Assessed By**

Information

## GENERAL INFORMATION ABOUT THIS ASSESSMENT WORKBOOK

Please review the attached Document

 [1\\_-Information-Regarding-this-Assessment-Tool-V1\\_0-Mar20.pdf](#)

## INSTRUCTIONS TO STUDENTS – HOW TO USE THIS TOOL

Please review the attached Document

 [2\\_-Instructions-to-Students-\\_-How-to-use-this-Tool-V1\\_0-Mar20.pdf](#)

## STUDENTS PLEASE NOTE:

- Your suitability for this program has been determined at your Pre Training Review and again at Enrolment. If at any point you feel that this program is not suitable you are able to withdraw at any time. If this is the case please notify your trainer.
- A zero tolerance to cheating and plagiarism is taken with InterCare Training.
- If you the student are found to have cheated on any forms of assessment, including plagiarism of another's work, you will be required to re-sit an alternative assessment under the supervision of an assessor to confirm competence in this unit.
- You must satisfy the requirements for competency within this Assessment Workbook to achieve a competency outcome.

**It is highly recommend that you keep a copy of all assessment work that you submit.**

**Evidence provided by you is retained for our records and not returned to you.**

## INDIVIDUAL ASSESSMENT MODES

The attached documentation provides information relating to the assessment.

Please review the attached Document

 [3\\_-Individual-Assessment-Modes-V1\\_0-Mar20.pdf](#)

## LEARNING GUIDES

Primary resource, Please review the attached document

 [CHCCCS006-Facilitate-individual-service-planning-\\_-Resource-\\_-IC.pdf](#)

## POWERPOINT PRESENTATION

 [CHCCCS006-Facilitate-individual-service-planning-and-delivery-\\_-PowerPoint-Presentation.pdf](#)

## STUDENT ASSESSMENT DECLARATION

- ☒ I have undertaken sufficient activities within this unit of competency and I am ready to attempt the assessment required to demonstrate competency.
- ☒ I understand the assessment framework and requirements that will be used by an Assessor to make a formal judgement of my competency
- ☒ The work that I have submitted in this Assessment Workbook is my own.
- ☒ I understand that it is my responsibility to make a copy of my Assessment Workbook and any additional assessment evidence for my own records prior to submitting to my Assessor for marking.
- ☒ I understand the re-assessment process that will be followed if I am unsuccessful in gaining a satisfactory result in the required Assessment Modes.

### Student Declaration

Please tick the box below to confirm all of the information above

- ☒ I confirm all of the above

### Student Signature

If able please sign below:



## ASSESSMENT MODE ONE

### Assessment Mode Instructions:

Carefully read the assessment task requirements detailed below and complete as instructed. Completed Project and the required work sample evidence will need to be attached in the required section of this assessment.

Please ask your Assessor to clarify if needed.

The following Assessment tasks are individual assessment and **no group work is permitted**.

Assessment extensions can **only** be authorised by your Trainer.

Upon completion of this Assessment Mode's requirements, the Assessor must complete and sign the Assessment Mode Record of Result.

Student is also required to sign to confirmation feedback and understanding of Assessment outcome.

### Assessment Task 1:

1.

To facilitate individual service to clients, explain the roles of the following:

***The suggested response for this question is approximately 30 - 50 words or 3 – 5 detailed bullet points per answer***

a)

Assessor

Interviewing or making formal times to talk with the person you are supporting, is a good place to start when assessing needs. The first step in interviewing someone is to establish a relationship with them. The worker has to take the lead in making sure that the relationship is established successfully. Once you have spent time to getting know your client and informing them of your role and the goal of assessment, you can begin to ask a range of questions that will help you and your client get the information you both need to help you assess needs.

### Assessors Comments (\* if applicable)

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None	✓ Satisfactory	✗ Not Satisfactory
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b)

Carers and other support workers

Providing emotional support by talking to clients about their needs and listening to their concerns. Assisting with domestic tasks including shopping, cooking, cleaning, and washing. Tending to the healthcare needs of each client. Helping clients to apply for jobs, disability grants, and housing loans.

### Assessors Comments (\* if applicable)

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None	✓ Satisfactory	✗ Not Satisfactory
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c)

Health professionals

Health professionals play a central and critical role in improving access and quality health care for the population. They provide essential services that promote health, prevent diseases and deliver health care services to individuals, families and communities based on the primary health care approach.

### Assessors Comments (\* if applicable)

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None	✓ Satisfactory	✗ Not Satisfactory
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d)

Other service providers

Taxi services, Life guards and delivery services.

### Assessors Comments (\* if applicable)

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None	✓ Satisfactory	✗ Not Satisfactory
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2.

Briefly outline anatomical and physiological changes that may occur with ageing disabled clients

**The suggested response for this question is approximately 50 – 100 words or 5 - 10 detailed bullet points**

1. People lose bone mass or density as they age, especially women after menopause. The bones lose calcium and other minerals.
2. The spine is made up of bones called vertebrae. Between each bone is a gel-like cushion (called a disk). With ageing, the middle of the body (trunk) becomes shorter as the disks gradually lose fluid and become thinner.
3. Vertebrae also lose some of their mineral content, making each bone thinner. The spinal column becomes curved and compressed (packed together). Bone spurs caused by ageing and overall use of the spine may also form on the vertebrae.
4. The foot arches become less pronounced, contributing to a slight loss of height.
5. The long bones of the arms and legs are more brittle because of mineral loss, but they do not change length. This makes the arms and legs look longer when compared with the shortened trunk.
6. The joints become stiffer and less flexible. Fluid in the joints may decrease. The cartilage may begin to rub together and wear away. Minerals may deposit in and around some joints (calcification). This is common around the shoulder.
7. Hip and knee joints may begin to lose cartilage (degenerative changes). The finger joints lose cartilage and the bones thicken slightly. Finger joint changes, most often bony swelling called osteophytes, are more common in women. These changes may be inherited.
8. Lean body mass decreases. This decrease is partly caused by a loss of muscle tissue (atrophy). The speed and amount of muscle changes seem to be caused by genes. Muscle changes often begin in the 20s in men and in the 40s in women.
9. Lipofuscin (an age-related pigment) and fat are deposited in muscle tissue. The muscle fibers shrink. Muscle tissue is replaced more slowly. Lost muscle tissue may be replaced with a tough fibrous tissue. This is most noticeable in the hands, which may look thin and bony.
10. Muscles are less toned and less able to contract because of changes in the muscle tissue and normal aging changes in the nervous system. Muscles may become rigid with age and may lose tone, even with regular exercise.

### Assessors Comments (\* if applicable)

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None	✓ Satisfactory	✗ Not Satisfactory
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3.

Explain the following strengths-based planning processes:

1. assessment process
2. collaborative approach
3. documentation and reporting requirements

**The suggested response for the following is approximately 15 - 40 words or 2 - 3 detailed bullet points per answer**

a).

#### Assessment process

The assessment process is the gathering of all the information you may need in order to develop the personal support requirements of people with a disability. This takes planning and knowing who to contact to help you and what to do with information you gather.

b).

#### Collaborative approach

Planning is a collaborative process. In the field of community services, there is a diverse range of interest parties who have an investment in how your service work and who are operational in determining the service you are able to provide. In developing a case plan, there are likely to be a number of stakeholders who will need to be involved in this collaboration and informed about action and outcomes.

c).

#### Documentation and reporting requirements

1. Information needs to be recorded in an appropriate way for the client.
2. It needs to be in format that can be followed by everyone.
3. It needs to be clear and concise.
4. It needs to be set out in an organised manner.
5. It needs to be focused.
6. Only containing relevant information.

#### Assessors Comments (\* if applicable)

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None

✓ Satisfactory

✗ Not Satisfactory

4.

Provide details of the features and modes of the following:

***The suggested response for the following is approximately 25 - 50 words or 3 - 5 detailed bullet points per answer***

a)

Outline the range of service delivery options:

Services may include transport, domestic and personal care, home maintenance, home modifications, aids and equipment, meals, nursing and allied health care, social support and respite. A person approved for CHSP services will generally only need one or two services to support them to continue living independently.

#### Assessors Comments (\* if applicable)

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None

✓ Satisfactory

✗ Not Satisfactory

b)

Briefly describe the variations for individualised service delivery

You will need to consider the physical and psychological factors that are likely to impact on the service delivery. As a person moves from childhood into adolescence, adulthood and finally older adulthood, many factors change in their lives and this needs to be considered in the planning process. It should also be remembered that some life events like a disability, illness or mental health issue can impact on the person's development.

**Assessors Comments (\* if applicable)**

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None	✓ Satisfactory	✗ Not Satisfactory
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c)

List four (4) resource requirements for service delivery

The goals in an individualised service delivery plan will require resources to achieve. These resources could be friends, family, community groups, health professionals or support workers, who provide general support or can provide specific services. Resources can also be physical resources such as money, time, transport, technology, physical or education. You will need to work with the person to identify the resources required and to find strategies to access these resources as required.

**Assessor's Comment (if applicable):**

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None	✓ Satisfactory	✗ Not Satisfactory
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d)

What is motivational goal setting for the delivery of service?

Goal setting theory is a technique used to raise incentives for employees to complete work quickly and effectively. Goal setting leads to better performance by increasing motivation and efforts, but also through increasing and improving the feedback quality.

**Assessor's Comment (if applicable):**

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None	✓ Satisfactory	✗ Not Satisfactory
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e)

What is required for service delivery when collaborating with other service providers to address diverse and multi-faceted needs?

People accessing an organisation will come from a variety of backgrounds and will accordingly have diverse needs. These needs may relate to their personalities, their cultural backgrounds, their life experiences and the skills or level of support they have within their families and the community. For example, two people with the same mental health diagnosis may access the same organisation. One person may require support to access accommodation and health care. The other person may require support to return to education or employment. Individual needs are rarely simple, and often have many different aspects or sides to them. These diverse and multifaceted needs may require you to collaborate with other service providers to ensure the person's needs are met.

**Assessor's Comment (if applicable):**

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None	✓ Satisfactory	✗ Not Satisfactory
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f)

What is involved when transitioning to other services?

Transition planning involves working out the skills and resources that a client need to move out of the homelessness system and the steps they need to take along the way. Communication is required when handing over or transitioning care from one service provider to another. Information is involved when transitioning to other service and client information can be shared with the consent only.

**Assessor's Comment (if applicable):**

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None

✓ Satisfactory

✗ Not Satisfactory

g)

What is involved when exiting a service?

A person exits your service if they no longer want or need home care, pass away or change providers. You must work out and pay their unspent home care amount. If you charge an exit amount to help cover the cost of administration, you must follow the rules on how much you can deduct.

**Assessor's Comment (if applicable):**

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None

✓ Satisfactory

✗ Not Satisfactory

5.

Explain the legal and ethical considerations related to the planning and service delivery and how these are applied in an organisation and individual practice including:

***The suggested response for the following is approximately 15 - 40 words or 2 - 3 detailed bullet points per answer***

a)

Duty of care

This refers to the obligation to take responsible care to avoid injury to a person whom, it can be reasonably foreseen, might be injured by an act or omission. A duty of care exists when someone's actions could reasonably be expected to affect other people.

None

✓ Satisfactory

✗ Not Satisfactory

b)

Privacy, confidentiality and disclosure

Providing individuals with access to their information held by the Service; Disclosing personal information to 3rd parties only with the written consent of the individual; Securely storing Service Users personal information.

None

✓ Satisfactory

✗ Not Satisfactory

c)

Safety and security

Creating safe and secure environments for the elderly is as important as securing our school and hospitals. Security issues for residents in an aged care home revolve mostly on the hiring and management of trustworthy staff but also in managing abrupt violence from the residents themselves.

None

✓ Satisfactory

✗ Not Satisfactory

**Assessors Comments (\* if applicable)**

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6.

What are risk management considerations and ways of minimising risk relating to the following:

***The suggested response for the following is approximately 15 - 40 words or 2 - 3 detailed bullet points per answer***

a)

Environmental

Environmental risk is the probability and consequence of an unwanted accident. Because of deficiencies in waste management, waste transport, and waste treatment and disposal, several pollutants are released into the environment, which cause serious threats to human health along their way. It can be managed by following the steps as - Better identify, assess and control risks that could impact air, land, water and groundwater, as well as harm caused by noise. Prevent harm to human health and the environment. Comply with your environmental duties and obligations. Meet community expectations.

None

✓ Satisfactory

✗ Not Satisfactory

b)

Physical

This is known as risk management and involves the four key steps: Identify hazards—find out what could cause harm. Assess the risks – understand how serious the harm could be and the likelihood of it happening. Actively seek information, guidance or training on working safely. Use any equipment or tools provided to reduce exposure to body stressing hazard. Take regular breaks – stand up, sit less and move more.

None

✓ Satisfactory

✗ Not Satisfactory

c)

Physiological

Psycho social risk factors are things that may affect workers' psychological response to their work and workplace conditions (including working relationships with supervisors and colleagues). Examples are: high workloads, tight deadlines, lack of control of the work and working methods. It can be managed by following the steps - Identify the hazards that could inflict psychological harm. Assess the risks of the hazards to prioritise. Control the risks. Monitor and review your control measures.

None

✓ Satisfactory

✗ Not Satisfactory

**Assessors Comments (\* if applicable)**

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7.

Explain your understanding of the Continuous Improvement process.

***The suggested response is approximately 15 - 40 words or 2 - 3 detailed bullet points***

The term Continuous improvement describes the ongoing effort of an organisation to improve services, systems, processes or products to maximise benefits for clients. The process of continuous improvement relies on evidence based information to support the organisation's success in achieving its goals and outcomes. This also means adapting to changing needs of the community or people using services.



### Assessors Comments (\* if applicable)

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None	✓ Satisfactory	✗ Not Satisfactory
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### Assessment Task 2:

#### Client's personal support requirements

1.

How and when is information collected about clients?

**The suggested response for the following is approximately 15 - 40 words or 2 - 3 detailed bullet points**

Personal information may be collected when you, or someone on your behalf, contact the Department via the My Aged Care Website, Contact Centre or other government agencies to access or request information on services. It can be through email, fax, letter or complete an online or paper form.

### Assessors Comments (\* if applicable)

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None	✓ Satisfactory	✗ Not Satisfactory
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2.

What types of information is collected?

**The suggested response for the following is approximately 15 - 40 words or 2 - 3 detailed bullet points**

1. Name and date of birth.
2. Contact details (including address, phone number(s), email).
3. Health information (which will include care needs, records of care assessments, clinical records about care or treatment, medical history, test results).
4. Anyone client have chosen, or who has been appointed to act on their behalf, including friends or relatives, next of kin, persons appointed as power of attorney or guardian.
5. Pension or DVA details.
6. Personal preferences (for example, in relation to activities or events).

### Assessors Comments (\* if applicable)

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None	✓ Satisfactory	✗ Not Satisfactory
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3.

What steps are used to assess a client upon entry to a service provider?

**The suggested response for the following is approximately 15 - 40 words or 2 - 3 detailed bullet points**

1. Interviews with the client/caregiver
2. Daily observation of activities
3. Consultation with co-workers from different shifts
4. Social and Cultural Profile

**Assessors Comments (\* if applicable)**

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None	✓ Satisfactory	✗ Not Satisfactory
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4.

How are a client's personal preferences catered for?

***The suggested response for the following is approximately 15 - 40 words or 2 - 3 detailed bullet points***

Support should be provided according to the individualised plan, which should in turn reflect the client's preferences and strengths. The provision of support should also be carried out in accordance with organisational policies, protocols and procedures, and within the constraints of your job role.

**Assessors Comments (\* if applicable)**

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None	✓ Satisfactory	✗ Not Satisfactory
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5.

What types of aids, professional services and technical procedures may be included on a client's plan? List 6.

***The required response for the following is six (6) examples***

Aids and equipment such as wheelchairs, walking frames, ramps, shower chairs, splints, braces and home oxygen services can help you live at home and participate in the community. What might be documented in an Individualised plan? Individual plans contain client goals, with time frames and clear strategies for achieving them. Goals must be client focused and based on what the client would like to achieve within the duration of the plan.

**Assessors Comments (\* if applicable)**

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None	✓ Satisfactory	✗ Not Satisfactory
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Assessment Task 3:

**Maintaining existing client skills and or increasing client skill levels**



1.

Research, list and describe five (5) different sources of information from your local community that might assist a client with personal care support.

***The required response for the following is five (5) support services and descriptions, approximately 15 - 40 words each***

**Example 1.**

Respite care - Respite care is designed to give carers a break for a limited period of time. Someone else provides care so the carer can go on holiday, attend to everyday activities or just relax. Respite care can last from a few hours to a few weeks.

**Example 2.**

Carer assistance - A Care Assistant, or Professional Carer, is responsible for up keeping their clients' hygiene, ensuring their safety and facilitating social-emotional support. Their duties include administering medications, cleaning a client's living area and managing activity or care schedules.

**Example 3.**

Dementia support programs - he NDSP aims to: help people living with dementia and their carers and families understand more about dementia. connect people living with dementia, their families and carers with services that support them to self-manage and live well with dementia for as long as possible.

**Example 4:**

Transport assistance - Community transport is a service for eligible seniors, pensioners, those with accessibility needs or those who have limited access to public transport. If you need transport to medical appointments or someone to help you with errands, you may be eligible for community transport services.

**Example 5.**

Home help - The support of healthcare professionals that covers services such as assisting with personal hygiene and care, dressing and undressing, mobility and transportation, rehabilitation regimes, and more.

**Assessors Comments (\* if applicable)**

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None

✓ Satisfactory

✗ Not Satisfactory

Assessment Task 4:

## Planning and service delivery

Mr David Smyth is a 75 year old male who was formerly working as a Design Engineer and enjoyed living independently in a residential care facility with some support. David wears glasses and uses a magnifying glass when working on his model trains. David needs hearing aids and tends to only use them when he has to go out, which can be difficult for people working with him. David is not religious.

Things changed for David 9 months ago when he was diagnosed with type one diabetes and became insulin dependent. David is finding it difficult to accept the changes that came with his diagnosis. He also developed gangrene in both of his legs due to poor circulation and pressure sores. As a result, David had both of his legs amputated below the knee 3 months ago.

David, with the encouragement, support and help from the PT and OT twice weekly, has been working very hard to walk with prosthetic legs. He is almost competent in walking on both of his prosthetic legs. The PT continues to encourage David to use a wheel chair for long distances.

David refuses to use the wheel chair preferring to walk with two walking sticks as his aim is to walk independently (without walking sticks).

David needs full assistance with transfers from his bed to a shower chair. He also requires assistance with all aspects of personal care.

David has a supportive extended family who visit twice a week. He has been observed to be depressed which may be linked to his loss of appetite; this can make him quite irritable as well. David's GP has been notified of this and will be seeing him on his next visit. Prior to the amputation David played lawn bowls twice a week and he has been missing being with his friends.

**Use the following blank Care Plan complete all sections that are required/relevant to David's circumstances to provide support. If something in the Care Plan is not relevant please write N/A. You may complete either a PDF or Word.doc version of the Care Plan, you only need to complete one version.**

 CHCCCS006-Care-Plan-\_-EDITABLE-PDF.pdf

1.

Attach your completed version of the Care Plan

 CHCCCS006\_Care\_Plan\_\_\_EDITABLE\_PDF.pdf

07/07/2022 09:33

None

✓ Satisfactory

✗ Not Satisfactory

2.

List three (3) situations / activities you feel this client, Mr David Smythe, may be limited to participate in.

**The required response for this question is three (3) detailed situations**

1. He cannot walk due to his legs problem which is limiting his ability to walk.

2. He is not able to shower independently.

3. He played lawn bowls twice a week and he has been missing being with his friends due to his health concerns.

**Assessors Comments (\* if applicable)**

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None

✓ Satisfactory

✗ Not Satisfactory

3.

What could be done to assist this client?

***The suggested response for this question is approximately 20 - 50 words or 2 – 4 detailed bullet points***

1. He needs encouragement to believe more in himself to deal with the current situation.
2. We needs to make him feel that he can still do his some things independently and enjoy the life with the help of aids as well.

**Assessors Comments (\* if applicable)**

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4.

Provide an example of how you would accommodate abilities and preferences when working with this client.

***The suggested response for this question is approximately 20 - 50 words or 2 – 4 detailed bullet points***

1. We need to take care that he wants to live his life independently so we have to assist him in a way that he not feels that he is completely dependent on someone.
2. We have to make sure that he gets his personal care assistance properly to maintain hygiene and improve his health and well-being.

**Assessors Comments (\* if applicable)**

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5.

How would you respond to and/or provide the following information to your client?

***The suggested response for the following is approximately 20 - 50 words or 2 – 4 detailed bullet points per answer***

a).

There are a range of social activities that are available for clients to participate in.

1. Listen And Clarify Their Desires.
2. Demonstrate Your Expertise.
3. Don't Sell Services, Sell Solutions.
4. Fix Your Value Proposition First.
5. Focus On The Client.
6. Reward Them For Action.
7. Build Trust In Your Answers.

b).

Your client now prefers to shower at 8pm in the evening

We have to respect their choices and do assist them as per their needs and requirements. If client want to shower at 8 PM then we should respect their choice and do follow that because we have no right to force them what they do not want to do.

c).

You have been asked to weigh your client on a daily basis as he has lost weight.

1. Address your clients main issue first, independent of weight.
2. Open the discussion.
3. Decide if your client is ready to maintain healthy weight.
4. Set a weight goal.
5. Prescribe healthy eating and physical activity behaviours.
6. Set realistic daily/weekly goals.
7. Follow up.

None

✓ Satisfactory

✗ Not Satisfactory

**Assessors Comments (\* if applicable)**

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6.

When would you review the Individual Support Plan for this client, who would be involved and why is a review necessary?

**The suggested response for the following is approximately 20 - 50 words or 2 – 4 detailed bullet points per answer**

Doctor, PT and OT, Extended family and supervisor. But before disclosing any information about the client it is necessary to take the consent of the client.

**Assessors Comments (\* if applicable)**

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None

✓ Satisfactory

✗ Not Satisfactory

**Assessment Task 5:**

**Describing necessary processes and use of equipment to a client**



1.

How would you assist a client with the following pieces of equipment and how might you explain how to use them?

**The suggested response for the following is approximately 20 - 50 words or 2 – 4 detailed bullet points per answer**

a) A manual wheelchair

It is primarily for use by an individual with a mobility disability for the main purpose of indoor, or both indoor and outdoor, locomotion. Ask the client to place both feet firmly on the ground, slightly apart and with one foot further back. Ask the client to place both hands on the front of the armrests, then get them to lean forwards with their head and shoulders over their knees to give balance.

**Assessors Comments (\* if applicable)**

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None

✓ Satisfactory

✗ Not Satisfactory

**b)**

A standing lifter

Standing hoists are used to secure patients while transferring them from a seated position to standing. - Also known as stand-up lifters and sit to stand hoists, they provide easy and safe lifting and movement, which benefits both the patient and their carer. Move client with stand lifter. when client is in standing position, move hoist as required. client as needed. lifter to slowly push to new location, move with direction of hoist, do not twist.

**Assessors Comments (\* if applicable)**

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None	✓ Satisfactory	✗ Not Satisfactory
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**c)**

Hip protectors/savers

Hip protectors minimise the risk of a hip fracture by softening the impact of a fall when landing. Hip protectors are recommended for people who are frail, at high risk of falls or suffer from osteoporosis, and are often implemented in aged care as part of a falls prevention strategy. When wearing the hip protector, the padding must always stay in place over your hip bone. To find the right size for you, measure the widest part of your hips.

**Assessors Comments (\* if applicable)**

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None	✓ Satisfactory	✗ Not Satisfactory
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**d)**

Toileting and continence aids

Toileting suggestions for carers of people with incontinence - Consider aids such as a raised toilet or a wall-mounted grab bar if the person is unsteady on their feet. Remove floor mats and make sure the seat is securely fastened to the toilet. Don't rush the person while they are on the toilet. Provide education about bladder and bowel function. Discourage the use of known bladder irritants. Provide education on continence products if required and: check and assist the older person to change their disposable pads after each episode of incontinence if necessary.

**Assessors Comments (\* if applicable)**

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None	✓ Satisfactory	✗ Not Satisfactory
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**e)**

Modified cutlery/drinking aids

Adaptive eating equipment has been specifically designed to help people who experience these difficulties to continue to feed themselves, enhancing independence and self-esteem. Adaptive drinking devices include covered cups with straws, cups that screw down and are held firmly in place on the table or wheelchair lap-table, or other innovative designs that help individuals to drink independently.

**Assessors Comments (\* if applicable)**

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None	✓ Satisfactory	✗ Not Satisfactory
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Assessment Task 6:

**Clarifying difficulties in meeting client's needs and addressing organisational protocols**

1.

As client's age they will also express changes in their health and personal support requirements. State what potential changes might occur with the following:

a) A decrease in cognitive functioning:

***The suggested response for the following is approximately 20 - 50 words or 2 – 4 detailed bullet points per answer***

1. Slower inductive reasoning / slower problem solving.
2. Diminished spatial orientation.
3. Declines in perceptual speed.
4. Decreased numeric ability.
5. Losses in verbal memory.
6. Few changes in verbal ability.

**Assessors Comments (\* if applicable)**

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None	✓ Satisfactory	✗ Not Satisfactory
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b)

Client shows social isolation

Social isolation increases the risk of mental health issues like depression, anxiety and substance abuse, as well as chronic conditions like high blood pressure, heart disease and diabetes. It also raises the risk of dementia in older adults.

**Assessors Comments (\* if applicable)**

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None	✓ Satisfactory	✗ Not Satisfactory
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c)

Changes in a client's personal environmental set up

The environmental factors that accelerate ageing are those that influence either damage of cellular macro- molecules, or interfere with their repair. Prominent among these are chronic inflammation, chronic infection, some metallic chemicals, ultraviolet light, and others that heighten oxidative stress. Environmental barriers for outdoor mobility subjectively reported by older adults include, for example, poor transportation, discontinuous or uneven side-walks, curbs, noise, heavy traffic, inadequate lighting, lack of resting places, sloping terrain, long distances to services and weather conditions.

**Assessors Comments (\* if applicable)**

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None	✓ Satisfactory	✗ Not Satisfactory
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d)

Dramatic change in physical and general health

As we age, our bones shrink in size and density. Some people actually become shorter! Others are more prone to fractures because of bone loss. Muscles, tendons, and joints may lose strength and flexibility. Exercise is a great way to slow or prevent the problems with bones, muscles and joints.

**Assessors Comments (\* if applicable)**

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None	✓ Satisfactory	✗ Not Satisfactory
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e)

How would you record and report these changes?

All these changes can be recorded by observing the clients on a daily basis, it can be documented in a progress plan and care plan notes. All these changes can be reported to the supervisor by taking the consent of the client.

**Assessors Comments (\* if applicable)**

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None	✓ Satisfactory	✗ Not Satisfactory
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Assessment Task 7:

A new client has been admitted to your Community Residential Unit; the following is the only information that you have been given as the facility is waiting on paperwork.

John is an 83 year old client. He is simply frail, slightly confused and has chronic cardiac fatigue. He uses a 4WF to ambulate and has a normal diet. He needs support with his ADL's.

1.

Briefly outline the steps required in order to obtain and develop an Individual Support Plan for John.

***The suggested response is approximately 30 - 50 words or 3 – 5 detailed bullet points***

1. Purpose Statement. Every client will have an overall reason for being on the program; this may be a long or short term purpose.
2. Strategies to meet the client's needs.
3. Services to be provided.
4. Goals.
5. Identifying responsibility.
6. Time and duration of service.
7. Reassessment.

**Assessors Comments (\* if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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Assessment Task 8:



1.

What actions could you take to ensure client confidentiality and privacy when performing technical procedures (e.g. Client transfers)?

**The suggested response is approximately 30 - 50 words or 3 – 5 detailed bullet points**

1. Create thorough policies and confidentiality agreements.
2. Provide regular training.
3. Make sure all information is stored on secure systems.
4. No mobile phones.
5. Think about printing.

**Assessors Comments (\* if applicable)**

-

None

✓ Satisfactory

✗ Not Satisfactory

2.

Write about three (3) situations that illustrate how a person's right to privacy has been denied:

**The required response for the following is three (3) situations approximately 20 - 50 words each**

An organisation can refuse to give you access to your personal information if they have a valid reason. Examples of a valid reason include: the organisation believes that giving you access may endanger the life, health or safety of any individual, or endanger public health or safety.

**Assessors Comments (\* if applicable)**

-

None

✓ Satisfactory

✗ Not Satisfactory

3.

Outline how an organisation could comply with effective storage of documentation and client's personal records.

**The suggested response is approximately 30 - 50 words or 3 – 5 detailed bullet points**

1. Create a client contact sheet.
2. Create a physical file.
3. Create a digital folder.
4. Add information to electronic contact database.
5. Add information to billing/financial software.

**Assessors Comments (\* if applicable)**

-

None

✓ Satisfactory

✗ Not Satisfactory

4.

How often should a client's records be updated and why?

**The suggested response is approximately 20 - 50 words**

It needs to be done whenever we see any changes in client. They maintain a reliable history of important information relating to your clients' health, treatments and relevant events, rather than relying on memory. Well maintained records will help your therapist insurance to give you the best possible defence if someone should make a complaint or a claim against you.

**Assessors Comments (\* if applicable)**

-

None

✓ Satisfactory

✗ Not Satisfactory

Assessment Task 9

**Risk Assessment**

1.

Use the attached form to briefly describe situations relevant to the areas that may impact on your safety and the safety of a client.

**The suggested response is approximately 3 – 5 detailed bullet points per area. you may complete either a PDF or a Word.doc version of the form, you only need to complete one (1) version.**



CHCCCS006-RISK-ASSESSMENT-\_-EDITABLE-PDF.pdf

Attach your completed version of the risk assessment form here



CHCCCS006\_RISK\_ASSESSMENT\_\_EDITABLE\_PDF.pdf

07/07/2022 09:32

**Assessor comments (\*if applicable)**

-

None

✓ Satisfactory

✗ Not Satisfactory

2.

Select three (3) hazards from above and describe how they may impact on your safety and that of a client.

**The required response is three (3) hazards and 20 - 50 words or 2 – 5 detailed bullet points per response**

1. If electrical equipment is not working properly then it can give a shock which will lead to a major life risk.
  2. If floor is slippery in the washroom, kitchen, laundry then client can fall down very badly which will cause major injuries especially back injuries.
  3. If cupboards are not reachable to the client then to reach there they use stairs or something which will increase a chances of fall.
- All these risks can impact on carer and client safety both.

07/07/2022 10:22

cloudassess.co  
Record ID: 16607832

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**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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3.

How would you involve other staff members to review strategies to minimise adverse outcomes?

***The suggested response is approximately 20 - 40 words or 2 – 4 detailed bullet points***

Before involving other staff member I will take the consent of the client and if client gives consent then I can discuss about the risk assessment with co-workers so that they can also give their opinions to improve the current situation which will be helpful for the client on a regular basis.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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Assessment Task 10:

**Personal Care Tasks**

1.

Describe your understanding of what personal care is

***The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points***

Personal Care consists of those tasks a person would normally be able to do as part of their normal daily functioning, but are unable due to a particular health issue, illness, disability or frailty. Assistance may be required with: Showering or bathing.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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2.

List what types of assistance some frail older and people with disabilities may need

***The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points***

1. Mobility aids such as walking frames or wheelchairs.
2. Allied health services, including occupational therapists, dietitians and physiotherapists.
3. Short stays in residential aged care homes and other kinds of respite care.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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3.

What general actions would you take when assisting a person to ambulate?

**The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points**

Ensure patient does not feel dizzy or lightheaded and is tolerating the upright position. Instruct the patient to sit on the side of the bed first, prior to ambulation. Ensure proper footwear is on patient, and let patient know how far you will be ambulating. Proper footwear is non-slip or slip resistant footwear.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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4.

What general actions would you take when assisting a person with toileting?

**The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points**

1. A bedpan or urinal container.
2. A removable raised toilet seat.
3. Handrails near to the toilet.
4. Bed or chair raisers.
5. A hoist.
6. A commode.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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5.

What general actions would you take when assisting a person with eating and drinking?

**The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points**

By using finger foods such as sandwiches, slices of fruit or vegetables and cheese. giving gentle verbal encouragement, for example, "oh this smells lovely" using gentle physical prompts, for example, place your hand over the person's hand to guide their food or drink to their mouth.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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6.

What general actions would you take when assisting a man with shaving?

**The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points**

Shave the beard on the cheeks and upper lip in the direction that the hair grows. Shave the beard on the neck against the direction of the hair growth. Wash off any remaining shaving cream. With clean water, finish washing the patient's face.

**Assessor comments (\*if applicable)**

PERSON, not patient.

None

✓ Satisfactory

✗ Not Satisfactory

7.

What general actions would you take when assisting a client with cleaning teeth, or dentures, gums and their tongues?

**The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points**

1. use a soft toothbrush.
2. clean your teeth or dentures twice a day.
3. use a fluoride toothpaste.
4. drink water when you are thirsty.
5. sip water if your mouth is dry.
6. eat a healthy diet.
7. avoid sweets and sugary drinks between meals.
8. visit your dentist for a regular check up.

**Assessor comments (\*if applicable)**

-

None

✓ Satisfactory

✗ Not Satisfactory

Assessment Task 11:

**Prepare for planning**

1.

In your own words define the following terms and describe the normal ranges of each:

**The suggested response is approximately 10 - 30 words and 'Normal Ranges' (if applicable) per term**

TERM	DEFINITION	NORMAL RANGES (IF APPLICABLE)
Vital Signs	These are measurements of the body's most basic functions.	Blood pressure: 90/60 mm Hg to 120/80 mm Hg. Breathing: 12 to 18 breaths per minute. Pulse: 60 to 100 beats per minute. Temperature: 97.8°F to 99.1°F (36.5°C to 37.3°C); average 98.6°F (37°C)
Body Temperature	The normal temperature of the human body A person's normal body temperature is 98.6 degrees Fahrenheit or 37 degrees Celsius.	The average body temperature is 98.6 F (37 C). But normal body temperature can range between 97 F (36.1 C) and 99 F (37.2 C) or more
Heart Rate	The number of times the heart beats within a certain time period, usually a minute.	A normal resting heart rate for adults ranges from 60 to 100 beats per minute
Respiratory Rate	The respiration rate is the number of breaths a person takes per minute.	Normal respiration rates for an adult person at rest range from 12 to 16 breaths per minute.
	cloudassess.co Record ID: 16607832	Normal blood pressure for most adults is

Blood Pressure	The force of circulating blood on the walls of the arteries	defined as a systolic pressure of less than 120 and a diastolic pressure of less than 80.
Blood Glucose Levels	A blood glucose test is a blood test that screens for diabetes by measuring the level of glucose (sugar) in a person's blood.	The expected values for normal fasting blood glucose concentration are between 70 mg/dL (3.9 mmol/L) and 100 mg/dL (5.6 mmol/L).
Specimen Sample	A specimen is a sample of something, like a specimen of blood or body tissue that is taken for medical testing.	normal: 77-99mg/dL"
Oxygen Therapy	Treatment in which a storage tank of oxygen or a machine called a compressor is used to give oxygen to people with breathing problems.	Normal blood oxygen levels are 95 percent and above
Tube Feeding	It is a special liquid food mixture containing protein, carbohydrates (sugar), fats, vitamins and minerals, given through a tube into the stomach or small intestine.	Feeding usually begins at a concentration of $\leq 0.5$ kcal/mL and a rate of 25 mL/hour.
Wound Care	Wound care involves every stage of wound management. This includes diagnosing wound type, considering factors that affect wound healing, and the proper treatments for wound management.	Not applicable
Urinalysis	A urinalysis is a test of your urine. It's used to detect and manage a wide range of disorders, such as urinary tract infections, kidney disease and diabetes.	A range of 5.0-8.0 is considered normal (Higgins, 2007).
Catheter Care	This catheter drains urine from your bladder into a bag outside your body.	The average catheter size used by adult men is between 14FR to 16FR.

#### Assessor comments (\*if applicable)

-

None
☒ Satisfactory
☐ Not Satisfactory

## 2.

Why are a client's vital signs measured?

**The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points**

Vital signs are used to measure the body's basic functions. These measurements are taken to help assess the general physical health of a person, give clues to possible diseases and show progress toward recovery. The normal ranges for a person's vital signs vary with age, weight, gender and overall health.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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3.

When would you measure a client's vital signs?

**The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points**

After a fall or unwitnessed fall, If client is unwell and If client is unconscious/ not responsive then we will measure a client's vital signs. Notify treating medical provider immediately if any change in observations.

**Assessor comments (\*if applicable)**

In ageing support, we don't have 'appointments' - this task is asking you when YOU would measure someone's vital signs eg after they have fallen over. when else?

None	✓ Satisfactory	✗ Not Satisfactory
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4.

What would you do if you noticed a radical change in a client's vital signs?

**The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points**

When an abnormal vital is measured, repeat the measurement and ensure that it has been measured correctly using the appropriate equipment for the person. A person's medication list as well as history of recent over the counter medication use can help account for certain abnormal vitals or unmask hidden abnormalities. To ensure the correctness of the measurement and to check any changes after the previous measurement we need to observe the client and do the measurements again to see if measurement are done correctly. It should be reported to the Registered Nurse on duty immediately if signs are still out of range or Notify treating medical provider immediately if any change in observations.

**Assessor comments (\*if applicable)**

PERSON not patient. If the vital signs are still very out of range, what do you do and who do you report to??

None	✓ Satisfactory	✗ Not Satisfactory
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5.

Why measure a client's BGL / BSL's?

**The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points**

Nurses and other healthcare professionals routinely perform blood glucose level (BGL) measurement on clients with diabetes and non-diabetic clients to gather baseline data. The BGL reading also assists in determining the effectiveness of interventions implemented to manage unstable BGLs.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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6.

List six (6) factors that may alter a client's BGL / BSL's:

**The required response is six (6) bullet points**

New FOOD Factors such as Carbohydrate Quantity and type, Fat, Protein, Caffeine, Alcohol, Meal Timing, Dehydration.

New MEDICATION FACTORS such as Medication dose, timing and interactions, Steroid Administration, Niacin (Vitamin B3).

New ACTIVITY Factors such as Light exercise, High intensity & moderate exercise, Level of fitness/training, Time of day, Food and Insulin Timing.

New BIOLOGICAL Factors such as Too little sleep, Stress and Illness, Recent hypoglycemia, During-sleep blood sugars, Dawn phenomenon, Infusion set issues, Allergies, Puberty, Celiac disease, Smoking.

New ENVIRONMENTAL Factors such as Expired insulin, Inaccurate BG reading, Outside temperature, Sunburn, Altitude.

New Category: BEHAVIOURAL and DECISION-MAKING Factors such as More frequent BG checks, Default options and choices, Decision making biases, Family and Social pressures.

**Assessor comments (\*if applicable)**

give examples of these biological and behavioural factors, as these parts of your answer are currently too general...

None

✓ Satisfactory

✗ Not Satisfactory

7.

What are specimen samples? Cite two (2) examples.

**The required response is two (2) detailed bullet points**

A specimen is a sample of something, like a specimen of blood or body tissue that is taken for medical testing. Examples are - Blood samples can be collected from blood vessels, Tissue biopsy, Cerebrospinal fluid (CSF), Other body fluids, Bone marrow and Amniotic fluid etc.

**Assessor comments (\*if applicable)**

-

None

✓ Satisfactory

✗ Not Satisfactory

8.

Describe what Naso-gastric and PEG are and what they are used for.

**The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points**

A nasogastric (nay-zo-gas-tric) tube (NGT) is a thin, soft tube that is passed through your child's nostril, down the back of their throat, through the oesophagus (food pipe) and into their stomach. Inserting the tube is usually a short procedure, and the tube will go down easily if your child is relaxed. PEG stands for percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus.

**Assessor comments (\*if applicable)**

-

None

✓ Satisfactory

✗ Not Satisfactory

9.

What is O2 therapy and what is it used for and why?

**The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points**

Oxygen therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from your health care provider. You may get it in the hospital, another medical setting, or at home.

**Assessor comments (\*if applicable)**

-

None

✓ Satisfactory

✗ Not Satisfactory

10.

What is the purpose of a stoma and what is involved to care for it?

**The suggested response is approximately 20 - 50 words or 3 – 5 detailed bullet points**

A stoma is an opening in your abdomen that allows waste to exit your body, rather than going through your digestive system. They're used when part of your bowels or bladder either need to heal or be removed. Wash skin with warm water and dry it well before you attach the pouch. Avoid skin care products that contain alcohol. These can make skin too dry. Do not use products that contain oil on the skin around stoma. Use fewer, special skin care products to make skin problems less likely. Sit on or next to the toilet, Pull your clothes away from the pouch, Hold the bottom of the pouch up, Slowly unroll the tail, or spout, over the toilet, Bend over the toilet to help prevent splashing, Slide your fingers down the pouch to push out all the stool, Stoma guards are most commonly used to protect a stoma from an impact.

**Assessor comments (\*if applicable)**

how do we care for a stoma? what needs to be done to empty it, assess for infection etc..... cleaning the area?

None

✓ Satisfactory

✗ Not Satisfactory

11.

Describe two (2) wounds and the purpose of wound care beyond basic care and dressing it.

**The required response is two (2) wounds and approximately 20 - 50 words per response**

Abrasions - Abrasions aren't usually as serious as laceration or incision wounds. These are cuts that typically affect deeper skin layers. They may cause intense bleeding and require medical care and Incisions is a cut through the skin that is made during surgery. It is also called a surgical wound. Some incisions are small, others are long. The size of the incision depends on the kind of surgery you had. The purpose of wound care is to help you heal faster so you can get back to your life. A chronic wound can detract from your quality of life and prevent you from doing things you enjoy.

**Assessor comments (\*if applicable)**

-

None

✓ Satisfactory

✗ Not Satisfactory

12.

What is a pressure ulcer and what are the underlying cause/s?

**The suggested response is approximately 20 - 50 words and/or 3 – 5 detailed bullet points**

Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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**13.**

What is an amputation? List three (3) types of amputations

***The required response is approximately 20 - 50 words and three (3) examples***

Amputation is the loss or removal of a body part such as a finger, toe, hand, foot, arm or leg. It can be a life changing experience affecting your ability to move, work, interact with others and maintain your independence. Continuing pain, phantom limb phenomena and emotional trauma can complicate recovery. Types of amputations are Arm amputation. Hand amputation. Finger amputation. Foot amputation, removing part of the foot.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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Assessment Task 12:

**1.**

List five (5) types of information you may come into contact with:

***The required response is five (5) examples***

Name and date of birth; Contact details; health information (which will include care needs, records of care assessments, clinical records about care or treatment, medical history, test results); Personal care issues; Bank Details.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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**2.**

List ways information is recorded / documented and stored:

***The required response is approximately 30 - 50 words or 3 – 5 bullet points***

Physical records may be stored on-site at the association's place of business. If there is insufficient and appropriate space, records can be stored off-site by storage companies. It is essential documents are stored in safe, secure and appropriate facilities.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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3.

How can information / client's records be kept secure?

**The required response is approximately 20 - 50 words or 2 – 5 bullet points**

Paper client records must be kept in a cabinet that cannot be accessed by anyone who does not need or require access. The storage system should be protected by a physical security system such as locks, alarms etc.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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4.

How long are client's records kept for?

**The required response is approximately 10 - 30 words**

The record must be kept for at least 7 years from the date the patient was last provided with medical services or treatment.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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5.

How can information be conveyed / communicated to others you are working with and supporting – inclusive of families?

**The required response is approximately 20 - 50 words or 3 – 5 bullet points**

1. Really Listen. Most of us do more talking than listening.
2. Come Alongside The Other Person.
3. Don't Give Unwanted Advice.
4. Check Your Tone And Body Language.
5. Be Real.
6. It's Not About You.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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6.

Who has access to a client's records and confidential information / charts?

**The required response is approximately 20 - 50 words or 2 – 5 bullet points**

Care workers, supervisor, organisation, doctor etc. Information can be shared with the consent of the client always.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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7.

Why is it important to consider the client's perspective when providing their care?

**The required response is approximately 20 - 50 words or 2 – 5 bullet points**

By incorporating the perspectives of both clients and providers into efforts to improve the quality of health care, policymakers and program managers can develop a deeper understanding of the needs and constraints faced by both groups.

**Assessor comments (\*if applicable)**

-

None	✓ Satisfactory	✗ Not Satisfactory
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8.

Who would be consulted to assess the quality and satisfaction of care provided?

**The required response is approximately 20 - 50 words or 2 – 5 bullet points**

Measure aspects of care that go beyond technical quality, e.g. responsiveness, acceptability and trust. Measure perceived quality and compare with clinical quality. Measure quality at different points in the patient pathway through the health system. Measure the immediate and upstream drivers of quality of care. Practices can solicit feedback from patients in a variety of ways: phone surveys, written surveys, focus groups or personal interviews. Most practices will want to use written surveys, which tend to be the most cost-effective and reliable approach, according to Myers.

**Assessor comments (\*if applicable)**

Clients, not 'patients'.

None	✓ Satisfactory	✗ Not Satisfactory
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9.

What actions should be taken to address any issues raised with the quality of care provided?

**The required response is approximately 20 - 50 words or 2 – 5 bullet points**

Listen and Understand. First, always listen to the client, Take note of your activities with senior patients, Empathies, Offer a Solution, Execute the Solution, Follow-Up.

Collect Data and Analyze Patient Outcomes, Set Goals and Commit to Ongoing Evaluation, Improve Access to Care, Focus on Patient Engagement, Connect and Collaborate With Other Organizations.

Always treat patients with courtesy and respect, The practice of extending courtesy and respect shouldn't just stay within the realm of family and friends, Act with confidence, Make sure to practice hygiene and sanitation.

**Assessor comments (\*if applicable)**

specifically, what can be done? eg what solutions can there be so the issue doesn't happen again?

None	✓ Satisfactory	✗ Not Satisfactory
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Assessment Complete

# Well Done!

**You have now completed  
all the Assessment Tasks  
in this workbook.**

**Your Trainer will advise  
you on the next step in  
completing your course.**

Please note that the following pages in this workbook are  
Work Sample Evidence, Reasonable Adjustment,  
Feedback on the Assessments and Overall Mode One  
Assessment Outcome, these are only to  
be completed if required.

**Please click below to save and  
submit this workbook.**

## Work Sample Evidence

### Evidence Upload for Work Sample

Here you are able to upload evidence of your work sample, this can be photographs, video or audio evidence along with any file required.

-

### Work Sample Evidence

Please identify the evidence that you upload in the table below

Attachment Number	Attachment Description	Attached Yes	Attached No
1.	-	<input type="checkbox"/>	<input type="checkbox"/>
2.	-	<input type="checkbox"/>	<input type="checkbox"/>
3.	-	<input type="checkbox"/>	<input type="checkbox"/>
4.	-	<input type="checkbox"/>	<input type="checkbox"/>
5.	-	<input type="checkbox"/>	<input type="checkbox"/>

### Students Comments

-

### Assessors Comments (\* if applicable)

Excellent start to this unit Jaspreet. Please just see all assessor comments and update your five remaining answers, then resubmit.

7/7/ - great answers Jaspreet. Just one task is left on when WE would measure vital signs - think about what would make you check a person's vital signs in your workplace? (how might they look, tell you they feel or what might have happened for you to check their temperature, blood pressure, blood glucose etc...)

### Reasonable Adjustment Information

#### Reasonable Adjustment Information

Reasonable Adjustment details applied to this student

### Confirmation of verbal responses if required

☐ I declare that the student and I have verbally answered, clarified and provided the responses as listed above.

### Verbal Response Upload

A audio recording along with any support evidence if required can be uploaded to the training record here.

-

**What reasonable adjustment was made:**

-

**Why this adjustment was made:**

-


**Assessor Declaration**

☐ I confirm that the reasonable adjusts have been made as listed above.

**Assessor Signature**

If able please sign below:



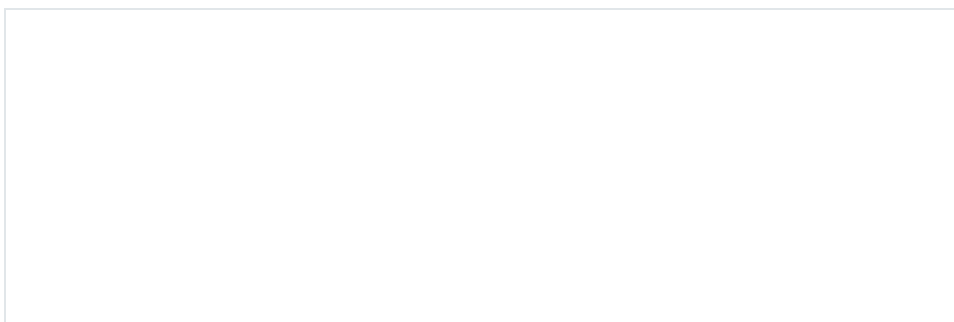


**Student Declaration**

☐ I agree with the reasonable adjustment made as listed above and I was consulted in the adjustments made to suit my individual needs.

**Student Signature**

If able please sign below:



Feedback on the Assessments

**Feedback Form Instructions:**

In an effort to continuously improve our Assessments, please feel free to document any feedback or suggestions you may have.

This feedback will be used by our programs and quality teams for further review and consideration.

**Feedback:**

-



Overall Mode One Assessment Outcome

Assessment Guide

Assessment Guide	
Satisfactory Outcome	The Assessor has reviewed the Assessment Workbook against the requirements of the Assessment Mode and is satisfied that all requirements have been met.
Not Satisfactory Outcome	The Assessor has reviewed the Assessment Workbook against the requirements of the Assessment Mode and is not satisfied that all requirements have been met.

Student Instructions

You are able to SAVE this assessment if required and this will allow you continue to make changes,  
Once complete please SUBMIT this assessment.

Overall Assessment Outcome

None