A Review of Competency Frameworks for Disability Service Staff

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# Introduction

The ongoing reconfiguration of Irish disability services recognises the need for staff to develop new and different competencies so that people with disabilities can live a life of their choosing in the community (HSE 2011, HSE 2012). Competencies that are associated with the institutional residential model of disability care tend to stem from a medical model of care. A new competency framework is required for the social model of care. The social model of disability says that disability is caused by the way society is organised, rather than by a person’s impairment or difference. The social model tries to remove barriers that restrict choices for people with a disability. This can lead to more independence and equality for people with disabilities with choice and control over their own lives.

Existing staff who are moving from institutional settings to the community require a competencies framework that puts the person with the disability at the centre and avoid creating a mini-institution in the community. For staff already working in the community, the disability service reform programme, including New Directions, require competencies around supporting positive risk taking and choice of the person with a disability (HSE, 2012).

The purpose of this report is to review some existing competency frameworks for staff working in disability services in Ireland and elsewhere. It is a companion document to the NDA’s Competencies and Skill Mix Report (2018) that outlines the barriers and opportunities to the development of a different staff skill set and staff competencies for a new model of disability services. That report recommends the development of a disability competency framework for Ireland. This report looks at similarities and differences in competency frameworks and provides a starting point for developing a disability specific competency framework for Ireland, should this recommendation be advanced.

# Competencies

Competencies are skills that workers need to have in order to do their jobs well. A worker is judged competent when they have the ability to do a job properly. Core competencies are limited to those competencies that are commonly needed by workers to do a specific job, for example, to support people with disabilities living at home or in community-based settings (An Bord Altranais, 2005). The purpose of a set of core competencies is to identify the operational skills required to do a job. Some competency frameworks include behavioural and personality traits (such as being flexible and adaptable) although these are often considered to be foundational skills that are job prerequisites and therefore deemed to be too general to be included in occupational specific competency frameworks (The Lewin Group, 2014). However, in the competencies for staff working with people with disabilities, it could be argued that these type of competencies, that determine attitude, are crucial.

A ‘competency framework’ is a standardized structure that sets out and defines clearly each individual competency.[[1]](#footnote-1) These are usually in the form of skills statements that are specific observable actions that can be demonstrated by the worker. Table 1 outlines the difference between competencies and skill statements.

Table 1: Difference between a competency and a skill statement

|  | Definition | Example |
| --- | --- | --- |
| Competency Area | A broad category within a competency frameworks containing related information that describes knowledge skills or abilities for effective work performance | Communication |
| Competency description | A statement describing themes of knowledge, skills or abilities for effective work performance within a discrete competency area | The frontline staff member builds trust and productive relationships with people s/he supports, co-workers and others through respectful and clear verbal and written communication |
| Skill statement | A description of a competency standard that incorporates a highly specific observable action (related to a competency area) that may be demonstrated by the worker. | Communicates with the individual and his or her family in a respectful and culturally appropriate way |

Sources: Adapted from An Bord Altranais, 2005 and The Lewin Group, 2014

# Methods

A desk review of literature on competency frameworks from Ireland and elsewhere was undertaken. Rather than being fully comprehensive, a selection of competency frameworks reflecting frontline worker competencies, competencies required to obtain qualifications or professional registration and management related competencies were included. The competency frameworks for frontline workers are important as the frontline staff have the most day-to-day dealings with the person with a disability and are key to ensuring that they receive person centred support. Competency frameworks for staff to obtain qualifications or professional registration were considered important to identify whether the competencies obtained through training matched those that were important to be a frontline staff member. If there is a mis-match then work would be needed on changing those competency frameworks. The competencies of frontline staff are somewhat dependant on the competencies of their supervisors and organisation management. Therefore, some organisations have developed sector specific management competency frameworks and a selection of these were reviewed. A competency framework will only be successful with a high level of buy in from across an organisation.

Competency frameworks from Ireland, the United Kingdom, Australia, New Zealand and the United States were included. Competency frameworks were also selected to reflect different types of disability including mental health difficulties, intellectual disabilities, behaviours that challenge and physical disabilities.

Terminology differed throughout the competency frameworks reviewed. Some used ‘competency areas’ but others used ‘proficiency standards’, ‘core values’, ‘core capacities’ or ‘competency domains’. While for most of these it was just the use of a different term in place of what was a competency area, the term ‘core values’ differed more substantially. However, a decision was taken to include ‘core values’ as they are similar to competencies and, were those organisations to develop competencies, they would likely be very similar to their core values. In general, competency frameworks should be underpinned by a set of values.

A brief comparative analysis of the competencies frameworks was conducted to examine the similarities and differences between the frameworks and to examine whether the management competencies and competencies for qualification/professional registration were coherent with the frontline staff competencies. The competency frameworks were reviewed as follows:

* 16 competency frameworks were selected for review (10 frontline staff, 3 qualification/registration, 3 management/organisational)
* 162 competency areas were contained in the 16 frameworks (range 4-29 per competency framework)
* Competencies were grouped into 25 broad competency areas
* 20 of these competency areas, that had featured in at least three of the competency frameworks, were included in the analysis
* The frequency of occurrence of each competency area was recorded and compared across the competency frameworks
* The competency areas were aligned with disability outcomes

# Review of competency frameworks

## 4.1 Description of the competency frameworks

In some of the competency frameworks reviewed, significant detail was provided by the authors on the methodology used to develop the competency frameworks (For example, National Direct Service Workforce, 2014). The key methods used were subject matter literature reviews, reviews of existing competency frameworks, and consultation with people using disability services, their families, and staff. Expert reviews using focus groups or Delphi methods were also used. These methods all demonstrate the accepted practice in validation research to draw evidence from multiple research methods (Johnson, et al, 2007). For some of the competency frameworks reviewed however, no detail was provided as to how they were developed.

Sixteen disability related competency frameworks from five countries were reviewed and are summarized in Table 2. The first 10 are competencies that relate to frontline staff, the next three are related to professional registration or qualifications and the final three are related to the supervision or management of frontline staff. Further details on each of these competency frameworks and their associated skills statements are available in Appendix A (the relevant appendix letter and number are included in Table 2).

Table 2: Summary of sixteen disability related competency frameworks

| Target group | Name of Competency Frameworks Reviewed (reference) | Main disability type | Country | Appendix |
| --- | --- | --- | --- | --- |
| **Frontline staff** | Direct Service Workforce Core Competencies (National Direct Service Workforce, 2014) | All disabilities and ageing | US | A1 |
|  | Direct support Professionals Competency Areas (Direct Support Professionals Competency Areas, 2016) | Intellectual and developmental disability | US | A2 |
|  | Intellectual Disability Mental Health Core Competency Framework (Department of Developmental Disability Neuropsychiatry, 2016) | Intellectual disability and mental health | Australia | A3 |
|  | Recovery competencies for Mental Health Workers (O’Hagan M, 2001) | Mental health | New Zealand | A4 |
|  | Core capacities required for community agencies to generate and sustain substantively good individualised outcomes (Kendrick M, 2014) | Disability not specified | US | A5 |
|  | WALK[[2]](#footnote-2) | Disability not specified | Ireland | A6 |
|  | Core values of Cheshire Ireland[[3]](#footnote-3) | Physical disability | Ireland | A7 |
|  | The Daughters of Charity Disability support Services[[4]](#footnote-4) | Intellectual disability | Ireland | A8 |
|  | Generic service intervention pathway[[5]](#footnote-5) | Intellectual disability | UK | A9 |
|  | Positive Behavioural Support Competence Framework [[6]](#footnote-6) | People with challenging behaviour | UK | A10 |
| **Registration/ qualification** | Competencies of frontline staff who support people with a dual diagnosis[[7]](#footnote-7) | Intellectual or developmental disability and mental health | US | A11 |
|  | Standards of Proficiency for Social Care Workers (CORU, 2016) | Includes people with a disability | Ireland | A12 |
|  | QQI Level V course in Intellectual Disability Practice[[8]](#footnote-8) | Intellectual disability | Ireland | A13 |
| **Supervisors/ managers** | National Frontline Supervisor Competencies: (Sedlezky, 2013) | Intellectual and developmental disability | US | A14 |
|  | Management Competency Framework for Health and Social Care Professions[[9]](#footnote-9) | Includes people with a disability | Ireland | A15 |
|  | National Occupational Standards for Leadership and Management in Care Services[[10]](#footnote-10) | Includes people with a disability | UK | A16 |

## 4.2 Analysis of the competency frameworks

There were 162 competency areas included in the 16 competency frameworks. The actual wording of each competency is detailed in Appendix B. Table 3 presents the frequency of each of the 20 competency areas that were obtained from grouping these 162 competencies.[[11]](#footnote-11)

Communication was the most commonly occurring competency area with 69% of all competency frameworks, and 90% of frontline staff competency frameworks including this competency. However, only 33% of the qualification/registration and supervisor/manager frameworks included the communication competency area. Person-Centred Practice, Professionalism and Ethics, and Planning and Organisation were the next most frequently occurring competency areas with 63% of all competency frameworks including these competency areas. Surprisingly, none of the qualification/registration frameworks required a competency in Person-Centred Practice. This is worrying as the sector increasingly moves towards person-centred practice. Unsurprisingly 100% of the qualification/registration frameworks required a competency in Professionalism and Ethics although only 40% of the frontline workers competency frameworks required this. As expected, Staff Management and Leadership were only included in the supervisor/manager competency frameworks.

One would have expected some of the frontline competency areas to occur more frequently. For example only 30% included Respect, Dignity and Privacy which are core tenants of moving towards independent living and leading a fulfilling life. Only 30% of the frontline competency areas included ‘Innovation, Creativity and Problem Solving’. Interestingly, two of these three were from Ireland which perhaps reflects the current major changes in service configuration. Moving disability services to the community will result in many challenges for staff and clients and innovative solutions will have to be developed for some of the logistical issues in addition to the social inclusion issues. Innovation can also include the area of technology which is becoming increasingly important in helping people with disabilities live more independently.

It is very positive that the competency frameworks seem to reflect a more social than medical model of care. ‘Person-Centred Practice’, ‘Community Inclusion and Networking’ and ‘Community Living Skills and Supports’ occur frequently within the competency frameworks whereas ‘Specific Clinical Supports’ appears only four times.

Table 3: Frequency of broad competency areas among 16 competency frameworks

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| No. | **Broad competency area** | **No. (%) of frontline staff competency overlaps**  **(n=10)** | **No. (%) of registration /qualification competency overlaps**  **(n=3)** | **No. (%) of supervisor /manager competency overlaps**  **(n=3)** | **Total**  **(n=16)** |
| 1 | Communication | 9 (90%) | 1 (33%) | 1 (33%) | 11 (69%) |
| 2 | Person-centred practice | 8 (80%) | 0 | 2 (67%) | 10 (63%) |
| 3 | Professionalism and ethics | 4 (40%) | 3 (100%) | 3 (100%) | 10 (63%) |
| 4 | Planning and organization | 7 (70%) | 1 (33%) | 2 (67%) | 10 (63%) |
| 5 | Evaluation, observation and assessment | 6 (60%) | 1 (33%) | 2 (67%) | 9 (56%) |
| 6 | Community inclusion and networking | 6 (60%) | 1 (33%) | 2 (67%) | 9 (56%) |
| 7 | Education, training and self-development | 5 (50%) | 2 (67%) | 2 (67%) | 9 (56%) |
| 8 | Community living skills and supports | 7 (80%) | 1 (25%) | 0 | 8 (50%) |
| 9 | Specific clinical support | 4 (40%) | 2 (67%) | 1(33%) | 7 (44%) |
| 10 | Health and Wellness | 4 (40%) | 1 (33%) | 2 (67%) | 7 (44%) |
| 11 | Quality | 4 (40%) | 1 (33%) | 2 (67%) | 7 (44%) |
| 12 | Empowerment and advocacy | 4 (40%) | 1 (33%) | 2 (67%) | 7 (44%) |
| 13 | Safety | 4 (40%) | 1 (33%) | 1 (33%) | 6 (38%) |
| 14 | Resilience, positive attitude and openness to change | 4 (40%) | 0 | 2 (67%) | 6 (38%) |
| 15 | Cultural | 4 (40%) | 0 | 1 (33%) | 5 (31%) |
| 16 | Crisis prevention and intervention | 3 (30%) | 1 (33%) | 0 | 4 (25%) |
| 17 | Respect dignity and privacy | 3 (30%) | 0 | 0 | 3 (19%) |
| 18 | Innovation, creativity and problem solving | 3 (30%) | 0 | 0 | 3 (19%) |
| 19 | Staff management | 0 | 0 | 3 (100%) | 3 (19%) |
| 20 | Leadership | 0 | 0 | 3 (100%) | 3 (19%) |

In general the supervisor/manager frameworks were better aligned to the frontline staff frameworks than the qualification/registration frameworks. The role of supervisors (and managers) has become increasingly more complex due to the increased individualisation of services, the move from group to community settings, and the increasing autonomy of the person with a disability in the process of directing his or her own services. (Sedlezky et al, 2013) competency. There is a competency on being open to change (‘Resilience, Positive Attitude and Openness to Change’). However, while this may be adequate for frontline staff, it may not go far enough for managers, and a specific change management competency may be required for the Irish setting.

There is work to be done in terms of making the qualification/registration frameworks more coherent with national policy around disability services and more in line with what graduates will be doing post qualification as frontline staff. This could be addressed if a common competency framework for disability services in Ireland were developed that was embedded in all relevant training curricula.

## 4.3 Alignment of competency frameworks with outcomes

The National Disability Authority developed a set of outcome measures for the new model of person-centred disability services in Ireland (2016). The intention of developing outcomes was to move away from just measuring inputs (such as number of staff) and activities/outputs (such as number of personal assistance hours delivered) to measuring the impact of disability services on the lives of people with disabilities. Outcomes are also important in measuring value for money and in being accountable to people with disabilities, their families and the wider public for what is being achieved.

Table 4 aligns the outcomes along with the 20 competencies areas identified from the 16 competency frameworks reviewed. Although there is not always a natural fit with specific outcomes, it is clear that all of these competencies would be required to achieve the proposed outcomes. It is recommended that any competencies that are developed for frontline staff in Ireland should be aligned as far as possible with these outcomes.

Table 4: Alignment of the 20 most common staff competencies with the nine outcomes for people with disabilities

|  | **Outcomes for people with disabilities** | **Staff competency that fits with a specific outcome** | **Staff competency required for all outcomes** | **Staff competency required for good professional practice** |
| --- | --- | --- | --- | --- |
| 1 | Are living in their own home in the community |  | * Communication * Evaluation, Observation and assessment * Empowerment and advocacy * Community inclusion and networking * Person-centred practice * Planning and organization * Community living skills and support * Quality * Cultural * Respect, dignity and privacy * Innovation, creativity and problem solving | * Education, training and self-development * Professionalism and ethics * Resilience positive attitude and openness to change * Leadership (for managers /supervisors) * Staff management (for managers/ supervisors) |
| 2 | Are exercising choice and control in their everyday lives |  |
| 3 | Are participating in social and civic life |  |
| 4 | Have meaningful personal relationships |  |
| 5 | Have opportunities for personal development and fulfilment of aspirations |  |
| 6 | Have a job or other valued social roles |  |
| 7 | Are enjoying a good quality of life |  |
| 8 | Are achieving best possible health and well being | * Health and wellness * Specific clinical supports |
| 9 | Are safe, secure and free from abuse | * Crisis prevention and intervention * Safety |

# Conclusion

This review indicates that there are several existing competency frameworks for staff working in disability services. To develop a competency framework for the disability workforce working in the new models of disability service in Ireland would not require starting from scratch. This is particularly so as six of the competency frameworks reviewed are from Irish services. As competencies can be quite broad and generic, the development of clear and measurable skills statements for each competency is essential. At the local level, these can then be made more specific for certain job roles. Appendix A of this document provide hundreds of skills statements that can be used for guidance.

The 20 broad competency areas identified in this review is probably too many to include in a competency framework if it is to be adopted and embedded within organisations in Ireland. There is scope however to merge some competency areas e.g. ‘Crisis Prevention and Intervention’ with ‘Safety’. There would also need to be a prioritization exercise conducted among all stakeholders followed by a validation exercise. There is also the option of having a smaller core set of competencies that everyone would be required to have and a broader set that can be added for particular roles or grades of staff.

A separate competency framework for supervisory and management staff would also be required. This should be aligned to the frontline staff competency framework as much as possible with the main differences being present in the skill statements. Similarly, competency frameworks for the qualification or professional registration of staff should be aligned to the generic competency framework with sector specific additions.

# References

An Bord Altranais (2005) Requirements and standards for nurse registration education programmes, 3rd ed. An Bord Altranais, Dublin

CORU, 2016, Standards of Proficiency for Social Care Workers. Health and Social Care Professionals Council <http://coru.ie/uploads/documents/Draft_SOPs_SCWRB.pdf> **(accessed January 2018)**

Department of Developmental Disability Neuropsychiatry (2016) Intellectual Disability Mental Health Core Competency Framework. A Manual for Mental Health Professionals. NSW Ministry of Health

Direct support professionals competency areas (2016) National Alliance for Direct Support Professionals

Health Service Executive (2011). Time to Move on from Congregated Settings: A Strategy for Community Inclusion. Report of the Working Group on Congregated Settings. Dublin, Health Service Executive

Health Services Executive (2012) New Directions. Review of HSE Day Services and Implementation Plan 2012 – 2016. Working group report. HSE

Hewitt A, Larson S, O’Nell S, Sauer J, & Sedlezky L (1998) The Minnesota Frontline Supervisor Competencies and Performance Indicators. Research & Training Centre on Community Living <https://rtc3.umn.edu/docs/flsupcom.pdf> (Accessed January 2018)

Johnson RS, Onwuegbuze AJ, Turner LA (2007) ‘Towards a definition of mixed methods research’, **Journal of Mixed Methods Research**, 1 (2), 112-133

Kendrick M (2014) Key Capacities Involved in Agency Transformation to Personalised Life and Support Options. Belonging Matters. Thinking About Transforming Lives and Services, 19: 24-30

Larson SA, Doljanac R, Nord DK et al, (2007). National Validation Study of Competencies for Frontline Supervisors and Direct Support Professionals: Final Report. Minneapolis, MN: University of Minnesota, Research and Training Center on Community Integration

National Direct Service workforce (2014) Resource Centre. Final Competency Set. Direct Service Workforce Core Competencies. Centers for Medicaid & Medicare Services

National Disability Authority (2016) Outcomes for Disability Services. NDA - <http://nda.ie/nda-files/NDA-Paper-on-Outcomes-for-Disability-Services-May-20161.pdf> (Accessed April 2018)

National Disability Authority (2018) Staff Competencies and Skills Mix for a Community-Based Model of Disability Services. NDA

O’Hagan M (2001) Recovery Competencies for New Zealand Mental Health Workers. Mental Health Commission

Sedlezky L, Reinke J, Larson S, Hewitt A (2013) National Frontline Supervisor Competencies. The Research and Training Centre on Community Living in the US

The Lewin Group (2014) Phase III-B: Road Map of Core competencies for the Direct Services Workforce Project Validation. Centres for Medicare and Medicaid Services.

University of Minnesota (2011) Roadmap of core competencies for direct service workforce. Phase 1 Direct Service Worker Competency Inventory. Centre for Medicaid and Medicare Services

# Appendices

## Appendix A: Competency frameworks reviewed

Sixteen disability related competency frameworks were identified from a literature search. These are detailed below in appendices A1-A16. Appendices A1-A10 are competency frameworks for frontline staff. Appendices A11-A13 are competency frameworks related to professional registration or gaining a qualification. Finally, appendices A14-A16 are competency frameworks related to supervisors or managers of frontline staff.

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##### Appendix A1: Direct Service Workforce Core Competencies

The Direct Service Workforce Core Competencies were developed by the National Direct Service Workforce Resource Centre through a four-year research project that developed a validated set of core competencies for the long-term services and supports system (LTSS) direct service workforce. The LTSS comprises aging and senior services, behavioural health services, including mental health and substance abuse, intellectual/developmental disabilities (IDD) services, and physical disability services. The research was conducted in a number of phases and was funded by the Centres for Medicare and Medicaid Services (The Lewin Group, 2014).

Phase 1 provided an inventory and overview of competency initiatives developed in the US. This step verified the lack of a single nationally recognized and validated competency frameworks to guide the training and development of the entire LTSS workforce. The existing competency frameworks documented varied practices and used terminology often specific to each sector to describe core skills, making it difficult to equate skills across sectors. The competency frameworks also reflected inconsistencies due to various methods applied in developing, validating, and implementing competency standards. Phase 2 conducted a comparative analysis and systematic review of frontline staff competency frameworks identified during phase 1. Results of the analysis indicated a significant number of common competencies across sectors, which supported the notion that building consensus and validating these competencies is an effective strategy towards resolving workforce challenges. Phase three (part A) synthesised the results of the competency analysis in collaboration with stakeholders using the Delphi technique to reach consensus on an initial set of core competencies for direct service workers. Phase three (part B) consisted of a validation study of the set of core competencies to determine the applicability of each competency statement across all four sectors.

The authors of this research acknowledge that not every worker will necessarily need to have every skill in the set and some workers may need additional skills. For example, specialized skills may be necessary to help support a particular individual. They also acknowledge that the types of supports and services provided by frontline staff vary widely. Because The Lewin Group (2014) included all frontline staff across the long-term services and supports system network, and not just frontline disability staff, some skill statements were dropped despite having strong support from the disability sector. These included skills around transportation support and budgeting/financing support.

The core competency frameworks is outlined in table A1

#### Table A1: Frameworks of Core Competencies for the National Direct Service Workforce

| Competency area and description | Skills Statements |
| --- | --- |
| 1. **Communication:**   The DSW builds trust and productive relationships with people s/he supports, co-workers and others through respectful and clear verbal and written communication | 1. Uses positive and respectful verbal, non-verbal and written communication a way that can be understood by the individual, and actively listens and responds to him or her in a respectful, caring manner. 2. Explains services and service terms to the individual being supported and his or her family members. 3. Communicates with the individual and his or her family in a respectful and culturally appropriate way |
| 1. **Person Centred Practices:**   The DSW uses person-centred practices, assisting individuals to make choices and plan goals and provides services to help individuals achieve their goals. | 1. Helps design services or support plans based on the choices and goals of the individual supported, and involves the individual in the process. 2. Builds collaborative, professional relationships with the individual and others on the support team. 3. Provides supports and services that help the individual achieve his or her goals. 4. Participates as an active member of service or support team. 5. Works in partnership with the individual to track progress toward goals and adjust services as needed and desired by individual. 6. Gathers and reviews information about an individual to provide quality services. 7. Completes and submits documentation of services on time. |
| 1. **Evaluation and Observation**:   The DSW closely monitors an individual’s physical and emotional health, gathers information about the individual, and communicates observations to guide services | 1. Helps with the assessment process by gathering information from many sources. 2. Uses the results of assessments to discuss options with the individual and with team members to guide support work. 3. Collects data about individual goals and satisfaction with services. 4. Observes the health and behaviour of the individual within his or her cultural context |
| 1. **Crisis Prevention and Intervention:**   The DSW identifies risk and behaviours that that can lead to a crisis, and uses effective strategies to prevent or intervene in the crisis in collaboration with others | 1. Recognizes risk and works to prevent an individual’s crisis in a way that meets the individual’s need. 2. Uses positive behaviour supports to prevent crisis and promote health and safety. 3. Uses appropriate and approved intervention approaches to resolve a crisis. 4. Seeks help from other staff or services when needed during a crisis. 5. Monitors situations and communicates with the individual and his or her family and support team to reduce risk. 6. Reports incidents according to rules. 7. Sees own potential role within a conflict or crisis and changes behaviour to minimize conflict |
| 1. **Safety:**   The DSW is attentive to signs of abuse, neglect or exploitation and follows procedures to protect an individual from such harm. S/he helps people to avoid unsafe situations and uses appropriate procedures to assure safety during emergency situations | **Abuse and Neglect**   1. Demonstrates the ability to identify, prevent, and report situations of abuse, exploitation, and neglect according to laws and agency rules. 2. Recognizes signs of abuse and neglect, including the inappropriate use of restraints, and works to prevent them.   **Emergency Preparedness**   1. Maintains the safety of an individual in the case of an emergency. 2. Helps individuals to be safe and learn to be safe in the community. 3. Uses universal precautions and gives first aid as needed in an emergency. |
| 1. **Professionalism and Ethics:**   The DSW works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights | 1. Follows relevant laws, regulations and is guided by ethical standards when doing work tasks. 2. Supports individual in a collaborative manner and maintains professional boundaries. 3. Shows professionalism by being on time, dressing appropriately for the job, and being responsible in all work tasks. 4. Seeks to reduce personal stress and increase wellness. 5. Respects the individual and his or her family’s right to privacy, respect, and dignity. 6. Maintains confidentiality in all spoken and written communication, and follows in the rules in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). |
| 1. **Empowerment and Advocacy:**   The DSW provides advocacy, and empowers and assists individuals to advocate for what they need | 1. Helps the individual set goals, make informed choices, and follow-through on responsibilities. 2. Supports the individual to advocate for him or herself by encouraging the individual to speak for his or her self. 3. Supports the individual to get needed services, support and resources. 4. Assists the individual get past barriers to get needed services. 5. Tells the individual and his or her family their rights and how they are protected. |
| 1. **Health and Wellness:**   The DSW plays a vital role in helping individuals’ to achieve and maintain good physical and emotional health essential to their well-being | 1. Supports the spiritual, emotional, and social wellbeing of the individual. 2. Gives medications or assists the individual to take medication while following all laws and safety rules. 3. Assists the individual to learn disease prevention and maintain good health. 4. Assists the individual to use infection control procedures and prevent illness. 5. Helps the individual make and keep regular health and dental care appointments. 6. Helps the individual follow health care plans and use medical equipment as needed. 7. Helps the individual to learn the signs of common health problems and take actions to improve health. |
| 1. **Community Living Skills and Supports:**   The DSW helps individuals to manage the personal, financial and household tasks that are necessary on a day-to-day basis to pursue an independent, community-based lifestyle | 1. Assists the individual meet his or her physical and personal care needs (i.e. toileting, bathing, grooming) and provides training in these areas when needed. 2. Teaches and assists the individual with household tasks such as laundry and cleaning. 3. Assists the individual to learn about meal planning and shopping, and safe food preparation. 4. Provides person centred support and helps the individual to build on his or her strengths in life activities. |
| 1. **Community Inclusion and Networking:**   The DSW helps individuals to be a part of the community through valued roles and relationships, and assists individuals with major transitions that occur in community life | 1. Encourages and assists individuals in connecting with others and developing social and valued social and/or work roles based on his or her choices. 2. Supports the individual to connect with friends and to live and be included in the community of his or her choice. 3. Helps the individual transition between services and adapt to life changes, including moving into home and community based settings. 4. Respects the role of family members in planning and providing services. |
| 1. **Cultural Competency:**   The DSW respects cultural differences, and provides services and supports that fit with an individual’s preferences | 1. Provides or accesses services that fit with the individuals’ culture or preferences. 2. Seeks to learn about different cultures to provide better support and services. 3. Recognizes own biases and doesn’t let them interfere in work relationships. 4. Respects the cultural needs and preferences of each individual. 5. Assists the individual to find social, learning and recreational opportunities valued in his or her culture. |
| 1. **Education, Training and Self Development:**   The DSW obtains and maintains necessary certifications, and seeks opportunities to improve their skills and work practices through further education and training | 1. Completes training and continues to develop skills and seek certification. 2. Seeks feedback from many sources and uses to improve work performance and skills. 3. Learns and stays current with technology used for documentation, communication and other work activities |

Source: National Direct Service workforce, 2014

##### Appendix A2: Direct Support Professionals Competency areas

One of the competency frameworks reviewed during phase one of the development of the Direct Service Workforce Core Competencies was the Direct Support Professionals Competency Areas developed by the National Alliance for Direct Service Professionals (NADSP) (University of Minnesota, 2011). Although it was developed to be cross-sectoral, it was described as primarily serving the intellectual and developmental disabilities sector. The NADSP is a non-profit organization providing advocacy and certification for frontline staff across various sectors. It is one of the original champions of the Long-term Care, Supports, and Services Competency Model. In 2007, the NADSP formalized and approved 15 competencies that are common across the direct support profession. These are listed in Table A2.

#### Table A2: Direct Support Professionals Competency Areas

| Competency area | Skills statements |
| --- | --- |
| 1. **Participant empowerment** | 1. The competent DSP assists and supports the participant to develop strategies, make informed choices, follow through on responsibilities, and take risks. 2. The competent DSP promotes participant partnership in the design of support services, consulting the person and involving him or her in the support process. 3. The competent DSP provides opportunities for the participant to be a self-advocate by increasing awareness of self-advocacy methods and techniques, encouraging and assisting the participant to speak on his or her own behalf, and providing information on peer support and self-advocacy groups. 4. The competent DSP provides information about human, legal, civil rights and other resources facilitates access to such information and assists the participant to use information for self-advocacy and decision making about living, work, and social relationships. |
| 1. **Communication** | 1. The competent DSP uses effective, sensitive communication skills to build rapport and channels of communication by recognizing and adapting to the range of participant communication styles. 2. The competent DSP has knowledge of and uses modes of communication that are appropriate to the communication needs of participants. 3. The skilled DSP learns and uses terminology appropriately, explaining as necessary to ensure participant understanding. |
| 1. **Assessment** | 1. The competent DSP initiates or assists in the initiation of an assessment process by gathering information (e.g., participant’s self-assessment and history, prior records, test results, additional evaluation) and informing the participant about what to expect throughout the assessment process. 4 NADSP Competency Areas • The Foundation of Direct Support Practice 2. The competent DSP conducts or arranges for assessments to determine the needs, preferences, and capabilities of the participants using appropriate assessment tools and strategies, reviewing the process for inconsistencies, and making corrections as necessary. 3. The competent DSP discusses findings and recommendations with the participant in a clear and understandable manner, following up on results and re-evaluating the findings as necessary. |
| 1. **Community and service networking** | 1. The competent DSP helps to identify the needs of the participant for community supports, working with the participant’s informal support system, and assisting with, or initiating identified community connections. 2. The competent DSP researches, develops, and maintains information on community and other resources relevant to the needs of participants. 3. The competent DSP ensures participant access to needed and available community resources coordinating supports across agencies. 4. The competent DSP participates in outreach to potential participants. |
| 1. **Facilitation of services** | 1. The competent DSP maintains collaborative professional relationships with the participant and all support team members (including family/friends), follows ethical standards of practice (e.g., confidentiality, informed consent, etc.), and recognizes his or her own personal limitations. 2. The competent DSP assists and/or facilitates the development of an individualized plan based on participant preferences, needs, and interests. 3. The competent DSP assists and/or facilitates the implementation of an individualized plan to achieve specific outcomes derived from participants’ preferences, needs and interests. 4. The competent DSP assists and/or facilitates the review of the achievement of individual participant outcomes. |
| 1. **Community living skills and supports** | 1. The competent DSP assists the participant to meet his or her physical (e.g., health, grooming, toileting, eating) and personal management needs (e.g., human development, human sexuality), by teaching skills, providing supports, and building on individual strengths and capabilities. 2. The competent DSP assists the participant with household management (e.g., meal prep, laundry, cleaning, decorating) and with transportation needs to maximize his or her skills, abilities and independence. 3. The competent DSP assists with identifying, securing and using needed equipment (e.g., adaptive equipment) and therapies (e.g., physical, occupational and communication). 4. The competent DSP supports the participant in the development of friendships and other relationships. 5. The competent community based support worker assists the participant to recruit and train service providers as needed. |
| 1. **Education, training, and self-development** | 1. The competent DSP completes required training education/certification, continues professional development, and keeps abreast of relevant resources and information. 2. The competent DSP educates participants, co-workers and community members about issues by providing information and support and facilitating training. |
| 1. **Advocacy** | 1. The competent DSP and the participant identify advocacy issues by gathering information, reviewing and analyzing all aspects of the issue. 2. The competent DSP has current knowledge of laws, services, and community resources to assist and educate participants to secure needed supports. 6 NADSP Competency Areas • The Foundation of Direct Support Practice 3. The competent DSP facilitates, assists, and/or represents the participant when there are barriers to his or her service needs and lobbies decision-makers when appropriate to overcome barriers to services. 4. The competent DSP interacts with and educates community members and organizations (e.g., employer, landlord, civic organization) when relevant to participant’s needs or services. |
| 1. **Vocational, educational, and career support** | 1. The competent DSP explores with the participant his/her vocational interests and aptitudes, assists in preparing for job or school entry, and reviews opportunities for continued career growth. 2. The competent DSP assists the participant in identifying job/training opportunities and marketing his/ her capabilities and services. 3. The competent DSP collaborates with employers and school personnel to support the participant, adapting the environment, and providing job retention supports. |
| 1. **Crisis intervention** | 1. The competent DSP identifies the crisis, defuses the situation, evaluates and determines an intervention strategy and contacts necessary supports. 2. The competent DSP continues to monitor crisis situations, discussing the incident with authorized staff and participant(s), adjusting supports and the environment, and complying with regulations for reporting. |
| 1. **Organization participation** | 1. The competent DSP contributes to program evaluations, and helps to set organizational priorities to ensure quality. 2. The competent DSP incorporates sensitivity to cultural, religious, racial, disability, and gender issues into daily practices and interactions. 7 www.nadsp.org • Updated March, 2016 3. The competent DSP provides and accepts co-worker support, participating in supportive supervision, performance evaluation, and contributing to the screening of potential employees. 4. The competent DSP provides input into budget priorities, identifying ways to provide services in a more cost-effective manner. |
| 1. **Documentation** | 1. The competent DSP maintains accurate records, collecting, compiling and evaluating data, and submitting records to appropriate sources in a timely fashion. 2. The competent DSP maintains standards of confidentiality and ethical practice. 3. The competent DSP learns and remains current with appropriate documentation systems, setting priorities and developing a system to manage documentation. |
| 1. **Building and maintaining friendships and relationships** | 1. The competent DSP assists the individual as needed in planning for community activities and events (e.g., making reservation, staff needs, money, materials, accessibility). ▪ The competent DSP assists the individual as needed in arranging transportation for community events. 2. The competent DSP documents community activities and events. 3. The competent DSP encourages and assists the individual as needed in facilitating friendships and peer interactions. 4. The competent DSP encourages and assists the individual as needed in communication with parents/ family (e.g., phone calls, visits, letters). 5. The competent DSP implements individual supports regarding community activities. 6. The competent DSP provides incentive or motivation for consumer involvement in community outings. 7. The competent DSP assists the individual as needed in getting to know and interacting with his/her neighbours. 8. The competent DSP encourages and assists the individual as needed in dating. 9. The competent DSP encourages and assists the individual as needed in communicating with social workers and financial workers. |
| 1. **Providing person-centred supports** | 1. The competent DSP provides support to people using a person centred approach. 2. The competent DSP modifies support programs and interventions to ensure they are person centred. 3. The competent DSP challenges co-workers and supervisors to use person centred practices. 4. The competent DSP is knowledgeable about person centred planning techniques. 5. The competent DSP assists individuals in developing person centred plans. |
| 1. **Supporting health and wellness** | 1. Administers medications accurately and in accordance with agency policy and procedures. 2. Observes and implements appropriate actions to promote healthy living and to prevent illness and accidents. 3. Uses appropriate first aid/safety procedures when responding to emergencies. 4. Assists individuals in scheduling, keeping, and following through on all health appointments. 5. Assists individuals in completing personal care (e.g., hygiene and grooming) activities. 6. Assists with identifying, securing and using needed adaptive equipment (i.e. adaptive equipment) and therapies (e.g., physical, occupational, speech, respiratory, psychological). 7. Assists individuals in implementing health and medical treatments. 8. Assists individuals to take an active role in their health care decisions. |

Source: Direct support professionals competency areas, 2016

##### Appendix A3: Intellectual Disability Mental Health Core Competency Framework

In New South Wales in Australia the need for a competency framework for mental health professionals caring for people with an intellectual disability was identified and subsequently developed termed the Intellectual Disability Mental Health Core Competency Framework (Department of Developmental Disability Neuropsychiatry, 2016). This need arose from a recognition that frequently the needs of people with an intellectual disability with a concurrent mental health illness were not been met. The core competencies are attributes required of the mental health workforce to meet the needs of people with an intellectual disability. Its development considered the perspective of people with an intellectual disability, their families and support networks. Implementation is not compulsory but is recommended in all public mental health services to strengthen professional competence and support service improvement.

The core competencies are divided into three areas with a number of domains in each and are presented with the full list of associated attributes in table A3.

#### Table A3: Intellectual Disability Mental Health Core Competency Framework

| Competency domain | Skills Statements |
| --- | --- |
| **Core competency 1: Working with people with an intellectual disability** | |
| **1.1 Responsible, Safe, and Ethical Practice** | 1. Provides information on– the rights of people with an intellectual disability, their families and support networks in accessible formats. 2. Facilitates supported decision making and gives priority to the person’s expressed wishes, as far as possible. 3. Identifies the person’s support network, and when appropriate to do so, and when consent to their involvement is given, works with them at all stages of service delivery. 4. Identifies when the person does not have a support network and actively assists them to find an independent support person(s).   Demonstrates the ability to support the person to use and strengthen their support networks. |
| **1.2 Recovery Focus** | 1. Is aware of the potential issues relating to: physical, sensory and motor disability; physical health problems; environmental factors; opportunities for skill development; choice, and how these may impact on recovery. 2. Supports the person, their family and support network to engage in services (health and non-health related) that are able to meet their recovery needs. 3. Engages with primary health care providers and when required, specialist intellectual health services to support the completion of a health assessment and the ongoing management of physical health issues. |
| **1.3 Meeting Diverse Needs** | 1. Examines the extent and limits of their understanding of intellectual disability and mental ill health in intellectual disability, and seeks support to address this. 2. Acknowledges and articulates how personal beliefs and emotional reactions toward people with a disability might influence their clinical practice. 3. Demonstrates the ability to determine how the person relates to their own abilities and disability. 4. Works collaboratively with mainstream/specialist mental health services, health services and other support services to meet the needs of people with an intellectual disability. 5. Acknowledges the varying views of intellectual disability within different cultures and the impact that this may have on access and participation in services. 6. Addresses barriers to engaging people with an intellectual disability, their family and support network from culturally and linguistically diverse backgrounds.   Consults with cultural groups to identify strategies to deliver culturally respectful services. |
| **1.4 Communication** | 1. Demonstrates the ability to determine the person’s preferred communication style and appropriately adapts their own communication style to meet the needs of the person. 2. Demonstrates a reflective approach to communication and confirms that their interpretation of the person’s communication is accurate. 3. Uses assistive communication technology and seeks support to use technology as required. 4. Adapts the environment to maximise independent and open communication. 5. Uses appropriate person first language when describing a person with an intellectual disability and co-occurring mental ill health. 6. Identifies when support is required from a communication specialist and seeks their support through appropriate referrals. |
| **1.5 Partnership, Collaboration and Integration** | 1. Demonstrates an awareness of the different skills and approaches available in the mental health and disability sectors, and uses this knowledge to facilitate collaborative work. 2. Uses terms and language that will be understood by all agencies. 3. Follows local protocols for collaboration and joint work between mental health services, specialist 4. intellectual disability mental health services and other key parties. 5. Works with partner organisations to deliver a seamless service to people with an intellectual disability, their families and support networks. |
| **Core competency 2: Clinical Competencies** | |
| **2.1 Common Clinical Competencies** | 1. Demonstrates the ability to assess the capacity of a person with an intellectual disability to understand information and make decisions about their mental health care. 2. Takes the time to prepare for working with a person with an intellectual disability by finding out about their strengths and the support that they may require, to ensure their active engagement and participation in the service. 3. Demonstrates the ability to identify and work with legal guardians and other substitute decision makers. 4. Confirms that the person, their family and support network are aware of the clinical process, and understand their right to be informed, give or withhold informed consent, and of their right to participate in their mental health care. 5. Works with the person, their family and support network to maximise participation in the assessment process, care planning and delivery of interventions. 6. Provides information to the person with an intellectual disability, their family and support networks in accessible formats at all stages of the clinical process, acknowledging that the format may be different for different stakeholders. 7. Identifies when support is required from specialist intellectual disability mental health professionals, and actively seeks their support. |
| **2.2 Intake** | 1. For re-referrals, avoids replication of the first referral pathway and extensive re-assessments, unless this adds to the existing assessment information. 2. Demonstrates an awareness of, and is able to inform the person, their family and support networks of the clinical pathway through the service in a readily understood way and confirms that the information has been understood. |
| **2.3 Assessment** | 1. Identifies signs that a person may have an intellectual disability and seeks assistance as required to confirm disability through an appropriate assessment or obtaining copies of existing assessment reports. 2. Demonstrates the ability to understand and consider the potential risk factors and compounding conditions that may influence the mental state of a person with an intellectual disability. 3. Prepares for an assessment by:    * allocating adequate time to accommodate for possible complexities    * understanding and organising an appropriate environment that addresses the person’s physical and sensory needs    * establishing the person’s communication needs and preparing to use their preferred method of communication in the assessment    * identifying and communicating with those who can provide an accurate history and/or further information or data related to the presenting problem    * reviewing detailed background health and mental health information    * establishing who will be accompanying the person with an intellectual disability, and accommodating them as appropriate in the consultation. 4. Adapts assessment techniques to reflect the possible difficulties in identifying signs of a mental disorder in someone with an intellectual disability. 5. Employs a longitudinal, multi-source, and multi-modal approach (including observational records such as sleep, weight and ABC charts) to the assessment. 6. Collects assessment information on relevant dimensions including, for example, developmental, biomedical, psychiatric, psychological/cognitive/social, adaptive behaviour, functional abilities, environmental, cultural and educational history. 7. Identifies when a multi-agency/service assessment is required and contributes to this joint assessment process. 8. Uses assessment information to establish a baseline function for each individual, and the possible functional manifestations of mental disorder. 9. Demonstrates the ability to assess the relative contribution of mental health, physical health, environment, communication and skills to behaviours. 10. Collaborates with disability services and other relevant stakeholders to provide a comprehensive assessment of challenging behaviour. |
| **2.4 Mental Health Interventions and Care Planning** | 1. Develops treatment strategies that consider the broader biopsychosocial aspects of the person including other interventions or treatments that they are receiving. 2. Identifies when peer support is appropriate and facilitates the engagement of such support. 3. Modifies the environment to maximise the person’s participation in an intervention. 4. Works with primary care physicians and other health professionals to manage physical health issues that impact on the person’s overall health and wellbeing. 5. Takes into account the training and experience of the person with the ID, family members and support networks when developing plans for the management and monitoring of illness. 6. Evaluates individual intervention outcomes globally and in relation to specific intervention goals. 7. Develops care plans which appropriately consider and recommend strategies for crisis prevention, early intervention and long-term follow up as necessary. 8. Includes mental health recovery and relapse prevention activities relevant to the person with an intellectual disability in their mental health care plan. 9. Works with the person and their support network to integrate information into a single plan that governs the services and support they receive. |
| **2.5 Transfer of Care** | 1. Demonstrates ability to identify potential risks associated with the transfer of care. 2. Develops with the person and other key partners strategies to manage the transfer of care at key transition points in the person’s life. |
| **Core competency 3: Quality Improvement and Professional Development** | |
| **3.1 Research, Quality Improvement, and Professional Development** | 1. Participates in research relating to people with an intellectual disability and co-occurring mental ill health 2. where possible, and where appropriate encourages the participation of people with an intellectual disability in research. 3. Demonstrates the ability to support people with an intellectual disability, their families and support networks to participate in service improvement activities.   Collects quality improvement data about people with an intellectual disability who participate in service.   1. Demonstrates a willingness to learn about intellectual disability mental health and to translate what has been learnt into improved practice.   Seeks opportunities for professional development from within the disability and other relevant sectors. |

Source: Department of Developmental Disability Neuropsychiatry, 2016

Appendix A4: Recovery competencies for New Zealand mental health workers

The Mental Health Commission in New Zealand developed Recovery Competencies for New Zealand Mental Health Workers (O’Hagan, 2001). Recovery is when people with mental illness develop the ability to live well in the presence or absence of their mental illness. It is when they take an active role in improving their lives, where communities are inclusive of people with mental illnesses and where the mental health services can enable interaction between the person with mental illness, their communities and their families.

The competencies outline what mental health workers need to acquire when using a recovery approach The report states that while competencies are usually defined to include the attitudes, skills, knowledge and behaviour required of the mental health workforce, the recover based competencies are more focused on the attitudes and knowledge components. They do not encompass all the competencies required by mental health workers but have focused on the ones that everyone requires for recovery work. The competencies were developed by people using mental health services using a review of international mental health recovery literature, literature on people’s experiences of mental illness, and services training standards for key mental health staff. Draft competencies were developed and were discussed and finalized through focus groups and written comments of key stakeholders. The competencies and skills statements are outlined in Table A4.

#### Table A4: Recovery competencies for New Zealand mental health workers

| Major categories | Sub-categories |
| --- | --- |
| 1. **Understands recovery principles and experiences in the Aotearoa/NZ and international contexts** | * 1. They demonstrate ability to apply the Treaty of Waitangi to recovery   2. They understand the philosophical foundations of recovery in the mental health setting   3. They demonstrate knowledge of and empathy with service user recovery stories or experiences   4. They demonstrate understanding of the principles, processes and environments that support recovery |
| 1. **Recognises and supports the personal resourcefulness of people with mental illness** | 1. They demonstrate knowledge of human resilience and strength and knowledge of how to facilitate it 2. They demonstrate the ability to support service users to deal constructively with trauma, crisis and keeping themselves well 3. They demonstrate the ability to support service users to experience positive self-image, hope and motivation 4. They demonstrate the ability to support service users live the lifestyle and the culture of their choice |
| 1. **Understands and accommodates the diverse views on mental illness, treatments, services and recovery** | * 1. They demonstrate knowledge of the major ways of understanding mental Illness   2. They demonstrate knowledge of major types of treatments and therapies and their contributions to recovery   3. They demonstrate the ability to facilitate service users to make informed choices for recovery   4. They demonstrate knowledge of innovative recovery-oriented service delivery approaches |
| 1. **Has the self-awareness and skills to communicate respectfully and develop good relationships with service users** | * 1. They demonstrate self-awareness of their life experience and culture   2. They demonstrate communication styles that show respect for service users and their families/whanau   3. They manage relationships so they will facilitate recovery |
| 1. **Understands and actively protects service users. rights** | 1. They demonstrate knowledge of human rights principles and issues 2. They demonstrate knowledge of service users. rights within mental health services and elsewhere 3. They demonstrate the ability to promote and fulfil service users. rights |
| 1. **Understands discrimination and social exclusion, its impact on service users and how to reduce it** | * 1. They demonstrate knowledge of discrimination and social exclusion issues   2. They demonstrate an understanding of discrimination and exclusion by the wider community   3. They demonstrate an understanding of discrimination by the health Workforce   4. They demonstrate an understanding or other kinds of discrimination and how they interact with discrimination on the grounds of mental illness   5. They demonstrate familiarity with different approaches to reducing discrimination |
| 1. **Acknowledges the different cultures of Aotearoa/NZ and knows how to provide a service in partnership with them** | * 1. They demonstrate an awareness of cultural diversity   2. They demonstrate knowledge of Maori protocols and models of care   3. They demonstrate knowledge of European-derived cultures   4. They demonstrate knowledge of Pacific Islands cultures   5. They demonstrate knowledge of Asian cultures |
| 1. **Has comprehensive knowledge of community services and resources and actively supports service users to use them** | * 1. They demonstrate ability to facilitate access to and good use of mental health services   2. They demonstrate ability to facilitate access and good use of other government sectors   3. They demonstrate ability to facilitate access to and good use of community resources and services |
| 1. **Has knowledge of the service user movement and is able to support their participation in services** | * 1. They demonstrate knowledge of the principles and activities of the service user movement   2. They demonstrate knowledge of the range of service user participation and principles and policy behind it   3. They demonstrate understanding of the different methods of service user Participation   4. They demonstrate the ability to apply knowledge of service user participation to different groups and settings |
| 1. **Has knowledge of family/whanau perspectives and is able to support their participation in services.** | * 1. They demonstrate knowledge of the range of family participation and the principles and policy behind it   2. They demonstrate knowledge of the methods of family participation   3. They demonstrate the ability to apply their knowledge of family participation to different groups and settings   4. They demonstrate awareness of the experiences of families and their potential to support recovery |

Source: O’Hagan M, 2001

##### Appendix A5: Core capacities required for community agencies to generate and sustain substantively good individualised outcomes

Kendrick in the US developed a set of core capacities required for community agencies to generate and sustain substantively good individualised outcomes (2014). The terms capacity and competence are often used interchangeably. He recognizes the different set of capacities and skills required for creating ‘tailor made’ support arrangements built around the specific needs of a given person, compared to managing a standardised service model. Those who are skilled in operating standardised service models may not be the right kind of people needed to create a service from scratch based on individual need. Kendrick maintains also that person centred proficiency requires specific talents and abilities to be present. His core capacities are outlined in Table B5.

#### Table A5: Core capacities for community agencies to generate and sustain good individualised outcomes

| Core capacities | Description |
| --- | --- |
| 1. **The capacity to establish and maintain ‘right relationship’ with a very diverse range of people** | Build and earn long-term quality relationships. Determine what is a good or optimal partnership in the context where authority and power are to be shared |
| 1. **The capacity to deeply and accurately understand people, their aims, needs in life and their true potentials** | The lives of people with disabilities cannot improve if those supporting them lack sufficient understanding of their core needs and their potential |
| 1. **The capacity to imagine and create ‘better’** | If ‘better’ cannot be imagined, then it cannot be implemented. The way to achieving the ‘better’ can be difficult to achieve at first |
| 1. **The capacity to master the developmental challenges involved in ongoing lifestyle developments** | Avoid stagnation through the cultivation of a developmental mind-set to enable ‘life-tasting’ and life building to happen. |
| 1. **The capacity to develop and operationalise vision and values that actually leads to quality in people’s lives** | Translate vision into workable implementation tasks and follow through. Requires creativity, perseverance, negotiation and finesse. |
| 1. **The capacity to dismantle group models and their components and gradually replace them with individualised options** | Deal with the significant impacts and many consequences of reconfiguration of services. |
| 1. **The capacity to maintain the ongoing productive management of the multi-party negotiations involved in transformational change** | Ability to keep all stakeholders onside to allay any vested interests and keep everyone working towards a common goal. |
| 1. **The capacity to manage steady forward movement on the schedule of implementation of individual options in the face of limitations** | Expect and persist in overcoming the multiple challenges that can mitigate against the achievement of the end goal. |
| 1. **The capacity to build incrementally from small beginnings towards the entrenchment of quality gains.** | Aiming for the person with the disability to thrive and flourish. Start small and build up to something sustainable |
| 1. **The capacity to provide, support and mobilise personal leadership from multiple persons** | Ongoing proactive conduct by many people to shape more favourable life opportunities for the person with a disability |
| 1. **On the feasibility of intentional capacity building** | Develop and strengthen the workforce to give them the confidence and skills to implement the capacities outlined. |

Kendrick M, 2014

##### Appendix A6: WALK

WALK is an Irish organisation that works towards improving the quality of life **for all people in the community through building social capital and community living. It uses a person-centred process and both formal and informal community networks. They support individuals to fulfil their employment aspirations including training to become work ready and to lead fulfilling lives in the community. The core competencies for WALK are outlined in Table A6.**

#### Table A6: Core competencies for WALK

| Core competency | Description |
| --- | --- |
| 1. **Human Rights Based Approach** | 1. Believe and demonstrate that all people are equal citizens of society, with the same rights and responsibilities. 2. Treat and value all people as equals. 3. Assist the people we support in understanding and upholding their rights. 4. Promote the abolition of restrictive practice and always use ‘least restrictive practice’ where rights are restricted |
| 1. **Low Arousal Philosophy and practice** | 1. Support people who use our service in a non-confrontational manner. 2. Avoid sanctions and consequence based punitive strategies 3. .Question own contribution to incidents of behavioural expression. 4. See things from others’ perspective. 5. Demonstrate sincere interest and concern when dealing with people situations. 6. Accept and be open to the Organisation’s position on behaviour support for people who use our service |
| 1. **Resilience, positive attitude and openness to change** | 1. Introduce and support interventions which help to enhance and maintain self-confidence and self-esteem of others. 2. Hold a positive image of and attitude towards the Organisation and the people we support with a willingness to promote that image both internally and externally. 3. Ability to remain calm under pressure. 4. Support or initiate change which will enable the achievement of the goals of the people we support and the Organisation’s goals |
| 1. **Effective communication and working relationship** | 1. Build positive and constructive, mutually beneficial relationships with all organisation stakeholders. 2. Use effective communication and appropriate interpersonal skills to ensure effective exchange of ideas and information 3. .Identify with and work co-operatively with others, through teamwork, to promote a culture where information sharing and support are encouraged |
| 1. **Planning, organising and prioritizing** | 1. Work to optimise outputs with available resources. 2. Plan and complete work to agreed standards. 3. Identify and organise time to enable work to be completed. 4. Handle any unforeseen circumstances using initiative and flexibility. |
| 1. **Innovation, creativity and problem solving** | 1. Think creatively to introduce alternative approaches or adapt existing ones to meet new situations. 2. Look outside of traditional solutions when appropriate. 3. Generate workable solutions and make informed decisions. 4. Have sufficient knowledge to make an informed decision, always think before you act. 5. Identify plans of action and share pathways for completion prior to taking action. 6. Respond to unforeseen eventualities in an innovative fashion |

Source: <http://www.walk.ie/who-we-are/core-competencies/> (Accessed January 2018)

##### Appendix A7: Core values of Cheshire Ireland

Cheshire Ireland works primarily with people with physical disabilities to provide quality, person-centred services, which facilitate people with disabilities to live a life of their own choosing. They do not have published competencies but core values. Although there are differences between core values and competencies, it was considered that relatively little work would be required to convert core values into competencies, and they are therefore included. The core values are outlined in Table A7.

#### Table A7: Core Values of Cheshire Ireland

| Core Values | Value statements |
| --- | --- |
| 1. **To be person-centred** | Cheshire works to a person-centred approach so that the expressed needs, choices and valued outcomes of individual service users are at the centre of service delivery, planning and evaluation. |
| 1. **To listen & learn** | Cheshire recognises the importance of open and continuous communication with all stakeholders. In particular, we value the learning to be gained through listening to people who use, or who would wish to use, Cheshire services |
| 1. **To respect dignity & privacy** | Cheshire recognises and respects the right to dignity and privacy of all service users, staff and volunteers |
| 1. **To be accountable and effective** | Cheshire is committed to clear accountability and transparency concerning all of its actions and to providing services which deliver value-for-money |
| 1. **To be responsive & flexible** | Cheshire aims to be flexible, innovative and responsive to the changing needs of its service users and other stakeholders. |
| 1. **To promote partnership** | Cheshire works in partnership with internal and external stakeholders to develop good practice and to achieve mutually agreed and beneficial outcomes. |
| 1. **To improve continuously** | Cheshire is committed to developing and supporting a culture of continuous quality improvement |
| 1. **To value diversity & potential** | Cheshire believes in promoting an equal opportunities environment which welcomes difference and values diversity; an environment within which both service users and staff can maximise their potential and contribution. |

Source: <http://www.cheshire.ie/about_corevalues> (Accessed January 2018)

##### Appendix A8: Daughters of Charity Disability Support Services

The Daughters of Charity is a faith based service that provides disability services and supports for children and adults with a moderate, severe or profound intellectual disability and include day, residential, and respite services. Rather than core competencies, they have a comprehensive set of core values. These core values along with the value statements are outlined in Table A8.

#### Table A8: Core Values of the Daughters of Charity

| Value | Value statement |
| --- | --- |
| 1. **Service:** | 1. We will look for opportunities to provide service by:    * ensuring that each person will experience unconditional acceptance and respect in a safe, loving, caring and purposeful environment    * supporting and enabling service users with love and compassion to meet their own needs    * being helpful and considerate, always doing that little bit more than is necessary and to keep on doing it    * meeting the smallest needs of the individual graciously    * recognising and empathising with the needs of others and delivering a service which encompasses a holistic approach    * listening, observing and learning about the individual rather than assuming we already know    * providing opportunities for each person to engage in functional activities that are valued by society and meaningful for the individual themselves    * treating each person as an individual with individual needs and requirements, and their own belief system    * maintaining the dignity of each person and respecting their privacy. 2. We will maintain partnership by:    * using a team approach that is client-centred and inclusive    * facilitating friendships and family contact    * sharing our skills and expertise    * working with service users, their families and significant others    * availing of local community services and providing opportunities for service users to participate in wider social networks with non-disabled people    * ensuring that each person is empowered to make personal choices and take control of their own life. 3. We will provide a safe environment by:    * protecting and respecting the rights and entitlements of each person    * ensuring that everybody has an opportunity and a safe place to speak about issues or problems    * providing safe work practices. 4. We will pursue improvement by:    * developing our skills, techniques and knowledge so as to deliver the best quality of service for all service users    * learning from experience gained    * ongoing evaluation of work practices    * striving to achieve a high quality service    * providing a service that is responsive to the changing needs of service users    * being proactive rather than reactive in our provision of care    * focussing on the provision of a service which is responsive to individual service users’ needs and requirements. 5. We will fulfil our obligations by:    * focussing on ability rather than disability    * providing a service that is person-centred    * respecting the need for advocacy    * appreciating the resources available to us and making good use of them    * ensuring that each person is enabled to develop the skills and experience they need in order to move into employment or pursue individual interests    * adhering to the Service’s Policy Documents. |
| 1. **Respect:** | 1. We will appreciate the dignity of all persons by:    * respecting individuality and acknowledging uniqueness    * accepting differences in a non-judgemental manner    * acknowledging their giftedness    * respecting each one as a valued member of community with a contribution to make to that community    * allowing each one to grow at their own pace    * being sensitive and respectful of each person’s beliefs and cultural customs    * making each person feel worthwhile    * treating each person as we would like to be treated. 2. We will be courteous and friendly by:    * initiating and responding to greetings    * responding appropriately to requests    * calling others by their name    * remembering to say ‘please, thank you’ etc.    * ensuring we never say or do anything to make another feel embarrassed or uncomfortable    * anticipating needs in vulnerable times    * presenting ourselves in a professional manner. 3. We will respect the privacy of others by:    * maintaining confidentiality    * abiding by professional standards    * knocking on doors before entering    * being careful with others’ belongings    * being sensitive when assisting service users with personal intimate needs. 4. We will take time to:    * listen attentively to others.    * provide opportunities for others to express their opinions and views    * converse with service users as we interact with them    * find out how others want to be treated. 5. We will recognise the right of service users to be:    * informed of interventions and options available to them    * involved in choices and decisions which affect their lives, as appropriate (or family/advocate on their behalf)    * in a comfortable, clean environment    * facilitated as far as possible in programmes/activities suited to their specific needs    * treated with sensitivity regarding issues, anxieties and traumas in their lives. |
| 1. **Excellence** | 1. Service users will receive:    * the highest standard of care    * health promotion    * person centred planning    * good care and working environment. 2. All staff members will engage in:    * accurate, timely reporting and record keeping    * effective resource management    * effective communications    * reflection on decisions and outcomes    * continuous quality improvement    * advocacy and involvement of family members. 3. Service management will engage in:    * audit and measurement    * evaluation and accountability    * accreditation    * benchmarking    * updating staff’s professional knowledge and skills    * coaching and mentoring    * promoting a team approach    * performance review. |
| 1. **Collaboration** | 1. We will collaborate with each service user by:    * allowing them to express their desires and needs    * being open to their ideas and contributions    * including them in decisions regarding their own lives. 2. We will involve family and significant others:    * by maintaining an open relationship with them, ensuring they are involved as partners in care on behalf of the service user    * by respecting their role in the service user’s life    * in regular reviews of Individual Programme Plans or Care Plans. 3. We will collaborate with our co-workers by:    * respecting each other’s point of view and valuing each other’s contribution    * encouraging each other    * acknowledging each other’s talents and limitations and remembering to say thank you    * taking responsibility for attending staff meetings or receiving feedback from same    * maintaining a good communication system, verbal and written, to ensure continuity of care    * approaching the performance review with openness    * working together and sharing the workload    * solving problems in a friendly and co-operative manner. 4. We will continue to develop and maintain an interdisciplinary approach by:    * respecting the professionalism of each discipline    * collaborating with the necessary disciplines to ensure quality of life for the service user    * promoting team involvement through all disciplines. 5. We will collaborate with other agencies to:    * share knowledge and skills    * advocate on behalf of service users. 6. We will link with the local community and use community facilities as appropriate. 7. We will strive to maintain an excellent system of communication between departments to avoid gaps in service so as to:    * maintain continuity of care    * review progress    * facilitate updating and revision of service user’s individual goals    * promote effective teamwork    * support and encourage each other    * provide format for staff to share views and discuss strategies    * keep others informed of developments and/or needs. |
| 1. **Justice** | 1. We will become the voice of our service users by:    * identifying and responding to their needs of body, mind and spirit    * making others aware of their needs    * making them aware of their rights and ensuring they are not restricted from practising them    * respecting their human rights and rights to privacy    * using opportunities to make the public and politicians aware of their rights    * empowering them    * promoting and encouraging self- advocacy groups    * promoting ability rather than disability    * treating each person fairly    * listening and responding to their complaints    * giving them choice in their daily lives    * ensuring they are not exploited    * recognising injustice and ensuring it is addressed    * not imposing our own will on them    * giving them the opportunity to access local facilities in the community    * providing meaningful activation, training and employment opportunities for them    * striving towards providing an equitable service for all.. |

Source: <http://www.docservice.ie/about-us-core-values.aspx> (Accessed January 2018)

##### Appendix A9: Generic Services Intervention Pathway

The Generic Services intervention pathway was created by the NHS in the UK as a competency framework to support development of the learning disability workforce. To ensure consistency, these have been mapped to the National Occupational Standards that describe each competence. The framework covers clinical learning disability workforce roles in delivery of care for people with complex needs. The competencies are outlined in Table A9.

#### Table A9: Generic service intervention pathway

| Competency | Activity |
| --- | --- |
| 1. **Promoting appropriate access to service** | 1. managing referrals, transfers, transitions and discharges 2. managing care programme approach, including care planning 3. positive risk management (including risk to self and others, safeguarding and personal safety) 4. crisis and emergency planning |
| 1. **Assessment, formulation and treatment planning** | 1. undertaking assessment processes including functional analysis 2. mental capacity 3. processing information and formulation 4. treatment planning |
| 1. **Enabling health interventions** | 1. signposting and supporting access to mainstream health services 2. promoting healthy lifestyle choices 3. supporting choices and self-determination 4. promoting effective communication about health needs |
| 1. **Therapeutic interventions** | 1. physical health care (including dysphagia and seizures management) 2. evidence-based talking therapies 3. medications management |
| 1. **Role support interventions** | 1. supporting person-centred activities and functioning (including promoting independence, including personal budgets, communication, social, spiritual, sexual health and personal care, also mitigate other stigmatising factors 2. maintaining and developing community links and opportunities to engage in mainstream activities including social care, education, employment, housing, transport and leisure services |
| 1. **Family and carer interventions** | 1. carers’ assessments 2. maintaining relationships 3. supporting families (including siblings) 4. supporting carers with their needs 5. supporting carers to undertake the caring role |
| 1. **Accommodation and welfare** | 1. practical housing support 2. accessing benefits |
| 1. **Monitoring and measurement, research and evaluation** | 1. physical health observations (focus on complications associated with learning disabilities) 2. mental wellbeing state 3. effectiveness of enabling therapeutic interventions 4. effectiveness of family carer interventions 5. effectiveness of accommodation and welfare interventions 6. effectiveness of role support interventions 7. effectiveness of care programme approach and risk management strategy 8. service user satisfaction 9. the ‘Health Equalities Framework’ 10. research and evaluation |

Source: <https://hee.nhs.uk/sites/default/files/documents/Generic%20Service%20Interventions%20Pathway.pdf> (Accessed January 2018)

##### Appendix A10: Positive Behavioural Support Competence Framework

The ‘Positive Behavioural Support (PBS) Competence Framework’ is a resource that provides a common and shared knowledge (the things that you need to know) and associated actions (the things that you need to do) necessary for the delivery of best practice positive behavioural support. The PBS Coalition, a collection of individuals and organisations promoting PBS in the UK, has produced the framework. The competencies are outlined in Table A10.

#### Table A10: Positive Behavioural Support Competence Framework

|  | Things you need to do |
| --- | --- |
| **Competency Area 1. Creating high quality care and support environments** | |
| **1.1 Ensuring that services are values led** | 1. Show dignity, respect, warmth, empathy, and compassion in all interactions 2. Treat every individual as a person and provide support that is tailored to meet need 3. Arrange and support participation in community activities and events 4. Search out and support the development of relationships 5. Arrange and support participation in activities of everyday life 6. Arrange and support meaningful choice 7. Arrange and support opportunities for learning and development 8. Help and support behaviour and daily interactions that make the person look and feel good. 9. Minimise any restriction of activities or movement; and use positive handling strategies when needed in emergency situations |
| **1.2 Knowing the person** | 1. Develop a rapport with the person (can be evidenced by observing multiple positive interactions between the staff member and person supported) 2. Identify and describe how the person expresses enjoyment and displeasure in activities 3. Directly support the person to access things that are important to them (preferences) and balances this with the things that are required for them to have a good quality of life 4. Support the person across a range of activities and contexts 5. Reflect on your relationship with the person |
| **1.3 Matching support with each person’s capabilities and with goals and outcomes that are personally important to them** | 1. Collect information about a person’s strengths, needs, preferences, hopes, dreams and desires 2. Help schedule the implementation of personally important goals 3. Help measure progress toward personally important goals 4. Help check that implementation balances across areas of life, type of outcome and preferences |
| **1.4 Establishing clear roles and effective team work** | 1. Demonstrate appropriate level of support to the person, rather than doing too much for them, or not engaging with them 2. Demonstrate the difference between care and providing personalised and active support5 3. Act as a key worker for one person or more 4. Provide peer support to colleagues 5. Actively participate in teamwork; attend and participate in team meetings and supervision 6. Maintain proper work timetables; advise supervisor if work hours risk becoming unreasonable 7. Reflect on own actions and feelings, and how these impact on the actions and feelings of others 8. Seek support from supervisor/manager/peers when needed 9. Declare any personal and/or professional relationships that will or might impact on job role or organisation’s functioning 10. Attend to own physical, psychological and emotional wellbeing |
| **1.5 Supporting communication** | 1. Effectively communicate and support the use of core communication systems (e.g., nonverbal, verbal, gestural, pictorial/textual) in all interactions with others 2. Use appropriate communication with different people depending on needs 3. Actively support, develop and change communication systems for each person (e.g., keep a PECS symbols 10up to date, adapt to learning and behaviour change) 4. Contribute to the development of a detailed description of how best to communicate with the person 5. Demonstrate appropriate communication methods at team meetings, and daily interactions with persons and colleagues |
| **1.6 Supporting Choice** | 1. Provide experiences that enable the person to be able to make an informed choice in respect of activities 2. Present opportunities for the person to make meaningful choices 3. Teach choosing skills |
| **1.7 Supporting physical and mental health** | 1. Implement individual health care plans including competent administration of medication 2. Support individuals to maintain physical health and wellbeing (cleaning teeth, checking testicles, health eating choices, weighing self, and exercise) 3. Support access to health care systems, e.g. visiting GP 4. Identify and interpret an individual’s physical and emotional state from non-verbal behaviours (i.e. facial expression, body movements, other behaviour) 5. Correctly administer medication according to the agreed protocol 6. Record and report any medical administration correctly 7. Ask senior manager or clinician for support/advice when needed 8. Articulate what they might feel and think in response to the strategies that are being implemented |
| **1.8 Supporting relationships with family, friends and wider community** | 1. Actively engages with professionals and family, friends. 2. Actively supports friendships and relationships with others. 3. Communicates effectively with the person’s circle of support by supporting the person to maintain key relationships, facilitating contact, visits etc., keeping family members and friends informed, 4. Use formal and informal ways of sharing information 5. Seek advice from circle of support regarding best interest decisions |
| **1.9 Supporting safe, consistent and predictable environments** | 1. Use strategies to help the person predict, understand and control their environment (e.g., visual timetable or social stories) 2. Identify and avoid if possible aspects of the environment that may be a risk factor for challenging behaviour 3. Implement interventions designed to help people cope with challenging environments 4. Develop personal activity schedules with routinely occurring activities as anchors and a menu of other activities for choice and responsive flexibility |
| **1.10 Supporting appropriate levels of participation in meaningful activity** | 1. Identify activities a person likes and create opportunities for the person to make them a part of daily life 2. Help the person do something they like for most of the time 3. Help the person do things they do not like, but that are essential 4. Introduce new activities so that a person has more activities to choose from 5. Support the person to develop skills in order to do things as independently as possible 6. View complex activities as a series of simpler activities arranged in a sequence of steps that a person is able to do with help. 7. Adapt the level of help for each step so the person can join in as much as possible 8. Supply extra motivation and reward for low- or non-preferred activities 9. Schedule the day so the person has at least one activity available at all times, (most often more than one), and the support required to perform the activity 10. Intersperse low-preference and high-demand activities with low-demand high preference activities 11. Keep track of what people do to make sure it is often enough, of good quality, spread out in time, and has enough variety and interest |
| **1.11 Knowing and understanding relevant legislation** | 1. Identify and apply key points from relevant legislation 2. Participate in assessing mental capacity of the person in everyday care giving and interactions |
| **1.12 A commitment to Behaviour Skills Training** | 1. Participate in training programmes identified for all staff 2. Participate in specific training in the implementation of interventions or support that have been identified within a Behaviour Support Plan |
| **Competency Area 2. Functional, contextual and skills based assessment** | |
| **2.1 Working in partnership with stakeholders** | 1. Contribute necessary information to the assessment process 2. Support the person so that they are able to contribute to their own assessment 3. Support the person through any assessment procedures that may require their participation 4. Identify and describe who key stakeholders are, how and why they are involved in the assessment and implementation of the Behaviour Support Plan (BSP) 5. Communicate effectively and politely, listen to views of others and ask relevant questions when working with stakeholders |
| **2.2 Assessing match between the person and their environment and mediator analysis** | 1. Provide constructive input to PBS plan development in terms of the practical aspects of delivery 2. Identify barriers to implementation in both the assessment process and as they arise and raise concerns with the team 3. Seek support appropriately and provide appropriate support to others within the team 4. Identify and describe resources available; find information and seek guidance about resources as required |
| **2.3 Knowing the health of the person** | 1. Support the person through any medical assessment needed 2. Monitor health of person and report any changes that may necessitate assessment 3. Recognise and report any signs of distress in the person that may indicate a health problem |
| **2,4 Understanding the principles of behaviour (4 term contingency), how behaviour is learned and understanding the function of behaviour** | 1. Identify and clearly describe behaviour and environmental antecedents in observable and measureable terms (distinguishes between judgements and descriptions) 2. Identify and report other variables that might affect the person (e.g. illness, relocation, medication) 3. Recognise the effect of own behaviour on the person and adapts accordingly |
| **2.5 Supporting data driven decision making** | 1. Record data according to the agreed procedures |
| **2.6 Assessing the function of a person’s behaviour** | 1. Contribute to the assessment process as required 2. Support the person through the assessment process as appropriate 3. Support other key stakeholders through the assessment process as appropriate |
| **2.7 Assessing a person’s skills and understanding their abilities** | 1. Participate in a skills assessment as required 2. Support the person in a skills assessment as required 3. Objectively record levels of independence in tasks |
| **2.8 Assessing a person’s preferences and understanding what motivates them** | 1. Identify what is important for the person’s, likes and dislikes and contributes this information to the BSP 2. Distinguish between what is important to and important for the person |
| **Competency Area 3. Developing and implementing a Behaviour Support Plan; Evaluating intervention effects and on-going monitoring** | |
| **3.1 Understanding the rationale of a Behaviour Support Plan (BSP) and its uses** | 1. Understand and be able to implement a BSP accurately 2. Follow three steps of    * read and absorb each BSP for every person being supported    * be able to demonstrate that the strategies described are understood and followed correctly    * seek clarification for any aspect that is not understood 3. Take part in supervision and receive feedback on accuracy of implementation. |
| **3.2 Synthesizing data to create an overview of a person’s skills and needs** | 1. Contribute to the assessment process as part of a multi-disciplinary team: those who provide direct support often know the person best |
| **3.3 Constructing a model that explains the functions of a person’s challenging behaviour and how those are maintained** | 1. Identify the environmental variables associated with challenging behaviour for the person |
| **3.4 Devising and implementing multi-element evidence based support strategies based on the overview and model** | 1. Contribute to the identification of antecedent strategies included in a BSP. Be able to demonstrate that they are understood and followed correctly and raise concerns if it is not possible to put them in practice. 2. Ensure understanding of the teaching strategies and protocols within the BSP and question anything that is not fully understood 3. Teach and support a new skill / communication and/or increase a development of a skill/communication method already in the person’s repertoire based on PBS implementation plan (to include appropriate use of discriminative stimuli, prompting and reinforcement methods). This includes skills and communications that are functionally related to the challenging behaviour and those that are to be supported in a broader sense 4. Increases engagement levels for an individual via strategies outline in implementation plan 5. Demonstrate implementation of antecedent strategies related to the person’s plan that may include: Making changes to the physical environment, increasing choice and control, providing non-contingent reinforcement24, increasing individual support during demanding activities, supporting mental health and or physical health needs that serve as setting events for behaviour that challenges 6. Offer choice and promote independence 7. Increase engagement levels for an individual via strategies outline in implementation plan 8. Actively support and respond to change in the system about the person they are working with |
| **3.5 Devising and implementing a least restrictive crisis management strategy** | 1. Check own understanding of the crisis management strategies and protocols included in the BSP and question anything that is not fully understood 2. Identify early warning signs that challenging behaviour may occur. 3. Remain calm and implement crisis plan quickly, ensuring safety of everyone. 4. Identify where on cycle of arousal person is at and respond accordingly 5. Change strategies (e.g. lowers demands, clarifies routine)s at different stages of cycle 6. Record and report accurately (e.g. strategies used, details of the incident, injuries sustained). 7. Follow BSP - doing proactive first, least restrictive, safety, escape route, paperwork completed appropriately – show what already tried 8. Use knowledge from training when unplanned strategies are needed; make sensible judgements in unforeseen circumstances 9. Seek help for self when necessary 10. Implement ethical reactive strategies in practice 11. Reflect on experience of delivering reactive strategies |
| **3.6 Developing the plan; outlining responsibilities and timeframes** | 1. Check understanding of role and responsibilities within the BSP and question anything that is not fully understood 2. Be supportive to colleagues to understand the plan, especially new staff 3. Highlight any misunderstandings or difficulties in implementation to supervisor |
| **3.7 Monitoring the delivery of the BSP (procedural/treatment fidelity/integrity)** | 1. Identify the possible outcomes of failing to adhere to the BSP – e.g., increase challenging behaviour, prevent the person learning skills, not help the person to have a better quality of life 2. Reflect on own practice, and that of other team members and try to ensure that everyone follows the plan properly (ensure integrity of practice) 3. Monitor and report changes in challenging behaviour, acquisition of skills such as communication, participation in activities and other quality of life indicators 4. Complete records and other documents that help describe or monitor the implementation of the BSP 5. Identify and Report obstacles to successfully delivering the BSP (e.g. a new team member who does not understand a strategy, part of BSP out of date etc) 6. Provide feedback on what worked well and what could have worked better 7. Regularly attend and actively participate in supervision and review meetings |
| **3.8 Evaluating the effectiveness of the BSP** | 1. Describe the goals of the BSP as they relate to all relevant outcome variables e.g. why measure changes in challenging behaviour? 2. Gather data on outcome variables using agreed systems 3. Report progress and identify the factors that facilitate progress 4. Report lack of progress or obstacles to achieving outcomes |
| **3.9 The BSP as a live document** | 1. Actively participate in review meetings 2. Address any inconsistencies in the delivery of the BSP both in own practice and supporting others 3. Follow through on any changes to the BSP made in light of the monitoring and evaluation procedures |

Source: <http://www.skillsforcare.org.uk/Document-library/Skills/People-whose-behaviour-challenges/Positive-Behavioural-Support-Competence-Framework.pdf>

(Accessed January 2018)

##### Appendix A11: Competencies for frontline staff that support people with a dual diagnosis

The NADD is a US based association for people with developmental disabilities and mental health needs. They developed a set of competencies for frontline staff that support people with a dual diagnosis of intellectual or developmental disability and a mental illness (IDD/MI).[[12]](#footnote-12) They recognized a gap in identifying the specific competencies a frontline staff member should have for this work. As a result, they found that many staff are under-qualified and lack the support and training to perform to a high standard. This can make finding, hiring, training, and retaining qualified frontline staff difficult. As a result, many people with IDD/MI do not have adequate daily support. The competence of the frontline staff member can make a big difference in the quality of life for people.

NADD has developed a program to certify the competency of frontline staff that support people with a dual diagnosis. It was developed with a working committee of professionals. The dual diagnosis competencies identified five critical areas where frontline staff need additional skills and knowledge in order to be competent to care for individuals with IDD/MI. These five areas are important in all frontline work. However, they take on additional significance when supporting a person with IDD/MI. The five areas of competence are listed in Table A3 below with the associated benchmarks.

#### Table A11: Competencies of direct service providers who support people with a dual diagnosis

| Competency area | Benchmarks |
| --- | --- |
| 1. **Assessment and Observation** | 1. Knowledge of Assessment and Observation Process 2. Use of Assessment and Observation Tools 3. Behavioural Assessment 4. Documentation and Communication Related to Assessment and Observation |
| 1. **Behaviour Support** | 1. Knowledge and Assessment of the Causes and Functions of Challenging Behaviour 2. Maintaining a Supportive Physical and Social Environment 3. Responding to Challenging Behaviour 4. Teaching New Behaviours and Skills |
| 1. **Crisis Prevention and Intervention** | 1. Knowledge and Use of Crisis Prevention Strategies 2. Knowledge and Use of Crisis Intervention Strategies 3. Documentation and Communication Related to Crisis Situation 4. Managing Stress and Burnout |
| 1. **Health and Wellness** | 1. Knowledge of Health and Wellness 2. Knowledge Intellectual and Developmental Disabilities, Mental Health Disorders and Co-Occurring Disorders 3. Use and Implications of Medication (psychotropic and others) 4. Illness Management and Recovery 5. Documentation and Communication Related to Health and Wellness |
| 1. **Community Collaboration and Teamwork** | 1. Knowledge of Service Systems 2. Communication across Systems 3. Building Positive and Cooperative Relationships 4. Promoting Person-Centred Support, Informed Consent and Advocacy |

Source: The NADD Competency Based Direct Support Professional Certification Programme http://acp.thenadd.org/dsp-executive.htm

Appendix A12: Standards of Proficiency for Social Care Workers

CORU is the registration body for health and social care professionals in Ireland. The registration board sets out the requirements for approval of programmes. Students who successfully complete the programme meet the standards of proficiency for the profession and as a result are eligible to apply to join the register and practice. Although the term proficiency standard is used, it is taken here to by synonymous with competency. The proficiency standards are outlined in Table A12.

#### Table A12: Standards of Proficiency for Social Care Workers

| Proficiency standard | Description |
| --- | --- |
| 1. **Professional Autonomy and Accountability** | 1. Be able to practise safely and effectively within the legal, ethical and practice boundaries of the profession 2. Be able to identify the limits of their practice and know when to seek advice and additional expertise or refer to another professional 3. Be able to act in the best interest of service users at all times with due regard to their will and preference 4. Be aware of current guidelines and legislation relating to candour and disclosure 5. Respect and uphold the rights, dignity and autonomy of every service user including their role in the diagnostic, therapeutic and social care process 6. Be able to exercise a professional duty of care 7. Understand what is required of them by the Registration Board and be familiar with the provisions of the current *Code of Professional Conduct and Ethics* for the profession issued by the Registration Board 8. Recognise the importance of practising in a non-discriminatory, culturally sensitive way and acknowledge and respect the differences in beliefs and cultural practices of individuals or groups 9. Understand the role of policies and systems to protect the health, safety, welfare, equality and dignity of service users, staff and volunteers 10. Understand and respect the confidentiality of service users and use information only for the purpose for which it was given 11. Understand confidentiality in the context of the team setting 12. Understand and be able to apply the limits of the concept of confidentiality particularly in relation to child protection, vulnerable adults and elder abuse 13. Be aware of current data protection, freedom of information and other legislation relevant to the profession and be able to access new and emerging legislation 14. Be able to recognise and manage the potential conflict that can arise between confidentiality and whistle-blowing 15. Be able to gain informed consent to carry out assessments or provide interventions and document evidence that consent has been obtained 16. Be aware of current legislation and guidelines related to informed consent for individuals with lack of capacity 17. Recognise personal responsibility and professional accountability for one’s actions and be able to justify professional decisions made 18. Be able to take responsibility for managing one’s own workload as appropriate 19. Understand the principles of professional decision-making and be able to make informed decisions within the context of competing demands including those relating to ethical conflicts and available resources 20. Be aware of and be able to take responsibility for managing one’s own health and wellbeing 21. Be able to maintain professional boundaries with service users within a variety of social care settings and be able to identify and manage any associated challenges |
| 1. **Communication, Collaborative Practice and Teamworking** | 1. Be able to communicate diagnosis/assessment and/or treatment/management options in a way that can be understood by the service user 2. Be able to modify and adapt communication methods and styles, including verbal and non-verbal methods to suit the individual service users considering issues of language, culture, beliefs and health and/or social care needs 3. Recognise service users as active participants in their health and social care and be able to support service users in communicating their health and/or social care needs, choices and concerns 4. Understand the need to empower service users to manage their well-being where possible and recognise the need to provide advice to the service user on self-treatment, where appropriate 5. Be able to recognise when the services of a professional translator are required 6. Be able to produce clear, concise, accurate and objective documentation 7. Be able to apply digital literacy skills and communication technologies appropriate to the profession 8. Be aware of and comply with local/national documentation standards including, for example, terminology, signature requirements 9. Be able to express professional, informed and considered opinions to service users, health professionals and others e.g. carers, relatives in varied practice settings and contexts and within the boundaries of confidentiality 10. Understand and be able to recognise the impact of effective leadership and management on practice 11. Understand and be able to discuss the principles of effective conflict management 12. Understand the need to work in partnership with service users, their relatives/carers and other professionals in planning and evaluating goals and interventions, as part of care planning and be aware of the concepts of power and authority in relationships with service users 13. Understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team 14. Understand the role and impact of effective interdisciplinary team working in meeting service user needs and be able to effectively contribute to decision-making within a team setting 15. Understand the role of relationships with professional colleagues and other workers in service delivery and the need to create professional relationships based on mutual respect and trust 16. Understand the principles and dynamics of group work in a range of settings and be aware of the role of different facilitation techniques to improve outcomes and enhance the participation of service users in care 17. Be able to recognise all behaviour, including challenging behaviour, as a form of communication and demonstrate an understanding of the underlying causes in order to apply appropriate strategies |
| 1. **Safety and Quality** | 1. Be able to gather all appropriate background information relevant to the service user’s health and social care needs 2. Be able to justify the selection of and implement appropriate assessment techniques and be able to undertake and record a thorough, sensitive and detailed assessment 3. Be able to determine the appropriate tests/assessments required and undertake/arrange these tests 4. Be able to analyse and critically evaluate the information collected in the assessment process 5. Be able to demonstrate sound logical reasoning and problem solving skills to determine appropriate problem lists, action plans and goals 6. Be able to demonstrate an evidence-informed approach to professional decision-making, adapting practice to the needs of the service user and draw on appropriate knowledge and skills in order to make professional judgments 7. Be able to prioritise and maintain the safety of both service users and those involved in their care 8. Be able to evaluate intervention plans using appropriate tools and recognised performance/outcome measures along with service user responses to the interventions. Revise the plans as necessary and where appropriate, in conjunction with the service user 9. Understand the need to monitor, evaluate and/or audit the quality of practice and be able to critically evaluate one’s own practice against evidence-based standards and implement improvements based on the findings of these audits and reviews 10. Be able to recognise important risk factors and implement risk management strategies; be able to make reasoned decisions and/or provide guidance to others to initiate, continue, modify or cease interventions, techniques or courses of action and record decisions and concerns 11. Understand the principles of quality assurance and quality improvement 12. Be able to carry out and document a risk analysis and implement effective risk management controls and strategies; be able to clearly communicate any identified risk, adverse events or near misses in line with current legislation/guidelines 13. Be able to comply with relevant and current health and safety legislation and guidelines and be able to access recommendations and findings of inquiries, investigations and associated reports relevant to social care 14. Be able to establish safe environments for practice which minimises risks to service users, those treating them and others, including the use of infection prevention and control strategies 15. Be able to identify and document the unmet needs of individual service users and demonstrate an ability to select the appropriate escalation route working with colleagues and the service user to resolve the gap in care |
| 1. **Professional Development** | 1. Be able to engage in and take responsibility for professional development 2. Understand the need to demonstrate evidence of ongoing continuing professional development and education, be aware of professional regulation requirements and understand the benefits of continuing professional development to professional practice 3. Be able to evaluate and reflect critically on own professional practice to identify learning and development needs; be able to select appropriate learning activities to achieve professional development goals and be able to integrate new knowledge and skills into professional practice 4. Understand and recognise the impact of personal values and life experience on professional practice and be able to manage this impact appropriately 5. Understand the importance of and be able to seek professional development, supervision, feedback and peer review opportunities in order to continuously improve practice 6. Understand the importance of participation in performance management activities for effective service delivery |
| 1. **Professional Knowledge and Skills** | 1. Know, understand and apply the key concepts of the domains of knowledge which are relevant to the profession 2. Understand and be able to apply principles of social justice in one’s work including being able to challenge negative discrimination and unjust policies and practices; demonstrate an understanding of cultural competence; and work towards social inclusion 3. Understand and apply a human rights based approach (HRBA) to one’s work including the promotion of the service user’s participation in his or her care; ensure clear accountability; apply principles of non-discrimination; empower other staff members and service users to realise their rights; be aware of the legality of actions within a service including the need to comply with any relevant legislative requirements including adhering to human rights obligations 4. Demonstrate a critical understanding of relevant biological sciences, human development, social and behavioural sciences and other related sciences, together with a knowledge of health and wellbeing, disease, disorder and dysfunction relevant to the role of social care worker 5. Know and understand the principles and applications of scientific enquiry, including the evaluation of intervention efficacy, the research process and evidence-informed practice 6. Demonstrate skills in evidence-informed practice, including an understanding of competing theories, concepts and frameworks underpinning social care work and demonstrate an ability to apply the appropriate method in professional practice 7. Demonstrate an understanding of the theories of individual and social development across the lifespan and contexts and within different cultures including the knowledge required to work with individuals, children, persons with disabilities, families and marginalised groups 8. Be able to analyse activity and adapt environments to enhance participation and engagement in meaningful life experiences and positively influence the health, well-being and function of individuals, families, groups and communities in their everyday activities, roles and lives 9. Demonstrate safe and effective implementation of a range of practical, technical and professional practice skills relating to the specific needs of the service user in a range of social care settings 10. Be able to identify and understand the impact of social care history, organisational, community and societal structures, systems and culture on social care provision 11. Recognise the role of advocacy in promoting the needs and interests of service users, and understand the influence of system-level change to improve outcomes, access to care, and delivery of services, particularly for marginalised groups 12. Understand the role of creative arts as an intervention and demonstrate knowledge of a variety of creative practices and techniques in social care work to meet the needs of the service user in a variety of contexts 13. Demonstrate ability to participate in or lead clinical, academic or practice-based research 14. Know the basic principles of effective teaching and learning, mentoring and supervision 15. Demonstrate an understanding of the importance of one’s own personal growth and development in order to engage in effective professional practice whilst developing the personal skills of self care and self-awareness in the role   . |
| 1. **Creativity** | 1. We will be innovative by:    * using different situations to stimulate our service users    * being open to change    * putting forward new ideas and new activities    * allowing freedom of expression    * adopting new ways of doing things    * allowing service users to experience new things    * planning new food menus    * utilising the strengths and interests of both staff and service users    * appreciating the service users’ creative approach to tasks, i.e. projects, rather than expecting them to conform to staff’s ideas on how things should be done. 2. We will be imaginative by:    * giving service users the opportunities to approach activities with an “open mind”    * trying new ideas/activities with existing materials    * having variety in schedules and daily routines    * allowing service users the opportunity to choose their own social outings    * looking and examining the activities provided by the Service through the eyes of service users, their families and carers    * setting up new groups suitable to the particular clientele, e.g. retirement groups    * using drama to facilitate service user led fantasy and creative expression. 3. We will be resourceful by:    * presenting service users with a range of choices and giving adequate support to maintain this    * encouraging participation in a wide variety of activities    * researching and knowledge expansion of the benefits of all areas of activation    * asking questions and learning from service users and from our coworkers    * sharing information and co-operating with one another with particular reference to new ideas    * seeking out the support of other agencies e.g. Arts Council. |

Source: CORU, 2016

##### Appendix A13: Quality and Qualifications Ireland (QQI) Level V Course in Intellectual Disability Practice

Having a relevant QQI Level 5 qualification is a basic requirement to access work as a Care Assistant, Special Needs Assistant, Health Care Assistant or Social Care Assistant in a large number of organisations in Ireland. It is an applied programme dealing with real world challenges. The purpose of this award in Intellectual Disability Practice is to, enable the learner to acquire the knowledge, skill and competence to work independently and under supervision applying best practice to enabling individuals with an intellectual disability to reach their potential and live the lives of their choosing and or to progress to further and or higher education and or training. The competencies are outlined in table A13.

#### Table A13: QQI Level V course in intellectual disability practice

| Competency | Description |
| --- | --- |
| 1. **Context** | Apply a range of knowledge and skills in a wide variety of different contexts in enabling persons with an intellectual disability to develop socially valued roles and relationships. |
| 1. **Role** | Demonstrate initiative and independence through working with a diverse range of groups and or teams in facilitating persons with an intellectual disability to develop socially valued roles and relationships. |
| 1. **Learning to learn** | Critically evaluate own learning experiences and implement changes when working and communicating effectively as part of a team. |
| 1. **Insight** | Reflect on personal practice to inform self-understanding and personal development. |

Source: <https://qsearch.qqi.ie/WebPart/AwardDetails?awardCode=5M1761> (Accessed January 2018)

**Appendix A14: National Frontline Supervisor Competencies**

The Minnesota based Research and Training Centres on Community Living developed the National Frontline Supervisor Competencies that, is an evidence-based set of knowledge, skills, and abilities that reflect best practice in the supervision of frontline workers who work with individuals with disabilities in residential, work, and community settings (Sedlezky et al, 2013).

The competencies were informed by a previous comprehensive job analysis done by the centre to identify the specific knowledge, skills, and attitudes required of Frontline Supervisors (Hewitt et al, 1998). Using these data and the data from a 2007 National Validation Study (Larson et al, 2007) a prioritization process was undertaken based on how important people in the study ranked each statement. A content analysis of best practices and contemporary service model skills was then conducted, including self-determination, person-centred services, community inclusion, professionalism, and cultural competency. Competency statements were then updated to more adequately reflect best practice. The review process also identified that the current competency areas did not adequately capture future service delivery designs and settings so additional competency areas were added such as remote supervision, the use of technology, and cultural competency. Competencies relating to building and promoting a highly qualified direct support workforce through recruitment, retention and training were also included.

The National Frontline Supervisor Competencies were reviewed by a panel of subject matter experts representing stakeholders in the intellectual and developmental disabilities services and in workforce development fields. These supervisor competencies are based on the assumption that the supervisor is competent in the NADSP competencies described in Appendix A2 above. As many supervisors are promoted to the role from the position of frontline worker, they usually enter their role already having developed these competencies (Sedlezky et al, 2013). The final competency framework includes the following 11 competency areas outlined in Table A14.

#### Table A14: National Frontline Supervisor Competencies

| Competency Area | Skills Statements |
| --- | --- |
| 1. **Direct support** | 1. Complete all direct support tasks competently and thoroughly when scheduled, demonstrate best practice in person-centred support, and be an exemplary direct support role model for the DSPs she or he supervises. 2. Provide support that demonstrates respect and value for diversity in cultural practices and all aspects of participant’s life. 3. Communicate effectively with participant using active listening skills, responding to requests and concerns, and interacting using most culturally competent and effective methods of communication. 4. Actively observe for signs of neglect, maltreatment, or violation of rights, and take immediate action to remedy situation and support advocacy in this process, reporting internally and to outside agencies as required by law and in the best interest of participant. 5. Assist participant to create a physical environment that is accessible, comfortable, and meets his or her unique style and needs. 6. Use interactions and observations as opportunities to critically evaluate and analyse the quality of supports provided to participant, and strive for ongoing quality improvement. 7. Encourage participant to be as engaged as possible in all aspects of his or her daily life, teaching as necessary. 8. Support participant in making and maintaining relationships by identifying, planning for, and supporting participation, contribution, and engagement in events and activities that support these. |
| 1. **Health and safety** | 1. Develop and monitor a unique risk management plan for participant that addresses all areas of health and safety, and provide guidance to DSPs in reducing and managing those risks in conjunction with the person supported. 2. Promote healthy living by ensuring DSPs have the information and training necessary to support participant in making healthy choices while respecting participant’s preferences. 3. Recognize the eight dimensions of wellness as social, environmental, physical, emotional, spiritual, occupational, intellectual, and financial, and develop a support plan directed by participant that includes important domains. 4. Access generic health and wellness activities offered in the community whenever possible to help participant engage in healthy behaviour and connect to naturally existing social support and peers. 5. Develop plan and oversee DSP administration of medications and treatments for participant, including active ongoing assessment of participant’s wellbeing in response to the medication. 6. Monitor participant for signs of illness or health-related concerns, and respond by implementing treatments, reporting issues to health care professionals and participant’s family as appropriate, documenting as needed, and ensuring coordination between care providers. 7. Ensure that infection control procedures are used as necessary and in accordance with best practice and OSHA/CDC recommendations. 8. Support participant and his or her support network in making informed decisions about health care plans by promoting understanding of available medical interventions, procedures, medications, and treatment options. 9. Ensure DSPs provide sufficient support and oversight to help participant follow health care provider’s orders in accordance with organization policies and procedures and as defined by participant’s needs or specific wishes. 10. Ensure participant receives both routine and emergency medical care related to physical and mental health, therapeutic services, and dental care, and coordinate transportation or take participant to related appointments. 11. Facilitate services with health care providers by obtaining informed consent and release of information from participant or participant’s legal decision maker, sharing necessary information with health care provider, and advocating when necessary to ensure proper and competent care. 12. Identify local emergency plans and hazards that affect local area, develop and maintain an emergency communications plan and disaster supplies kit, and ensure fire/emergency drills are completed and documented as required by best practice and OSHA/CDC recommendations. 13. Actively seek medical and dental practitioners who provide high quality services in the community and can work within participant’s budget, needs, and current health plan. 14. Order medical supplies, interact with pharmacies, and arrange for supplies and medications to be picked up or delivered as needed or as requested by participant or family. 15. Ensure records are maintained that are easy to use and provide the most critical information regarding health and wellness needs of participant. 16. Support participant to identify his or her choices related to end of life care, and assist participant in expressing these wishes to his or her family members and/or legal guardian. |
| 1. **Participant support plan development, monitoring, and assessment** | 1. Identify participant’s individual preferences and needs, and ensure service planning and implementation are designed to meet his or her preferences and needs. 2. Coordinate and/or conduct assessments of participant preferences, capabilities, and needs by using appropriate assessment strategies, involving legal decision makers, explaining the process to participant throughout, and discussing findings and recommendations with participant. 3. Coordinate, facilitate, or engage a facilitator in person-centred and participant-directed planning meetings for participant, or assist DSPs in this planning process. 4. Develop individual support plan in partnership with participant and his or her support networks and support them in monitoring the implementation of participant support plan. 5. Coordinate the development of services for new participant in partnership with person being supported and his or her family and/or support network. 6. Identify additional resources for participant and DSPs, or for changes to service delivery, both within and outside of supporting organization, and advocate for these resources with managers. 7. Using positive behaviour support strategies, develop, implement and monitor support plans designed to teach self-management and promote wellness, recovery, and crisis prevention when a person being supported engages in challenging or risky behaviour. 8. Coordinate and enhance support by communicating necessary information and maintaining positive working relationships with staff from other agencies, family, or allies that provide supports to participant as appropriate. 9. Maintain consumer records (hard copy and/or electronic) by completing necessary documentation according to best practices in data privacy, confidentiality, HIPAA compliance, and data management. |
| 1. **Facilitating community inclusion across the lifespan** | 1. Ensure that services are not engaged in ways that create barriers to maintaining positive relationships with family, friends, co-workers, or other community members. 2. Consult and engage members of participant’s support network (as appropriate and desired by participant) in efforts to identify and support the preferences for relationships and activities, as well as problem-solve any issues or challenges regarding these activities. 3. Promote positive relationships between participant, staff, and other individuals in participant network and the community at large. 4. Support participants facing age-related issues such as grief, loss, and declining health, by demonstrating healthy boundaries, care, empathy, and engaging participants in natural community supports. 5. Support participant in community educational, recreation, leisure, retirement, and employment opportunities, and facilitate coordination with generic community agencies to provide inclusive opportunities for participant. 6. Use information about participant’s hobbies, skills, and interests to assist participant in identifying desired educational, employment, or volunteer opportunities (in partnership with members of participant’s support team when appropriate). 7. Identify various stakeholders to ensure education, employment, volunteer, and retirement supports are appropriate and effective. 8. Assist participant in accurately and thoroughly completing education, membership or employment-related applications. 9. Ensure participant understands his or her right to not answer application questions about his or her disability by discussing the Americans with Disabilities Act and disability disclosure, and support participant in dealing with these situations in interviews. 10. Work with community guides and hire staff with linguistic and cultural competence to meet the unique needs of each individual. 11. Develop new jobs and procure new work in partnership with participant who works in community businesses or who receives support in employment support services. 12. Oversee participant’s work, workload, and schedule based on his or her individual preferences and needs, and ensure that Federal and local agency standards are met. 13. Oversee services to participant preparing for entry into educational, employment, or volunteer positions, and review opportunities for continued training and professional development. 14. Help participant and support team identify resources such as transportation, funds, and contacts within the community to ensure participant remains engaged in preferred community activities. 15. Support participant in coordinating, participating in, and/or facilitating support network meetings and participant council meetings. 16. Assist participant in the use of assistive, mobile, and other technology to support independence and meaningful engagement in the community, including virtual communities. |
| 1. **Promoting professional relations and teamwork** | 1. Facilitate teamwork and positive interactions among teams and between DSPs by managing conflict and providing counselling and support to DSPs as needed in all work sites, particularly for DSPs who work in remote settings. 2. Ensure DSPs at remote sites are not left without proper supervision and engage proactive strategies such regular as video chats, feedback from others, and other methods of regular communication to keep DSPs engaged and effective. 3. Use technology such as phone, email, text messaging, and video chats effectively in supervisory tasks and recognize in which situation each type of communication is best. 4. Respond to DSPs questions and crises when on-call and/or providing remote supervision, facilitating debriefing sessions and providing emotional support to DSPs as needed. 5. Maintain appropriate boundaries regarding personal vs. Professional issues, and educate and support DSPs in maintaining healthy professional boundaries. 6. Involve and empower DSPs by taking a direct interest in their roles and responsibilities, encouraging DSPs to try new ideas, seeking DSPs’ opinions and input regarding various issues, and empowering DSPs to make decisions. 7. Teach, model, and coach DSPs in the most effective approaches to achieve the direct support competencies. 8. Promote increased understanding among team members of individual differences and perspectives as it relates to teamwork and individual support services. 9. Maintain appropriate confidentiality in communication related to participant, and inform appropriate people when confidentiality cannot be kept. 10. Report and discuss participant-, family-, staff-, and individual support service-related issues and procedures with management, support staff, and other supervisors as needed. 11. Coordinate and facilitate staff meetings, ensuring a sense of trust and openness, and encouraging group participation and ownership. |
| 1. **Staff recruitment, selection, and hiring** | 1. Use best practices in recruitment activities to maximize the chances of finding DSPs who are likely to be a good match to the position and participant. 2. Effectively screen applicants before an interview, and conduct an interview using structured behavioural questions and other assessments based on identified competencies. 3. Develop and use Realistic Job Previews using the five key characteristics and appropriate delivery method for the setting and participant. 4. Schedule and complete interviews with potential new staff, and make hiring decisions in partnership with peers, participant, his or her family members, and organization staff. 5. Assess staff functional ability and capacity, ensure health physicals are completed (as required or needed), address identified ADA issues, and arrange for criminal background checks and driver’s license reviews (as required or needed) for newly hired staff. 6. Support and advocate for recruitment, admissions and hiring, and retention efforts that ensure a diverse employee pool. 7. Collect, measure, and evaluate turnover, tenure, vacancy rates, and employee job satisfaction (as is appropriate to the work setting), and design and implement effective interventions to promote retention including improving organizational personnel practices. 8. Recruit and mentor community volunteers and intern students in partnership with participant. 9. Use culturally competent practices in recruitment, selection, and hiring. |
| 1. **Staff supervision, training, and development** | 1. Provide on-boarding to new staff using a variety of orientation strategies, including the use of mentors and peer-to-peer feedback, and coordinate and document staff participation in orientation, training, and self-directed learning and professional development activities. 2. Promote the ongoing competency-based training and development of DSPs by effectively supporting DSPs in creating and updating professional development plans, and sharing resources related to best practices, emerging trends, and evidence-based practices. 3. Provide required training to DSPs on the needs of participant, attending to all relevant rules, regulations, the NADSP Code of Ethics, and other professional codes using a variety of competency-based training methods to address different learning styles. 4. Use a variety of methods and styles to provide coaching and feedback to DSPs regarding performance issues, including demonstrating correct performance and implementing necessary disciplinary action. 5. Build ongoing development of cultural awareness within staff body to promote effective communication and professional relationships. 6. Observe and solicit feedback from DSPs, participant, and his or her family regarding DSP training needs, and identify potential resources and other opportunities for training. 7. Complete staff performance reviews, and/or assist participant and his or her family to complete performance reviews, by gathering input from peers, participant, his or her family members, and organization as required by policy and procedures. 8. Complete salary reviews and make recommendations regarding increases and other means of recognition, including opportunities for promotion and staff celebrations. 9. Develop staff schedules, and/or assist participant and his or her family to develop staff schedules, within budgetary limitations, under union and organizational policies and rules, and in response to participant needs. 10. Solicit and approve staff time cards, approve staff leave, and secure staff to fill-in when vacancies occur. 11. Operate and manage multiple sites and remote locations, fostering a common vision of service delivery, and ensuring that DSPs complete core job tasks as required and expected. 12. Complete necessary paperwork for changes in staff status, developing and modifying staff job descriptions as needed, and/or assist participant and his or her family to do so. 13. Monitor, review, and implement labour contracts, attend labour management meetings, and respond to formal grievances when applicable, including following up on reports of staff injury at work and all workers’ compensation related issues. |
| 1. **Service management and quality assurance** | 1. Design, implement, and evaluate strategies to identify desires, preferences, issues, concerns, and other supports for participant while respecting participant’s rights. 2. Participate in and respond to issues identified in licensing reviews, audits, and quality assurance monitoring activities, including Protective Service investigations. 3. Maintain regular contact with participant, his or her family members, and support team members regarding concerns identified in participant satisfaction surveys. 4. Effectively communicate (verbally and in writing) in a concise and timely manner, ensuring the privacy of others and using respectful and person centred language. 5. When delegating responsibilities, provide instructions and resources to staff to ensure successful completion of tasks. 6. Be knowledgeable about, and ensure compliance with, all Federal and state rules, regulations, and policies specific to each work setting. 7. Maintain a safe environment by coordinating internal or external services, or performing duties as needed, to ensure maintenance and safety. 8. Prioritize tasks and responsibilities in order of importance to ensure that deadlines are met, delegating tasks or duties to staff as they are capable of achieving. 9. Manage, or assist in the management of, financial accounts, including participant bills and petty cash accounts as needed and as appropriate according to setting. 10. Manage all required financial documentation, including staff expense reimbursement reports, budget reports, and organization asset and depreciation inventories. 11. Complete annual paperwork to ensure that Medical Assistance, SSI, and other related government benefits are current for participant, and make adjustments or establish new per diem rates in partnership with participant. 12. Solicit the input of participant and his or her family in the development of organization policies and procedures as well as federal and state rules and laws. 13. Write, review, and update organization policies and procedures in response to licensing reviews, changes in rules and regulations, and participant needs. 14. Effectively complete administrative tasks, learning and using technology to promote efficiency. 15. Learn and remain current with appropriate and secured documentation systems, including electronic methods. |
| 1. **Advocacy and public relations** | 1. Promote self-advocacy when participant faces barriers to service needs, including educating and lobbying decision-makers. 2. Interact with and educate community members and organizations when relevant to participant’s needs or services. 3. Identify strategies and implement methods to improve the status and image of people supported and DSPs. 4. Provide education to community members regarding the organization and people with disabilities, in partnership with participant advocacy groups and organizational or community efforts. 5. Assist in the development of educational and promotional materials, including newsletters, newspaper articles, brochures, videos, and contacts with media. 6. Collaborate with and maintain relationships with community vendors, landlords, and other service agencies within the community. 7. Demonstrate knowledge of current laws, services, and community resources to assist and educate participant to secure needed supports. 8. Teach advocacy skills such as record-keeping, calm and objective descriptions of problems, persistence, and utilizing legal services or professional advocates to participant, DSPs, and families as needed. 9. Be knowledgeable about systems and advocacy issues in the community, and educate participants, families, and others as needed or desired. 10. Connect people to community resources that can help them with their advocacy issues. |
| 1. **Leadership, professionalism, and self-development** | 1. Employ effective leadership strategies for problem-solving, decision making, and conflict management. 2. Recognize own personal biases, stereotypes, and prejudices to maintain objectivity when interacting with others. 3. Demonstrate sensitivity and respect for the opinions, perspectives, customs, and individual differences of others, and actively seek opinions and ideas from people of varied background and experiences to improve decisions. 4. Complete duties with integrity by staying focused on the individual being supported, being honest, showing respect towards others at all times, and completing tasks in a timely and effective way. 5. Maintain professionalism by managing own stress, balancing personal and professional life, taking vacations and breaks, and utilizing stress management practices. 6. Complete required training education/certification, and continue professional development and development of expertise by keeping abreast of evidence-based best practices, technology, and relevant resources that will enhance knowledge and leadership in practice. 7. Actively participate in personal professional development plan by identifying occupational interests, strengths, options, and opportunities. 8. Attend and actively contribute to organizational activities, including planning and development activities, and leadership team meetings. |
| 1. **Cultural awareness and responsiveness** | 1. Ensure that media and printed information displayed within and disseminated by organization positively reflects the different cultures, languages, and literacy levels of individuals and families supported by organization. 2. Seek bilingual/bicultural or multilingual/multicultural staff, or volunteers who are skilled in the provision of medical interpretation services, during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance. 3. Intervene in an appropriate manner when other DSPs or participants within organization are observed engaging in behaviours that show cultural insensitivity, racial biases, and/or prejudice. 4. Recognize that the meaning or value of health, wellness, preventative health services, and medical treatment may vary greatly among cultures, acknowledging that individuals and families are the ultimate decision makers for services and supports impacting their lives. 5. Seek information from individuals, families, or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups supported by the organization. |

Source: Sedlezky, 2013

##### Appendix A15: Management Competency Framework for Health and Social Care Professions

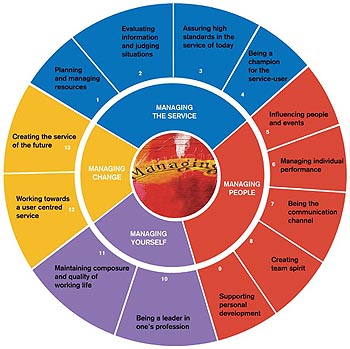
The second management example is in an Irish context where the need for the development of management competencies was identified in a report from the Expert Group on Various Health Professions[[13]](#footnote-13) (2000) and by the Action Plan for People Management[[14]](#footnote-14) (2002). The latter Action Plan highlighted the evidence of a gap between the skills and competencies perceived as most critical to delivering today’s health service and those actually possessed by managers. It acknowledged that in many organisations people are promoted into people management positions based on their proficiency in their existing job, rather than any demonstration of people management competencies.

In 2001, the Office for Health Management commissioned research to develop a Management Competency Framework for Health and Social Care Professions.[[15]](#footnote-15) A steering group including the Department of Health and Children, unions, human resource directors, and the Office of Health Management oversaw it. This research resulted in a clear, research-based statement of the skills and attributes required of effective managers in these roles. The competencies were intended to help managers to deliver on the priorities for their organisations and are divided into four sub-headings as outlined in Table A15. Figure A1 shows the same information in the form of a competency wheel.

#### Table A15: Management Competency Framework for Health and Social Care Professions

| Competency Groupings | Competency |
| --- | --- |
| 1. **Managing the Service** | 1. Planning and managing resources 2. Evaluating information and judging situations 3. Assuring high standards in the service of today 4. Being a champion for the service-user |
| 1. **Managing People** | 1. Influencing people and events 2. Managing individual performance 3. Being the communication channel 4. Creating team spirit 5. Supporting personal development |
| 1. **Managing Yourself** | 1. Being a leader in one’s profession 2. Maintaining composure and quality of working life |
| 1. **Managing Change** | 1. Working towards a user centred service 2. Creating the service of the future |

Source: Office for Health Management, 2001 <https://pnd.hseland.ie/corp/ohmpublications/newsletter/20030605145619.html> (Accessed April 2018, if username and password is requested just click cancel)



**Figure A1: Health and Social Care Professional competency wheel.**

##### Appendix A16: National Occupational Standards for Leadership and Management in Care Services

National Occupational Standards (NOS) in the UK are statements of the standards of performance individuals must achieve when carrying out functions in the workplace, together with specifications of the underpinning knowledge and understanding. The NOSs are statements of effective performance, which have been agreed by a representative sample of employers and other key stakeholders and approved by the UK NOS Panel.

In the UK’s National Occupational Standards Database, there are 33 performance criteria for leadership and management in care services. A selection of five of these performance criteria have been selected along with the corresponding standard and skill statements and are presented in the table A16 below.

#### Table A16: National Occupational Standards for Leadership and Management in Care Services

| Standard | Skill statement |
| --- | --- |
| **Performance criteria 1. Contribute to the strategic policies of care services** | |
| 1.1 Critically evaluate the impact of strategic policies on your service provision | 1. review the strategic policies for the service provision provided by the organisation 2. lead work with individuals and others to identify the criteria and indicators that should be used to measure the impact of the organisation’s strategic policies on the service provision 3. lead work with individuals and others to identify methods that should be used to measure the impact of the organisation’s strategic policies on the service provision 4. lead work with individuals and others to identify how and when they should contribute to the evaluation 5. lead work with individuals and others to evaluate the impact of the organisation’s strategic policies on the service provision 6. use evidence to record and report on the processes, procedures and outcomes from the evaluation |
| **1.2 Critically evaluate and implement strategic plans for the development of your provision** | 1. regularly contact and work with leaders and managers of different service provisions within your organisation 2. critically evaluate with managers from other service provisions, how well strategic policies meet the needs of individual and differing service provisions across the organisation 3. use evaluation to take action to optimise the strengths and opportunities offered by the organisation’s strategic policies 4. use evaluation to take action to address the weaknesses and threats created by the organisation’s strategic policies 5. identify specific and general issues relating to strategic policies of the organisation that may impact on the service provision |
| 1.3 Provide feedback on strategic policies to influence the direction of the service | 1. identify areas where strategic policies work well for individuals, key people and others 2. identify areas where strategic policies need to be improved and changed 3. provide feedback to relevant people in the organisation about the strengths and weaknesses of the strategic policies in meeting the needs of the service provision and contributing to the outcomes for individuals 4. recognise the aspects of the organisation and service provision that have been successful in achieving positive outcomes for individuals 5. identify areas where strategic policies could be adapted and changed to better support outcomes for individuals and the service provision 6. make suggestions about how strategic policies could be improved so that they could better meet current and future needs of the service provision 7. make suggestions about the direction of the organisation and how it could be changed to meet current and future demands of the service provision 8. use evidence to record and report on suggestions, priorities and the changing needs of the service provision in terms of the strategic policies and priorities of the organisation |
| **Performance criteria 2. Lead and manage change within care services** | |
| **2.1 Lead the implementation of a shared vision for the service provision** | 1. development of a shared vision for the service provision 2. consult with individuals, key people and others to develop a shared vision for the service provision 3. develop a communication strategy to relay the shared vision to individuals, key people and others 4. clarify to individuals, key people and others how the delivery of a high quality service and the achievement of positive outcomes is reflected in the shared vision 5. use a range of leadership styles and approaches to implement the vision in ways that are reflective, flexible, motivating and inclusive 6. manage the operation of the service and its workers effectively and openly 7. identify internal and external barriers that may hinder the service provision fulfilling its vision and achieving positive outcomes for individuals 8. take action to address barriers that hinder the achievement of the service provision and positive outcomes for individuals 9. recognise and celebrate successes of the service provision 10. engage with individuals, key people and others to review and adapt the vision of the service provision to meet its changing needs |
| **2.2 Develop a culture within the service provision that is open and facilitates participation** | 1. develop a culture within the service provision that is open, safe and inclusive and acknowledges and values diversity 2. lead practice that facilitates the participation of individuals, key people and others in the service provision 3. lead practice that recognises and respects individuals’ background and preferences 4. ensure that individuals, key people and others understand the Code of Practice and how it is used to support best practice in care services 5. ensure own and others practice maintains appropriate professional boundaries with individuals, key people and others 6. ensure that individuals, key people and others are aware of what can be expected from the service provision and those responsible for delivering it 7. develop reflective practice within the service provision where individuals, key people and others are able to learn from positive and negative experiences 8. recognise practice that contributes to the achievement of agreed service provision performance indicators and positive outcomes for individuals 9. encourage innovation and creativity within the service provision 10. regularly engage with individuals, key people and others to ensure awareness of any issues that may affect the service provision 11. ensure that individuals, key people and others know how they can express compliments and concerns or make complaints about the service provision 12. inspire confidence by responding efficiently, positively and constructively to any issues, compliments, concerns or complaints raised by individuals, key people or others 13. address poor practice of workers within the service provision |
| **2.3 Promote a positive image of the service provision** | 1. act as a positive role model for individuals, key people and others 2. act as an ambassador for the service provision 3. present decision makers with clear, accurate, succinct and timely information about positive outcomes achieved by the service provision 4. use a range of methods and strategies to promote the service provision as one that inspires confidence and achieves positive outcomes for individuals 5. make links between the service provision and other agencies or networks that will support the achievement of its vision and promote positive outcomes for individuals |
| **2.4 Lead and manage change within the service provision** | 1. facilitate a shared understanding of the need for change within the service provision 2. critically analyse the challenges that may arise during the process of change 3. critically analyse the impact of a proposed change to the viability of the service provision 4. produce a change management plan that takes account of the identified impact and views of individuals, key people and others 5. establish criteria against which the plan can be evaluated 6. secure any approvals required for the change management plan 7. implement a communication strategy to support individuals, key people and others to understand proposed changes 8. support individuals, key people and others to cope with change 9. agree roles and responsibilities for the implementation of the change management plan 10. support others to carry out agreed roles and responsibilities in the change management plan 11. adapt the change management plan to address issues as they arise 12. establish strategies for ensuring that the quality of service for individuals is maintained during times of change 13. agree systems to monitor the effectiveness of the change management plan 14. work with individuals, key people and others to review the change management plan against agreed criteria 15. critically evaluate the outcomes of change for individuals |
| **Performance criteria 3. Lead and manage service provision that promotes the well being of individuals** | |
| **3.1 Lead and manage service provision that involves individuals in decisions about the outcomes they wish to achieve** | 1. implement systems, procedures and practice that support person centred approaches that contribute to the identification and achievement of positive outcomes for individuals 2. lead practice that supports individuals to make decisions and take control over their lives 3. lead practice that ensures the active participation, independence and responsibility of individuals 4. lead practice that recognises and respects individuals’ background and preferences 5. ensure that workers have access to development opportunities that support them to develop the knowledge, understanding and skills needed to work with individuals to identify and achieve positive outcomes 6. ensure that workers work with individuals to establish their history, preferences, wishes and needs 7. develop a culture that empowers individuals to make decisions about the positive outcomes they wish to achieve 8. ensure that individuals are encouraged and supported to identify how they wish to achieve positive outcomes 9. ensure workers use risk management plans to support individuals to achieve positive outcomes 10. support workers to identify the resources required for individuals to achieve positive outcomes 11. manage resources so that individuals are supported to achieve positive outcomes 12. monitor the practice of workers to ensure that individuals are involved in choices about positive outcomes for themselves and decisions about all aspects of their lives 13. ensure that individuals receive advice, guidance and support from workers and others to assist them to achieve positive outcomes 14. ensure workers implement plans to achieve positive outcomes 15. ensure workers monitor the achievement of positive outcomes 16. employ strategies to manage conflict of interest, differences of opinion and dilemmas that may arise between individuals, workers, key people and others 17. lead work with individuals, key people, workers and others to evaluate the achievement of positive outcomes 18. ensure that the contribution of individuals, key people and workers to the achievement of positive outcomes is recognised and celebrated 19. ensure that accurate records and reports are kept on the identification and achievement of positive outcomes for individuals 20. critically analyse the use of outcome based practice on the achievement of positive outcomes for individuals 21. interpret the analysis of outcome based practice to report on areas of good practice and areas to be improved 22. identify changes required to meet areas that need to be improved 23. identify the resources required to implement recommended changes |
| **3.2 Lead and manage practice that promotes individuals’ social, emotional, mental, cultural, spiritual and intellectual well being** | 1. implement systems, procedures and practice that support the well being of individuals in the context of personal, legislative, regulatory and organisational requirements 2. develop a culture where workers consider all aspects of the well being of individuals in their day to day practice 3. provide workers with development opportunities to support them to develop the knowledge, understanding and skills needed to promote individuals’ well being 4. monitor the practice of workers to ensure that they are taking account of all aspects of the well being of individuals in their day to day work 5. manage practice that supports individuals to develop positive, secure and healthy attachments and relationships 6. provide workers with additional support to address complex needs and situations when supporting the well being of individuals 7. ensure workers use risk management plans to promote the well being of individuals 8. critically analyse the extent to which systems, procedures and practice support the well being of individuals 9. interpret the analysis of systems, procedures and practice to report on areas of good practice and areas for improvement 10. identify the changes required to meet areas that need to be improved 11. identify the resources required to implement recommended changes |
| **3.3 Manage practice that supports the achievement of positive outcomes for individuals’ health** | 1. implement systems, procedures and practice that support positive outcomes for individuals’ health in the context of personal, legislative, regulatory and organisational requirements 2. ensure that individuals are supported to make choices about their health needs 3. implement agreed practice and protocols for involving other health professionals to meet the health needs of individuals 4. ensure that there are agreed protocols where health related tasks are delegated from other health professionals to workers 5. ensure that workers are trained and competent to carry out any health related tasks 6. ensure that workers only carry out health related tasks that are based on assessed needs and agreed by a multi-disciplinary team 7. support workers to observe individuals to identify signs and symptoms of any changes to health needs 8. lead work with individuals and others to address changes to health needs 9. seek additional support from appropriate professionals when an individuals’ health needs are outside the competence of the service provision and its workers 10. ensure that accurate and up to date records and reports of individuals’ health needs, their medication and health interventions are maintained and monitored 11. critically evaluate the use of systems, procedures and practice in supporting the health needs of individuals |
| **Performance criteria 4. Lead and manage work with networks, communities, other professionals and organisations for care service provision** | |
| **4.1 Lead and manage effective working relationships with networks and communities** | 1. review systems, procedures and practice for working with networks and communities to ensure that they support the achievement of positive outcomes for individuals 2. implement systems, procedures and practice for working with networks and communities in the context of legislative, regulatory and organisational requirements 3. build relationships with networks and communities to support the vision and purpose of the service provision 4. provide workers with access to development opportunities that support them to develop the knowledge, understanding and skills needed to work effectively with networks and communities to achieve positive outcomes for individuals 5. ensure that workers engage with individuals and key people to identify networks and communities that could contribute to the achievement of positive outcomes 6. establish protocols with individuals and others for sharing information with networks and communities 7. ensure that workers support individuals to access networks and communities that could contribute to the achievement of positive outcomes 8. monitor engagement between individuals and networks and communities 9. support workers to address ethical and other dilemmas or conflicts that arise when working with networks and communities 10. gather feedback from individuals, key people and others on the effectiveness of relationships with communities and networks 11. analyse the effectiveness of relationships with communities and networks to identify how well they have supported the achievement of positive outcomes for individuals 12. interpret analysis of the effectiveness of relationships with communities and networks to make recommendations for improvements to systems, procedures and practice 13. implement changes to address areas to be improved |
| **4.2 Lead and manage effective working relationships and partnerships between the service provision and other professionals and organisations** | 1. implement systems, procedures and practice for working relationships and partnerships with other professionals and organisations in the context of legislative, regulatory and organisational requirements 2. establish the aims and purpose of working in partnership with other professionals and organisations 3. ensure that arrangements for partnership working with other professionals and organisations comply with legislative, regulatory and organisational requirements 4. agree expected outcomes from partnership working 5. clarify roles, responsibilities and accountabilities for all those involved in partnership working 6. ensure that you and others recognise the values, ethos and purpose of other organisations 7. ensure that you and others recognise the professional codes of practice and professional standards that apply to other professionals 8. ensure that you and others respect the different skills and expertise of other professionals 9. establish protocols with individuals and others for sharing information with other professional and organisations 10. manage the sharing of information with other professionals and organisations 11. ensure that protocols for sharing information are implemented by all those involved in partnership working 12. work with others to monitor and review the achievement of outcomes 13. take action to resolve difficulties in achieving outcomes 14. manage conflicts of interest and disagreements in ways that support positive outcomes 15. evaluate the effectiveness of partnership working against expected outcomes 16. implement changes to address situations where expected outcomes have not been achieved |
| 4.3 Contribute to the development of local strategies and services that impact upon positive outcomes for individuals | 1. review information on local strategies and services 2. work with others to identify how local strategies and services can support the service provision to achieve its’ vision and purpose 3. work with others to identify how the service provision can benefit from contributing to local strategies and services 4. work with others to identify gaps in services to meet the needs of individuals within the service provision 5. critically evaluate risks, costs and benefits of contributing to the development of local strategies and services to inform decision making about participation 6. lead the management of systems, procedures and practice to participate in the development of local strategies and services 7. ensure that you and others contribute effectively to the development of local strategies and services relevant to the needs and outcomes of the service provision 8. address dilemmas and conflicts that arise when contributing to the development of local strategies and services 9. critically analyse the effectiveness of contributing to the development of local strategies and services to identify the impact on the achievement of positive outcomes 10. interpret the analysis of the effectiveness of contributing to local strategies and services to make recommendations for future work |
| **Performance criteria 5. Manage the conduct and performance of workers in care services** | |
| **5.1 Manage the conduct and performance of workers within the service provision** | 1. ensure that systems, procedures and policies for performance management and conduct of workers comply with legislative, regulatory and organisational requirements 2. ensure that individuals and key people are aware of the standards of conduct and expected performance of workers and are familiar with the codes of practice that apply 3. ensure that workers are informed about the standards of conduct and performance expected of them 4. ensure that workers understand policies and procedures for dealing with misconduct or unsatisfactory performance 5. ensure that workers receive regular feedback on their performance and any potential conduct issues 6. develop a culture where individuals, key people and others feel able to challenge conduct and performance that falls below expected standards 7. consult with others to establish management options that can be considered when the conduct and performance of workers falls below the expected standard 8. carry out investigations to establish the facts relating to evidence of misconduct or unsatisfactory performance 9. use active listening, ask questions, clarify points and rephrase others’ statements to check mutual understanding of information related to the conduct and performance of workers 10. use supervision to address with workers conduct and performance that falls below legislative, regulatory or organisational standards and the codes of practice that apply 11. assess the achievement of conduct and performance objectives set for workers to establish whether improvement has been achieved 12. maintain confidentiality about any issues related to misconduct or unsatisfactory performance in line with legislative, regulatory and organisational requirements |
| 5.2 Implement disciplinary proceedings where the conduct or performance of workers continues to fall below expected standards or where there is evidence of gross misconduct | 1. follow policies and procedures to initiate disciplinary processes where the conduct or performance of workers has failed to improve to the required standard or where there is evidence of gross misconduct 2. provide the worker with information about the disciplinary process that is being undertaken and their rights 3. ensure that clear, accurate and factual records are kept for the initiation of disciplinary processes in line with legislative, regulatory and organisational requirements 4. ensure that clear and accurate records are kept about the misconduct or unsatisfactory performance of workers in line with legislative, regulatory and organisational requirements |
| 5.3 Contribute to disciplinary proceedings in line with role and responsibilities | 1. gather evidence on misconduct or unsatisfactory performance of workers in preparation for disciplinary proceedings 2. ensure that you do not do anything that may hinder the disciplinary hearing or contaminate the evidence that might be presented 3. analyse the risks to individuals, key people and others that result from the workers misconduct or unsatisfactory performance 4. compile a report for a disciplinary hearing that presents evidence gathered about the misconduct or unsatisfactory performance of the worker and any identified resulting risks to individuals, key people and others 5. present reports and evidence at disciplinary hearings 6. ensure that the disciplinary hearing is conducted according to legislative, regulatory and organisational requirements |
| 5.4 Manage the outcomes of disciplinary processes | 1. ensure that there is clarity of outcomes and agreed actions from disciplinary hearings 2. ensure that outcomes and actions are recorded accurately in accordance with legislative, regulatory and organisational requirements 3. ensure that reports from disciplinary hearings are disseminated to appropriate people 4. implement outcomes and agreed actions from a disciplinary process within remit of own role and responsibility 5. support individuals, key people and others to understand the implications of outcomes and actions from disciplinary procedures 6. provide additional support to individuals, key people and others where there are on-going difficulties as a result of disciplinary outcomes and actions |

Source: <http://www.skillsforcareanddevelopment.org.uk/Careersincare/Leadership_and_Management_in_Care_Services_Standards.aspx> (Accessed January 2018)

## Appendix B: Overlap in competency areas between the competency frameworks reviewed

**Table B1: Overlap in competency areas between the 10 competency frameworks for frontline staff**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Broad competency area** | **Direct Service workforce core competencies** | **Direct support professionals competency areas** | **Intellectual Disability Mental Health Core Competency Framework** | **Recovery competencies for Mental Health Workers** | **Core capacities required for community agencies to generate and sustain substantively good individualised outcomes** | **WALK** | **Core values of Cheshire Ireland** | **The Daughters of Charity Disability Support Services Core Values[[16]](#footnote-16)** | | **Generic Services Intervention Pathway** | **Positive Behavioural Support Competence Framework** |
| **Communication (9)** | Communication | Communication | Communication | Has the self-awareness and skills to communicate respectfully and develop good relationships with service users | The capacity to establish and maintain ‘right relationship’ with a very diverse range of people | Effective communication and working relationships | To listen and learn | Maintaining a good communication system… to ensure continuity of care’  Listen, converse, interact etc… | |  | Knowing the person  Supporting communication |
| **Person-centred practice (8)** | Person Centred Practices | Providing person-centred supports  Facilitation of services |  | Recognises and supports the personal resourcefulness of people with mental illness | The capacity to deeply and accurately understand people, their aims, needs in life and their true potentials.  The capacity to develop and operationalise vision and values that actually leads to quality in people’s lives |  | To be person centred | Include in decisions regarding their own lives  Providing a service that is person-centred. | | Role support interventions | Matching support with each person’s capabilities and with goals and outcomes that are personally important to them  Supporting choice |
| **Community living skills and supports (7)** | Community Living Skills and Supports | Community living skills and supports |  | Has comprehensive knowledge of community services and resources and actively supports service users to use them | The capacity to master the developmental challenges involved in ongoing lifestyle developments |  |  | Supporting appropriate levels of participation in meaningful activity | | Role support interventions  Accommodation and welfare | Supporting choice |
| **Planning and organization (7)** |  | Organisation participation,  Documentation | Mental Health Interventions and Care Planning  Partnership, collaboration and integration  Intake,  Transfer of care |  | The capacity to dismantle group models and their components and gradually replace them with individualised options. The capacity to maintain the ongoing productive management of the multi-party negotiations involved in transformational change | Planning, organising and prioritizing | To promote partnership |  | Promoting appropriate access to service | | Supporting data driven decision making |
| **Evaluation, observation and assessment (6)** | Evaluation and Observation | Assessment | Assessment |  |  |  |  | ‘Listening, observing and learning…’  ‘Evaluation and accountability…’ | | Assessment formulation and treatment planning.  Monitoring and measurement research and evaluation. | Assessing the function of a person’s behaviour, Assessing a person’s skills and understanding their abilities, assessing preferences |
| **Community inclusion and networking (6)** | Community Inclusion and Networking | Community and service networking. Building and maintaining friendship and relationships |  | Understands discrimination and social exclusion, its impact on service users and how to reduce it.  Has comprehensive knowledge of community services and resources and actively supports service users to use them. |  |  |  | ‘Collaborate with other agencies to share knowledge and skills and advocate…’  ‘Use community facilities as appropriate..’ | | Role support interventions | Supporting relationships with family, friends and wider community  Working in partnership with stakeholders. |
| **Education, training and self-development (5)** | Education, Training and Self Development | Education, training, and self-development | Research, Quality Improvement, and Professional Development |  | The capacity to provide, support and mobilise personal leadership from multiple persons. On the feasibility of intentional capacity building |  |  | Updating staff’s professional knowledge and skills | |  |  |
| **Specific clinical support (4)** |  |  | Recovery Focus, Common Clinical Competencies | Understands recovery principles and experiences in the Aotearoa/NZ and international contexts,  Understands and accommodates the diverse views on mental illness, treatments, services and recovery. |  |  |  |  | | Therapeutic interventions | Yes – all relating to a personal behaviour plan |
| **Health and Wellness (4)** | Health and Wellness | Supporting health and wellness |  |  |  |  |  |  | | Enabling health intervention | Supporting physical and mental health |
| **Quality (4)** |  |  | Research, Quality Improvement, and Professional Development |  |  |  | To improve continuously, To be accountable and effective | ‘Pursue improvements…’  Excellence – the highest standard of care… | |  | Evaluate the effectiveness of the Behavioural support plan |
| **Professionalism and ethics (4)** | Professionalism and Ethics |  | Responsible, Safe, and Ethical Practice |  |  |  |  | …respecting the professionalism of each discipline | |  | Establishing clear roles and effective team work |
| **Empowerment and advocacy (4)** | Empowerment and Advocacy | Participant empowerment. Advocacy |  | Has knowledge of the service user movement and is able to support their participation in services. Has knowledge of family/whanau perspectives and is able to support their participation in services |  |  |  | ‘Ensuring that each person is empowered to make personal choices…’  ‘Respect the need for advocacy’  Promote and encourage self-advocacy groups. | |  |  |
| **Safety (4)** | Safety |  | Responsible, Safe, and Ethical Practice |  |  |  |  | ‘Provide a safe environment by protecting and respecting the rights and entitlements of each person, ensuring …safe place to speak…safe work practices. | |  | Supporting safe consistent and predictable environments |
| **Cultural (4)** | Cultural Competency |  | Meeting diverse needs | Understands and actively protects service user’s rights.  Acknowledges the different cultures of Aotearoa/NZ and knows how to provide a service in partnership with them |  |  | To value diversity and potential |  | |  |  |
| **Resilience, positive attitude and openness to change (4)** |  |  |  |  | The capacity to manage steady forward movement on the schedule of implementation of individual options in the face of limitations. | Resilience, positive attitude and openness to change | To be responsive and flexible | Open to change | |  |  |
| **Crisis prevention and intervention (3)** | Crisis Prevention and Intervention | Crisis intervention |  |  |  |  |  |  | |  | A commitment to Behaviour Skills Training,  Assessing match between the person and their environment and mediator analysis, understanding the principles of behaviour |
| **Respect dignity and privacy (3)** |  |  |  |  |  |  | To respect dignity and privacy | maintaining the dignity of each person and respecting their privacy’ | |  | Ensuring services are values led |
| **Innovation, creativity and problem solving (3)** |  |  |  |  | The capacity to imagine and create better | Innovation, creativity and problem solving |  | ‘Innovate…appreciate the service users creative approach to tasks.. | |  |  |
| **Human rights based approach (1)** |  |  |  |  |  | Human rights based approach |  |  | |  |  |
| **Low arousal philosophy and practice (1)** |  |  |  |  |  | Low arousal philosophy and practice |  |  | |  |  |
| **Family and carer interventions (1)** |  |  |  |  |  |  |  |  | | Family and carer interventions |  |
| **Knowing and understanding relevant legislation (1)** |  |  |  |  |  |  |  |  | |  | Knowing and understanding relevant legislation |

**Table B2: Overlap in competency areas between the three competency frameworks for registration/qualifications**

|  |  |  |  |
| --- | --- | --- | --- |
| **Broad competency area** | **Frontline staff who support people with a dual diagnosis** | **Standards of proficiency for social care workers** | **FETAC** |
| **Communication (1)** |  | Communication, collaborative practice and teamwork |  |
| **Community living skills and supports (1)** |  |  | Community Inclusion |
| **Evaluation, Observation and Assessment (1)** | Assessment and Observation |  |  |
| **Community inclusion and networking (1)** | Community collaboration and teamwork |  |  |
| **Education, training and self-development (2)** |  | Professional development. | Personal effectiveness  Learning to learn  Insight  Facilitating learning |
| **Specific clinical support (2)** | Behaviour support | Professional knowledge and skills |  |
| **Health and wellness (1)** | Health and wellness |  |  |
| **Quality (1)** |  | Safety and quality |  |
| **Professionalism and ethics (2)** |  | Professional autonomy and accountability | Role |
| **Empowerment and advocacy (1)** |  |  | Empowering the individual |
| **Safety (1)** |  | Safety and quality |  |
| **Crisis prevention and intervention (1)** | Crisis prevention and intervention |  |  |
| **Context (1)** |  |  | Context |

**Table B3: Overlap in competency areas between the three competency frameworks for supervisors and managers**

|  |  |  |  |
| --- | --- | --- | --- |
| **Broad competency area** | **National frontline supervisor competencies, 2013 (US)** | **Management Competency Framework for Health and Social Care Professionals** | **National Occupational Standards for Leadership and Management in Care Services[[17]](#footnote-17)** |
| **Communication (1)** |  | Being the communication channel |  |
| **Person-centred practice (2)** |  | Working towards a user centred service | Lead and manage practice that promotes individuals’ social, emotional, mental, cultural, spiritual and intellectual well being  Lead and manage service provision that involves individuals in decisions about the outcomes they wish to achieve  Contribute to the development of local strategies and services that impact upon positive outcomes for individuals |
| **Planning and organization (2)** |  | Planning and managing resources | Critically evaluate the impact of strategic policies on your service provision  Critically evaluate and implement strategic plans for the development of your provision  Provide feedback on strategic policies to influence the direction of the service |
| **Evaluation, observation and assessment (2)** | Participant support plan development, monitoring, and assessment | Evaluating information and judging situations |  |
| **Community inclusion and networking (2)** | Facilitating community inclusion across the lifespan |  | Lead and manage effective working relationships with networks and communities |
| **Education, training and self-development (2)** | Staff supervision, training, and development | Supporting personal development  Maintaining composure and quality of working life |  |
| **Specific clinical support (1)** | Direct support |  |  |
| **Health and Wellness (2)** | Health and safety |  | Manage practice that supports the achievement of positive outcomes for individuals’ health |
| **Quality (2)** | Service management and quality assurance | Assuring high standards in the service of today |  |
| **Professionalism and ethics (3)** | Leadership, professionalism, and self-development. Promoting professional relations and teamwork | Being a leader in one’s profession | Lead and manage effective working relationships and partnerships between the service provision and other professionals and organisations. |
| **Empowerment and advocacy (2)** | Advocacy and public relations | Being a champion for the service-user  Influencing people and events |  |
| **Safety (1)** | Health and safety |  |  |
| **Cultural (1)** | Cultural awareness and responsiveness |  |  |
| **Resilience, positive attitude and openness to change (2)** |  | Creating team spirit | Develop a culture within the service provision that is open and facilitates participation  Promote a positive image of the service provision |
| **Staff management (3)** | Staff recruitment selection, and hiring | Managing individual performance | Implement disciplinary proceedings and manage the outcomes of disciplinary processes |
| **Leadership (3)** | Leadership, professionalism, and self-development. | Being a leader in one’s profession  Creating the service of the future | Lead the implementation of a shared vision for the service provision  Lead and manage change within the service provision |

1. Factsheet. Competence and Competency frameworks. 2016. CIPD <http://www.cipd.co.uk/hr-resources/factsheets/competence-competency-frameworks.aspx> (Accessed January 2018) [↑](#footnote-ref-1)
2. <http://www.walk.ie/who-we-are/core-competencies/> (Accessed January 2018) [↑](#footnote-ref-2)
3. <http://www.cheshire.ie/about_corevalues> (Accessed January 2018) [↑](#footnote-ref-3)
4. <http://www.docservice.ie/about-us-core-values.aspx> (Accessed January 2018) [↑](#footnote-ref-4)
5. <https://hee.nhs.uk/sites/default/files/documents/Generic%20Service%20Interventions%20Pathway.pdf> (Accessed January 2018) [↑](#footnote-ref-5)
6. <http://www.skillsforcare.org.uk/Document-library/Skills/People-whose-behaviour-challenges/Positive-Behavioural-Support-Competence-Framework.pdf> (Accessed Jan 2018) [↑](#footnote-ref-6)
7. The NADD Competency Based Direct Support Professional Certification Programme <http://acp.thenadd.org/dsp-executive.htm> (Accessed January 2018) [↑](#footnote-ref-7)
8. <https://qsearch.qqi.ie/WebPart/AwardDetails?awardCode=5M1761> (Accessed January 2018) [↑](#footnote-ref-8)
9. Office for Health Management, 2001, <https://pnd.hseland.ie/corp/ohmpublications/newsletter/20030605145619.html> (Accessed January 2018, if username and password is requested just click cancel) [↑](#footnote-ref-9)
10. <http://www.skillsforcareanddevelopment.org.uk/Careersincare/Leadership_and_Management_in_Care_Services_Standards.aspx> (Accessed January 2018) [↑](#footnote-ref-10)
11. Only competency areas where at least three of the 16 competency frameworks had a competency in that area are included. Five competency areas which were included in only one competency framework were excluded. These were human rights based approach; low arousal philosophy and practices; family and carer interventions; knowing and understanding relevant legislation; and context. [↑](#footnote-ref-11)
12. The NADD Competency Based Direct Support Professional Certification Programme http://acp.thenadd.org/dsp-executive.htm [↑](#footnote-ref-12)
13. <https://www.hse.ie/eng/staff/resources/hrstrategiesreports/report%20of%20the%20expert%20group%20on%20various%20health%20professions.pdf> (Last accessed April 2018) [↑](#footnote-ref-13)
14. <https://www.hse.ie/eng/staff/resources/hrstrategiesreports/action%20plan%20for%20people%20management%20in%20the%20health%20service.pdf> (Last accessed April 2018) [↑](#footnote-ref-14)
15. Office for Health Management, 2001, <https://pnd.hseland.ie/corp/ohmpublications/newsletter/20030605145619.html> (Accessed April 2018, if username and password requested just click cancel) [↑](#footnote-ref-15)
16. Note that value statements included in addition to value [↑](#footnote-ref-16)
17. Note that only four of 33 competencies included [↑](#footnote-ref-17)