Portfolio Document: Care Coordination (Primary Care)

Name:

Practice:

Workplace supervisor/mentor:

Learning Facilitator (LF):

You are responsible for keeping your Portfolio Document available in practice, to review your progress with your workplace supervisor or mentor

Welcome to your Portfolio Document (PD)

Purpose of the Portfolio

This Portfolio Document (PD) is designed to help you build a portfolio of evidence that demonstrates your capabilities as a Care Coordinator. It is both a record of your development and a practical tool to support your learning in the role.

It is expected that you will have completed a PCI-accredited, 2-day Care Coordination training programme, which provides the foundation knowledge and skills linked to the required competencies.

By completing this portfolio, you will be able to show how you have applied the training content in practice. This is achieved through **critical reflection** and **action-based learning** within your day-to-day role.

Care coordinator responsibilities.

As a Care Coordinator, you will often have access to confidential and sensitive information. It is essential that you follow the guidance below:

- **Restricted access:** Treat all sensitive information with the highest level of care and discretion.
- **No patient identifiers:** The PD must not include details that could identify patients, service users, or carers (e.g. names, addresses, medical conditions, or other unique identifiers).
- **No unauthorised disclosure:** Do not share information about patients, service users, or carers with anyone who is not authorised to receive it. This applies to conversations, written notes, and electronic data.

- **No misuse of information:** You must not remove, photocopy, or use confidential information outside of the workplace. This prevents unauthorised or accidental sharing of sensitive data.

Practice based learning facilitator responsibilities.

The Practice-Based Learning Facilitator is a key enabler within the Care Coordinator's workplace. Their role is to support, guide, and build the Care Coordinator's confidence through reflective, evidence-based practice.

- The facilitator will meet regularly with the Care Coordinator over a 6-month period to review progress against the competencies and help identify opportunities to demonstrate capability.
- They should be aware of any disabilities or needs that require reasonable adjustments and ensure these are in place.
- The facilitator's role is to provide information, guidance, and opportunities for learning, helping the Care Coordinator to make steady progress.
- If the designated facilitator is unavailable, support should be delegated within the team, with clear feedback processes in place. All team members are expected to contribute by identifying learning opportunities and giving constructive feedback.

Key Roles of the Practice-Based Facilitator

- **Identify learning opportunities** – Work with the Care Coordinator to identify suitable opportunities and create development plans.
- **Assess competencies** – Use a broad range of evidence, including knowledge, skills, attitudes, and the perspectives of those receiving care. Highlight excellent practice where appropriate, and identify development needs early, with an action plan in place.
- **Final assessment** – At the end of year one, assess the Care Coordinator's overall performance, including achievement of outcomes, professional attitudes, and behaviours. Record this in the PD.

Learning and Development Schedule

The Learning and Development Schedule is a customisable template to help plan and track your learning as a Care Coordinator. It provides a suggested structure of key themes and milestones to support the development of your skills, knowledge, and competencies. You are encouraged to adapt the template to meet your own objectives, needs, and preferences. By tailoring it, you can create a personalised roadmap that supports your journey and helps you achieve your professional development goals.

See next page for example schedule.

Learning and development Schedule	Jan	Feb	March	April	May	Jun
WS 1: Overview						
WS 2: Domain 1 Personalised Care						
WS 3: Domain 2 Communication						
WS 4: Domain 3 Relationships						
WS 5: Domain 4 Reflection and continuous learning						
WS 6: Developing case studies and action plan progress						
WS 7: 2: Domain 1 Personalised Care						
WS 8: Domain 2 Communication						
WS 9: Domain 3 Relationships						

WS 10: Domain 4 Reflection and continuous learning						
WS 11: Developing your case studies and action plan progress						
WS 12: Final meeting						

Practice Based Assessment Document Competencies

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

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

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

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

Assessment Criteria for Care Coordinators

Each section outlines a key competency area with clear expectations of practice and professional behaviours. To demonstrate achievement, Care Coordinators should provide appropriate evidence that shows how they have developed and applied their learning in real-world settings.

Evidence may include:

- Practical application of training content in day-to-day work
- Critical reflection on experiences and outcomes
- Action-based learning through trying out new approaches and evaluating impact
- Completion of further topic-specific training or development activities
- Use and completion of the 9 Values Worksheet to evidence alignment with core values

Personalised Care

Definition: Personalised care sees people as equal partners in planning, developing and monitoring care, ensuring it meets their needs and preferences. It is about focusing on what matters to the person and involving families, carers, and professionals to get the best outcomes.

Key Areas

Area	What Good Practice Looks Like	Achieved
Comprehend that effective personalised care and support planning requires several discussions.	Understands that effective personalised care and support planning requires ongoing discussions, not one-off events.	☐
Focus on what matters	Takes into account what matters to people as well as their expressed needs.	☐
Family and emotional support	Involves family and friends to provide emotional support where appropriate.	☐
Timely coordination	Provides care coordination that is timely, appropriate, and effective.	☐

Assessor Sign-off

Signature: _____ Date: _____ Achieved: ☐ Yes ☐ No

Comments / Rationale: .....

Communication Skills

Definition: The Care Coordinator demonstrates the ability to build rapport with patients and families in an empathetic and sensitive manner, ensuring communication meets information and decision-making needs.

Key Areas

Area	What Good Practice Looks Like	Achieved
Frequent Communication	Builds trust and relationships through regular, ongoing contact.	☐
Timely Communication	Provides information at the right time to support safe, effective decisions.	☐
Accurate Communication	Shares clear, reliable, and factually correct information.	☐
Problem-Solving Communication	Works with patients and colleagues to resolve issues and find solutions.	☐
Interpersonal Communication	Demonstrates respectful two-way dialogue (face-to-face, phone, email, written).	☐
Information Transfer	Ensures accurate sharing of key information such as medical history, test results, and medication lists.	☐
Link to Community Resources	Provides and coordinates access to external services that support health and wellbeing.	☐

Digital Health & Wellbeing Signposting	Supports patients to use digital tools and community resources that improve care.	☐
Teamwork in Coordination	Works effectively with professionals and teams to provide joined-up care.	☐
Handling Data & Information	Uses electronic records/databases appropriately. Accesses, records, and shares information securely to support care and service improvement.	☐

Assessor Sign-off

Signature: _____ Date: _____ Achieved: ☐ Yes ☐ No

Comments / Rationale: .....

Relationship Skills

Definition: The Care Coordinator demonstrates the ability to build and sustain relationships with patients, families, and professionals to support effective, coordinated care.

Key Areas

Area	What Good Practice Looks Like	Achieved
Facilitating transitions	Ensures smooth transitions by sharing timely, complete information between care entities.	☐
Creating a proactive plan of care	Co-develops a care and support plan with the patient/family and healthcare team that addresses needs, goals, and gaps.	☐
Monitoring and follow-up	Regularly reviews progress toward goals and adapts plans in response to change.	☐
Supporting self-management	Provides education, coaching, and support to empower patients and carers in managing their health.	☐
Building professional relationships	Engages effectively with multidisciplinary teams and community partners.	☐
Establishing accountability	Clarifies who is responsible for specific aspects of care and ensures accountability.	☐

Assessor Sign-off

Signature: _____ Date: _____ Achieved: ☐ Yes ☐ No

Comments / Rationale: .....

Continuous Learning

Definition: The Care Coordinator demonstrates reflective practice, using evidence to improve services, and engages in ongoing professional development.

Key Areas

Area	What Good Practice Looks Like	Achieved
Use of Digital Health IT	Effectively uses electronic systems (records, portals, databases) to coordinate care.	☐
Practice-based learning	Participates in activities to evaluate patient experiences, evidence, and resources.	☐
Evidence-informed practice	Identifies and applies evidence to improve integrated care.	☐
Applying new knowledge	Transfers new technical and professional knowledge into practice.	☐
Interdisciplinary training	Engages in training with colleagues across professions.	☐
Continuing professional development	Regularly undertakes CPD to build skills and knowledge.	☐
Patient safety	Implements and monitors patient safety standards.	☐

Assessor Sign-off

Signature: _____ Date: _____ Achieved: ☐ Yes ☐ No

Comments / Rationale: .....

Professionalism

Definition: Professionalism is grounded in ethical, moral, and legal principles of care. It includes integrity, self-awareness, respect for scope of practice, and a commitment to high standards of person-centred care.

Key Areas

Area	What Good Practice Looks Like	Achieved
Ethical practice	Acts with honesty, integrity, and in the best interests of patients and carers.	☐
Respect for diversity	Treats individuals with dignity, respecting culture, beliefs, and preferences.	☐
Accountability	Takes responsibility for actions and decisions, recognising limits of role and seeking support when needed.	☐
Commitment to development	Demonstrates commitment to improving practice through reflection and learning.	☐

Assessor Sign-off

Signature: _____ Date: _____ Achieved: ☐ Yes ☐ No

Comments / Rationale: .....

Essential Resources toolkit

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

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

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

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

Key Values of Person-Centred Care Worksheet

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

1 . What does the value mean?

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

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

Choice		

Privacy		

Independence		
Dignity		

Respect		

Partnership		

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

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

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

Action Plan

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

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

PD: Initial Discussion with Practice Based Supervisor

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

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

PD: Final Review

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

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

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

Record reflections on your learning with other staff

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

Date	Who and why	Reflections on your learning and importance of the relationship

Practice based facilitator comments:	
Practice based facilitator signature:	Date:

Ongoing feedback from key people

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

Date/time	Your role	Input the care coordinator has had

Ongoing feedback from staff in practice

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

Date/time	Your role	Input the care coordinator has had

Patient/Service users Feedback Form

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

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

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

Tick if you are: The patient/service user ☐ Carer/relative ☐

How happy were you with the way the care coordinator:	Very happy	Happy	I am unsure	Unhappy	Very unhappy
Understood your individual needs?					
Explained the importance of choice?					
They talked to you?					
They showed you respect?					
They understood the way you felt?					

What did the care coordinator do well?

What could the care coordinator have done differently?

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

Acknowledgments:

This updated version of the toolkit has been led by Tom Lawrence through the **Person Centred Academy**, where he is now based. Tom and his team have worked to refine and enhance these resources to ensure their continued relevance and impact. For more information, please visit: www.personcentred.academy.

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