Assessing people's abilities and needs, and planning care

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In this guide

- Outcomes

People of all ages receive care and support at home and in the community. They may have complex acute care needs, or are living with life limiting or long term conditions, or have multiple co-morbidities that affect their mental and physical health.

All registered nurses with a community nursing specialist practice qualification have the knowledge, skills and attributes to be the lead professional in caring for people within their intended field of community nursing practice. Their specialist knowledge and skills gives them the ability to exercise a high level of professional judgement and be capable of complex decision-making. They are highly skilled in using an evidence-based approach, and see the person before the condition, in order to undertake an individualised holistic assessment. They co-produce evidence-based care plans with people, taking the wider social and environmental context into account, along with each person's mental, physical, cognitive, behavioural, social and spiritual abilities and needs.

They develop therapeutic relationships with people, their families, carers or nominated person to facilitate shared decision-making. They take into account the diverse experiences, abilities, needs, preferences and challenges people are living with in order to make sure that plans are achievable and capable of delivering positive outcomes.

They provide information and support people, and their families, carers or nominated persons where needed, to make decisions about how their care is delivered and agree opportunities for supported self-care. They identifyand provide the appropriate level of support, education and knowledge for others such as parents, family, formal and informal carers, or a nominated person. They assess and manage risks when making referrals to or receiving referrals from other interagency teams.

Outcomes

Back to top

Registered nurses with this qualification in their intended field of practice, will be able to:

3.1create and apply a person-centred approach to care, working in partnership to support shared decision-making within the assessment and care planning process when working with people, their families or carers, and communities

3.2use advanced communication strategies and relationship management skills when interacting with people, including families and carers, who may have a range of mental, physical, cognitive, behavioural and social health challenges

3.3recognise and apply the principle of the presumption of capacity, and the requirement to seek informed consent throughout the assessment and planning process

3.4make reasonable adjustments to maximise opportunities for people to understand the outcome of their abilities and needs assessment, and the implications for their treatment and care

3.5make best interest decisions within the required legislative framework if, after seeking informed consent and making reasonable adjustments, their professional judgement is that a person lacks capacity to make a decision or give consent at that time

3.6assess and plan the care of people when they are vulnerable, agreeing on the required level of support needed to ensure maximum levels of independence throughout the continuum of care

3.7escalate, report, plan and coordinate immediate and continuing care for people in need of safeguarding

3.8proactively obtain and distil information from formal and informal sources to inform individual assessments, involving others as required

3.9critically analyse complex assessment information and data, distinguishing between normal and abnormal findings, ecognising when prompt action is required, including requesting additional investigations, and involving others when ppropriate

3.10critically apply clinical reasoning to decision-making, taking into account differential diagnosis and the potential for liagnostic overshadowing

3.11maximise the potential use of technology and informatics to assist with assessment and diagnosis

3.12apply knowledge and understanding of new and emerging science and technology, including genomics, to inform ssessment and treatment options, when agreeing personalised care plans with people and their families, carers or ominated persons

3.13apply a range of problem solving, influencing and negotiation skills to maximise opportunities for shared decision-naking when co-producing care plans

3.14assess individual abilities and needs when co-producing plans of care, agreeing opportunities for supported self-are and treatment interventions

3.15take into account the impact of people's preferences, their close relationships and support systems, their home nvironment, and the influence of social, environmental and spiritual factors when agreeing the plan of care

3.16create and maximise opportunities for people, and where needed their families, carers or nominated person, to emain independent and to facilitate self-care

3.17effectively communicate the benefits and risks of different care and treatment options, explaining how the person nd their family or carers will be supported in the choices they make

3.18anticipate and explain the impact that unexpected events and changes may have on the plan of care.