LEVEL 2 DIPLOMA

IN

HEALTH AND SOCIAL

Candidate Name…….....

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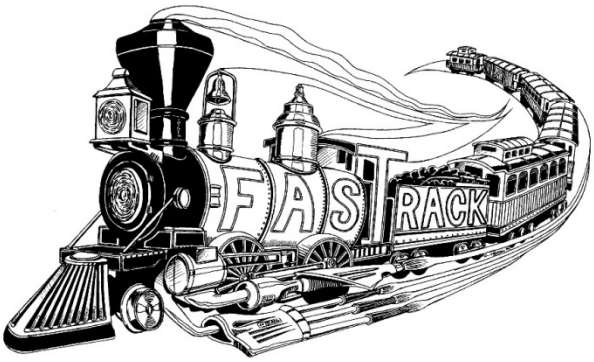

The Name of the Game is to Train

FOREWARD

The Jet Qualification and Credit Framework Modules are designed to Inform, Educate and Probe the Candidates Knowledge and Understanding of the subject matter to confirm their competence on the subject

This programme module is designed to help the candidate in several ways.

- To aid the understanding of what the criteria is asking for
- To give advice and guidance as to what is required
- To gain definitions to help the candidate understand the wording that underpins the criteria
- To give relevant answers to the specific questioning
- Information has been collected from previous NVQ training which still has validity as specific training needs and is specific to the subject matter.

I wish you well with your training.

John Eaton RMN, RGN, RN (New York) DipRSA D32/33/34/36

QUALIFICATIONS AND CREDIT FRAMEWORK

QCF Health and Social

Level 2 Diploma in HSC (adults) Mandatory Group A

HSC 026 IMPLEMENT PERSON CENTRED APPROACHES IN HEALTH AND SOCIAL CARE

Level 2 **Credit value 5**

Learning outcomes are the black on white overview statements that '*The learner will:'*

The **Assessment criteria (1.1 et al)is what after the assessment '***The learner can:'*

1. UNDERSTAND PERSON CENTRED APPROACHES FOR CARE AND SUPPORT

1.1 Define person-centred values

Person-centred care has its focus on the person with an illness and not on the disease in the person. To achieve truly person-centred care we need to understand how the individual experiences his or her situation if we are to understand their behaviours and symptoms. This requires in-depth understanding of the individual's life circumstances and preferences, combined with up-to-date evidence-based knowledge about individualised medical and social condition and treatment.

1.2 Explain why it is important to work in a way that embeds person centred values

Characterises a person-centred care:

- Has its focus on the person with an illness and not the disease in the person.
- Has the person's own experiences as its point of departure.
- Strives to understand behaviours and symptoms from the perspective of the person.
- Tailors care and treatment to each individual.
- Promotes both patient empowerment and shared decision making.
- Involves the patient as an active, collaborative partner.
- Strives to involve the person's social network in his/her care.

We believe that all individuals have the following person centred characteristics

UNIQUENESS

Regardless Of Illness, All Individuals Are Unique And This Must Be Acknowledged By Everyone

COMPLEXITY

Individuals Are Complex Beings And A Myriad Of Factors Influence The Way We See And Respond To The World Around Us.

ENABLING

We Need To Recognise The Strengths And Abilities Of Individuals With Needs And Ensure Opportunities Exist For Them To Be Utilised.

INDIVIDUALITY

The Recognition Of A Sense Of Self, Who We Are And What Place We Hold In The World Around Us.

It Places An Emphasis On The Positive Effects Of Daily Interaction

VALUE OF OTHERS

We recognises the individuality of all people. the roles of direct care staff, the formulation of policies and procedures and staff and managers supporting each other…

STATEMENT OF VALUES

The Home upholds the following values for its clients:

Choice
The opportunity to select independently from a range of Options as available.

Rights
The maintenance of all entitlements associated with Citizenship.

Fulfilment

The realisation of personal Aspirations and Abilities in all aspects of daily life.

Independence

The opportunity to Think and Act without reference to another person including a willingness to incur a degree of a Calculated Risk, unless that risk involves others.

Privacy

The right to be alone or undisturbed and free from intrusion, or public attention in relation to Individuals and their affairs.
The right to privacy includes the need to respect the confidential nature of information relating to the Resident their family and friends.

Dignity

A recognition of the intrinsic value of people regardless of circumstances by respecting their uniqueness and their personal needs. The right to dignity includes the recognition of, and the catering for, individual, ethnic, cultural and religious needs.

Freedom of Movement

The right of residents to move to an area or place of their preference within legal limitations

1.3 Explain why risk-taking can be part of a person centred approach

POSITIVE RISK TAKING POLICY

Policy Context:

The dichotomy between duties to safeguard alongside duties to maximise individual's choice and control is a long standing issue which has come to fore as we look to implement the Personalisation agenda. Lessons from national high profile abuse cases highlight the dangers of not adequately protecting vulnerable individuals from abuse. While risk adverse approaches, which try to eliminate all risk, is at odds with disability, health and social care policy, and also potentially undermines people's human rights.

In the home, rather than viewing Safeguarding and Personalisation as a choice between *either* 'protection' or 'choice and control' we are committed, to integrating the two concepts and striking a balance through an ethos of Positive Risk Taking.

This Positive Risk Taking Policy has been developed to underpin the move towards self directed support by ensuring that there is a consistent approach to the identification, assessment and management of risk across Personalisation. This will ensure that staff and managers are clear about their responsibilities, users of services and their families are fully involved in any decisions that are made, and vulnerable adults are safeguarded.

In accordance with 'Putting People First', 'Valuing People' and 'Our Health, Our Care, Our Say' a positive risk-taking approach is person-centred and focuses on working from a person's strengths and supporting them to achieve their aspirations. It is based on the ethos that as well as potentially negative characteristics, risk-taking can have positive benefits for individuals and their communities by fully involving individuals in any decisions that are made around risk that affects them.

The policy will support the home to discharge its responsibilities under the Disability Discrimination Acts 1995 and 2005 and the Mental Capacity Act 2005. Therefore, the proposed Positive Risk Taking Policy will help to develop a culture which promotes independence, wellbeing and choice and challenges risk-adverse practices whilst keeping people safe

What is positive risk-taking?

'Positive risk taking is: weighing up the potential benefits and harms of exercising one choice of action over another. Identifying the potential risks involved, and developing plans and actions that reflect the positive potentials and stated priorities of the service user. It involves using available resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes. It is not negligent ignorance of the potential risks…it is usually a very carefully thought out strategy for managing a specific situation or set of circumstances.' [1]

This means:

- Being empowering
- Working in partnership with adults who use services, family carers and advocates
- Developing an understanding of the responsibilities of each party
- Helping people to access opportunities and take worthwhile chances

- Developing trusting working relationships
- Helping adults who use services to learn from their experiences
- Understanding the consequences of different actions
- Making decisions based on all the choices available and accurate information
- Being positive about potential risks
- Understanding a person's strengths
- Working out what has not worked in the past
- Where problems have arisen, understanding why
- Ensuring support and advocacy is available for individuals, particularly if things begin to go wrong for someone.
- Sometimes tolerating short-term risks for long-term gains
- Through regular reviews gradually withdrawing inappropriate services that create dependency
- Having and understanding of the different perspectives of individuals, family carers, practitioners, advocates and services
- Developing person-centred and transition planning for individuals to support their involvement and that of their families decision making alongside practitioners.

1.4 ***Explain how using an individual's care plan contributes to working in a person centred way***

PERSON CENTRED PLANNING: KEY FEATURES AND APPROACHES

What is Person Centred Planning?

We all think about, and plan our lives in different ways. Some people have very clear ideas about what they want and how to achieve it, others take opportunities as they arise. Some people dream and then see how they can match their dreams to reality. Sometimes it is useful to plan in a structured way, and person centred planning provides a family of approaches that can help do this. These approaches share common values and principles, and are used to answer two fundamental questions:

- Who are you, and who are we in your life?
- What can we do together to achieve a better life for you now, and in the future?

Person centred planning is a process of continual listening, and learning; focussed on what is important to someone now, and for the future; and acting upon this in alliance with their family and friends. It is not simply a collection of new techniques for planning to replace Individual Programme Planning. It is based on a completely different way of seeing and working with people with disabilities, which is fundamentally about sharing power and community inclusion.

Key features of person centred planning

There are five key features of person centred planning. For many self- advocates, families and friends leading person centred planning, they will happen naturally. For example, if someone is organising their own planning, it will be difficult for them not to be at the centre, which is the first key feature of person centred planning!

However, many people are dependent upon service systems and we need to struggle with the problems and dilemmas of sharing power in person centred planning. The following assumes that a member of staff is supporting someone to plan their life, and illustrates how for many of us person centred planning reflects a different way of thinking about people with disabilities, rather than a new technique.

1) The person is at the centre

'Person centred planning begins when people decide to listen carefully and in ways that can strengthen the voice of people who have been or are at risk of being silenced.' John O'Brien

Person centred planning is rooted in the principles of shared power and self determination. Power is an issue because many people are limited in their power in comparison to others. Others control their lives. They direct how people spend their time, what they eat, how they behave, even what they say. In this context, planning can become just a further indignity. Person centred planning can be used to redress this balance as far as possible. People using person centred planning make a conscious commitment to sharing power. Built into the process of person centred planning are a number of specific features designed to shift the locus of power and control towards the person. Where person centred planning is used within services, the following issues should be thoughtfully considered as ways of keeping the person is the centre, whilst remembering that having meetings, involving the person and making the plan is not the outcome. The outcome is to help the person to get a better life on her own terms.

The person is consulted throughout the planning process

If the person has been involved in planning before then it makes sense to talk to her about how s/he wants to plan, if s/he wants a meeting, and if so, what kind of meeting, and how she wants to be involved. If the person is new to planning, it is important to spend time with her explaining the purpose of planning and looking at different options.

The person chooses who to involve in the process

Unlike traditional models of planning, it is for the person to decide who she wants to include in the planning process, and how. This is easy to say, but within services this is highly counter-cultural to the way meetings are typically organised. If the people around the person cannot find a way to help her make and communicate that decision for herself, then they have to decide in good faith who they think the person would want to involve. A good starting-point is 'people who know and care about the person'. This may well yield a different list from 'people who provide a service to this person'.

The person chooses the setting and timing of meetings

If a meeting does take place it is at a time convenient to the individual and those she wishes to invite and it is in a place where she feels at home. The planning is carried out in a way that is accessible to the individual as far as possible. Graphics, tapes, video or photos are often used.

Using person centred planning involves finding creative ways to involve people whilst recognising that some people will have limited experience on which to base a choice and others will have limited ability to follow and contribute to the process.

Family members and friends are partners in planning

'Person-centred planning celebrates, relies on, and finds its sober hope in people's interdependence. At its core, it is a vehicle for people to make worthwhile, and sometimes life changing, promises to one another.' John O'Brien

Person centred planning puts people in the context of their family and their community. It is therefore not just the person themselves that we seek to share power with, but family, friends and other people from the community who the person has invited to become involved. These represent two of the most important

challenges for services using person centred planning: how can we share power with the person and support them to participate as much as possible?, and how can we encourage and include family, friends and non-service people?

The plan reflects what is important to the person, their capacities, and what support they require.

Person centred planning seeks to develop a better, shared understanding of the person and her situation. A person centred plan will describe the balance between what is important to the person, their aspirations and the supports that they require.

Focus on capacities

The focus of professional effort in the lives of people has traditionally been on the person's impairment. People are channelled into different services depending on the category of their impairment, for example, learning difficulty, sensory impairment or loss of mobility. This leads to a process of assessment, which analyses and quantifies the impairment and its impact on the person's ability to undertake a range of tasks. This assessment results in a description of the person in terms of what she cannot do: her deficits. Professionals then set goals for people to try and overcome these deficits.

Identifying supports

Professionals have been training people towards `independence` for years. It is said that there are two definitions of independence. The first is the familiar rehabilitation model where people are trained to be able to meet their own basic needs with minimum assistance. The second is a `support model` which sees independence as choosing and living ones own lifestyle - regardless of the amount and type of assistance necessary. Independence would therefore not be measured by the number of tasks which people can do without assistance but the quality of life a person can have with whatever support they need.

A person centred plan clearly records what support someone requires, on her own terms.

The plan results in actions that are about life, not just services, and reflect what is possible, not just what is available.

The focus of person centred planning is getting a shared commitment to action, and that these actions have a bias towards inclusion. By articulating the tension between what is important to the person and what is happening now, person centred planning creates a sense of urgency and a commitment to work for change.

The plan results in ongoing listening, learning, and further action.

Person centred planning should not be a one off event. It assumes that people have futures; that their aspirations will change and grow with their experiences, and therefore the pattern of supports and services that are agreed now will not work forever. It is often described as a promise to people. To fulfil this promise we need to reflect on successes and failures, try new things and learn from them and negotiate and resolve conflict together. Acknowledging and resolving conflict is important if people are to really work together to make change. Person centred planning is based on learning through shared action, about finding creative solutions rather than fitting people into boxes and about problem solving and working together over time to create change in the persons life, in the community and in organisations.

What are the different approaches to person centred planning?

There are several different approaches or styles of person centred planning. Each style is based on the same principles of person centred planning: all start with who the person is and end with specific actions to be taken. They differ in the way in which information is gathered and whether emphasis is on the detail of day to day life, or on dreaming and longer term plans for the future.

Different styles of planning

Each planning style combines a number of elements: a series of questions for getting to understand the person and her situation; a particular process for engaging people, bringing their contributions together and making decisions; and a distinctive role for the facilitator(s).

Conclusion

Person centred planning is defined as a process of continual listening, and learning; focussed on what is important to someone now, and for the future; and acting upon this in alliance with their family and friends. There are different approaches, however, good person centred planning is always recognisable because the person will be at the centre; working in partnership with family and friends, the plan will clearly identify what the person's capacities are, what is important to her and what support she requires; there will be actions that have a bias towards inclusion, and the learning and reflecting are ongoing. There are issues presented here to be debated and discussed, and ways forward to agree. It is vital that we do this, as person centred planning creates opportunities for us to change our lives and our relationships, to share power and listen in a deeper way, and discover to what inclusive communities are really about.

2. BE ABLE TO WORK IN A PERSON-CENTRED WAY.

2.1 Find out the history, preferences, wishes and needs of the individual

History

There are quite a few issues that are looked into when a professional is assessing someone, usually a GP or Psychiatrist. In order to obtain the relevant information in order to gain the correct diagnosis the areas below are reviewed against the individual is used for Psychiatric Assessment:

- Identifying Information
- Main Complaint or Problem
- History of Same
- Medical History
- Social History
- Family History
- Past History
- Mental Status
- Physical Examination
- Psychometric Tests.

Please continue for a more detailed description under each of the above sub-headings.

IDENTIFYING INFORMATION

- Age
- Sex
- Religion
- Ethnicity
- Marital Status
- Next of Kin
- Address
- Others at same address
- Occupation
- Education
- Number of Admissions

MAIN COMPLAINT

It is important to assess in the clients own words the reasons for seeking (informal admission) or to be sent (detained) to hospital for treatment or assessment (whichever is more appropriate or relevant).

HISTORY OF COMPLAINT

- Date of Onset
- Events leading to Onset
- Precipitants
- Formation of Symptoms
- Conditions under which the symptoms emerge.
- Reactions of others to client

SYMPTOMS

CHANGES IN FEELING

- Depression
- Elation
- Mood (lability)
- Anxiety
- Fear/s
- Nihilism
- Guilt
- Emptiness
- Coping efficiency

CHANGES IN COGNITION (KNOWING)

- Orientation
- Memory
- Concentration
- Attention
- Delusions
- Phobias
- Obsessions
- Ideas of Reference

- Paranoia
- Grandiosity
- Judgement

CHANGES IN BEHAVIOUR

- Volition
- Activity
- Motor Retardation
- Impulsiveness
- Aggression
- Suicidal Ideation
- Drug / Alcohol Abuse
- Relationships
- Sex

CHANGES IN PERCEPTION

- Hallucinations (type)
- Depersonalisation
- De-Javu
- Illusions

CLIENTS TREATMENT GOALS

- Sleep Pattern
- Weight Change
- Appetite
- Libido

PAST HISTORY OF PSYCHIATRIC CONTACTS

Note for each contact:

- Dates
- Agency
- Diagnosis
- Precipitants
- Treatment
- Progress.

MEDICAL HISTORY

- Childhood Illnesses
- Major Medical / Surgical problems and treatments,
- Accidents / Traumas
- Neurological Problems
- Head Injuries
- Fevers
- Convulsions / Seizures
- Headaches / Migraines
- Visual Disturbances

- Disorientation
- Tremors
- Tics.

ENDOCRINE PROBLEMS

- Thyrotoxic
- Pituitary
- Adrenal
- Allergies
- Alcohol Consumption
- Current Medication

FOR WOMEN

- Age at Menarche
- Menstrual Cycle
- Contraceptive use
- Pregnancies etc.

SOCIAL HISTORY

This includes social and developmental history.

- Symptoms of behavioural problems:
- Temper- Tantrums
- Headbanging
- Enuresis
- Cruelty to Animals
- Mutism
- Hyperactivity

INTERACTIONS WITH OTHERS

- Dreams and Memories
- Friends
- School
- Puberty
- Sexual Development

PROBLEMS OF ADOLESCENCE

- Running from Home
- Drug Abuse
- Self Image
- Religion

WORK HISTORY

- Unemployment etc,
- Satisfaction
- Finance

- Social Activity
- Living Conditions

FAMILY HISTORY

- Family Members
- Description each Nuclear member
- Relationships
- Amount of Contact.

MENTAL ASSESSMENT

APPEARANCE

- Dress
- Posture
- Facial Expression
- Motor Activity
- Mannerisms

EMOTIONAL STATE

As above under symptoms

SPEECH CONTENT

- Quantity
- Quality
- Organization

NON-VERBAL COMMUNICATION

- Mannerism
- Posture

STATE OF CONSCIOUSNESS

- Thought Content
- Perceptual State
- Dreams

ATTITUDE

- Cooperation
- Reliability
- Motivation
- Insight
- Eye Contact

For a more complete set of criteria see under 'symptoms' in section headed

HISTORY OF COMPLAINT.

PHYSICAL EXAMINATION

FULL SYSTEM REVIEW

- FBC
- Thyroid Test
- LFT
- Routine Urinalysis
- Chest Xray
- Skull Xray
- ECG
- EEG
- Kidney Studies
- U&E

PSYCHOMETRIC TESTS

- I.Q. Tests
- Personality Profile
- Mini Mental State
- Depression Scale
- Dependency Scale

PRE-ADMISSION ASSESSMENT

Assessments should not start at the point of admission. The Assessment should begin with the first telephone Referral. Questioning should begin by the appropriateness of the referral to the client group of the Home, and be in line with the Homes Aims and Objectives. Even if the telephone conversation leads to the belief that the prospective client may be unsuitable, it is always sensible to see the person referred and make a formal Pre-Admission Assessment.

Basic details need recording commencing with the client's name, date of birth, who has referred them and date, who is to do the assessment and on what date, and who was present. The client's current address, Consultant, G.P., Social Worker and C.P.N need to be recorded. A brief description of their present care is also required. Due to funding requirements, issues of Preserved Rights and agreed funding have to be identified, and which type of care that is being offered. A diagnosis for the client and what the presenting problem is will aid the assessor in establishing whether or not the prospective client is suitable for admission to the Home

MOBILITY

This is an issue with the Mentally Ill, the Home must decide whether a client can be accommodated if there are difficulties, corridors may not be wide enough for wheelchairs without a risk to Health and Safety. The Home may be an active one and mobility may be of prime importance, or conversely, a Home may have the ability to care for a less mobile client, and may see the client as totally appropriate. The important point is that the decision to admit is in the best interests of the client, other clients in the Home and the Home itself.

PERSONAL CARE

This is an issue, which affects this client group. It is one of the first parts of a person's dignity that becomes neglected once an illness takes place. Knowledge of the depth of need for personal care, including hygiene, means that the Home will give attention to the client and ensure that it forms the appropriate responses in the Care Plan.

DAILY LIVING SKILLS

The skills gained will enable the client to live as independently as possible within the Home. Any inability to manage can lead the Home to make efforts to improve the clients abilities, as the better they can manage, and the more their self esteem rises, the Home will be seen as pro-active and improve or maintain its reputation in the field.

HEALTH PROBLEMS

Health Problems need investigating, as there may be issues regarding diet, medications, dressings, special equipment, the ability to communicate and other reasons that must be taken regard of if a successful admission is to take place. Health problems once recognised, may be major or minor, once understood can be dealt with adequately.

SENSORY LOSS

This can in itself lead to a form of Mental Illness. It can make the client fearful of sounds if sight is affected, or misunderstand light formation, i.e. believe a Grandfather clock is a person, or someone with Hearing loss may believe others are talking about them. If they suffer Tinnitus this may increase their delusional thoughts.

SOCIAL BEHAVIOUR

The client must be socially acceptable to the Home and its other clients; otherwise disruption can take place. If there is a known behavioural problem, then the question must be whether the Home can control and manage that behaviour. Their communication skills should be relevant to their place in the Home. If they are confused, is this a suitable place to live. If they have a tendency to wander, has the Home adequate security to manage this behaviour. At what level can behaviour be accepted that is upsetting to other clients? Is social isolation a problem, or is it acceptable for clients to stay in their own room all day. If they smoke, are they a fire risk, or will the burn their clothes or the Homes furnishings and devalue its quality? If they enjoy alcohol, how much and does it make them aggressive or incontinent, and will it affect their medications.

MENTAL STATE

Is the person referred mentally stable, are they in fact in need of admission to an Acute Unit, but are being referred to the Home because of other issues? If they are admitted to the Home, will their symptoms affect others, including the rest of the Community? A mistake may cost the Home local goodwill.

CURRENT MEDICATION

This will be required to be known as it will affect the mental state of the client, oral medications, tablets or liquid, injections, creams or other forms. A mental note may make the enquirer believe the medication appears about right, or too much or too little. If the client is moving to a new Doctor, then these points may need to be raised.

If suitable a date is made for the client to visit the Home, and how they will get to and from the Home. At the time of the Assessment, the client should be given information about the Home, i.e. brochure, later a note should be made in the Homes diary that a visit is to take place, and details should be recorded in the referral book. Information about the prospective client should be handed over to the next shift. The Assessor should then sign and date the form and state their designation.

The outcome of the Assessment should be made at the end of the form, whether to admit or not. If to be admitted, what date and whether Residential, Nursing, or Social Support. If not, the Assessor should give their reasons, and again date, sign with their designation. The form is then complete.

Needs Assessment

All individuals who move into the home has his/her needs assessed and been assured that these will be met.

New clients are admitted only on the basis of a full assessment undertaken by people trained to do so, and to which the prospective clients, his/her representatives (if any) and relevant professionals have been party.

A history is taken as part of their care plan, including

- personal care and physical well-being;
- diet and weight, including dietary preferences;
- sight, hearing and communication;
- oral health;
- foot care;
- mobility and dexterity;
- history of falls;
- continence;
- medication usage;
- mental state and cognition;
- social interests, hobbies, religious and cultural needs;
- personal safety and risk;
- carer and family involvement and other social contacts/relationships.
- preferences, wishes and needs of the individual

Each client has a plan of care for daily living, and longer term outcomes, based on the Care Management assessment and Care Plan or on the home's own needs assessment The registered nursing input required by service users in homes providing nursing care is determined by NHS registered nurses using a recognised assessment tool, according to Department of Health guidance.

Meeting Needs

Clients and their representatives know that the home they enter will meet their needs.

The registered person is able to demonstrate the home's capacity to meet the assessed needs (including specialist needs) of individuals admitted to the home. All specialised services offered (e.g. services for people with dementia or other cognitive impairments, sensory impairment, physical disabilities, learning disabilities, intermediate or respite care) are demonstrably based on current good practice, and reflect relevant specialist and clinical guidance.

The needs and preference of specific minority ethnic communities, social/cultural or religious groups catered for are understood and met. Staff individually and collectively have the skills and experience to deliver the services and care which the home offers to provide.

2.2 ***Apply person centred values in day to day work taking into account the history, preferences, wishes and needs of the individual***

In my work role I:

- Provide Home Care to individuals, taking into account the history, preferences, wishes and needs of the individual and identified needs
- Provide Care including general counselling, personal hygiene and Meals tailored preferences, wishes and needs of the individual
- Take individuals to appointments and activities
- Assist with exercises, physiotherapy and other medical and care plans
- Monitor wellbeing and other physical conditions, as required
- Follow medical and care instructions carefully and consistently
- Organize time and resources based on the individual needs of clients
- Manage any unanticipated events or unstable situations
- Administer Care Plan in order to ensure that it is delivered in an appropriate, caring and respectful manner
- Ensure that care is provided according to all relevant policies, procedures and regulations
- Monitor supplies and resources
- Identify individual's requiring more interventions and personal input
- Listen to the individual, take their views into consideration and make recommendations for changes and improvements to their care needs, as required
- Discuss any issues and concerns with individual and then pass on any relevant issues to the appropriate person
- Ensure that all care needs are identified
- Coordinate appropriate care and equipment including appropriate resource, as required
- Conduct and maintain a current, accurate, confidential client reporting system
- Provide information to other health care professionals, as required
- Consult with family members and other supports to ensure that care is on-going and that all client needs are identified and met
- Encourage clients and families to be involved in care, if appropriate
- Encourage clients and families to take responsibility for care, where and if appropriate
- Liaise with all family, medical and other resources, as required
- Advocate on behalf of clients for additional service and resources, as required
- Establish and maintain current, accurate, confidential files for each client
- Inform clients, families on what can be provided and when to access other resources
- Perform other related duties as required

3. BE ABLE TO ESTABLISH CONSENT WHEN PROVIDING CARE OR SUPPORT

3.1 Explain the importance of establishing consent when providing care or support

The need for consent

For one person to touch another without committing a criminal offence, he or she must have lawful justification. Consent is one such justification. This principle applies to medical treatment. Consent to a particular form of treatment allows that treatment to be given lawfully. Consent must usually be obtained before any treatment is given and can only be meaningful if a full explanation of the treatment has been given

Consent can be either expressed or implied. For example, participation in a contact sport usually implies consent to contact by other participants, when contact is permitted by the rules of the sport. Express consent exists when verbal or written contractual agreement occurs.

If a person signs a document stating that he or she is aware of the hazards of an activity, and that individual is then injured during that activity, the express consent given in advance may excuse another person who caused an injury to that person.

How much information should I be given about the treatment?

You should be given all the information you need to enable you to make a decision about giving consent to be treated. This includes what the treatment is, what it will achieve, any likely side effects, what will happen if the treatment is not given and what alternatives there are. Guidance issued to doctors says they should encourage you to ask questions and they should answer these fully.

Can I be treated without giving consent to the treatment?

Whether you are at home or in hospital, if you are an adult (aged 18 or over) and have the **mental capacity** needed to give consent to a form of medical treatment, you are generally entitled to refuse it and no undue pressure should be placed on you. However, the law does allow treatment to be given to an adult without consent where the adult lacks the mental capacity needed to give consent and where certain sections of the Mental Health Act 1983 (MHA) apply – see Parts 2 and 3 of this guide for details.

If you are experiencing mental distress and are offered treatment, you need to be aware of any legal powers that could be used if you refuse. However, the powers must not be used as threats to coerce you into consenting and if you feel this is happening, seek independent legal advice and consider making a complaint. Discuss any concerns you have about treatment with your doctor, making sure he or she knows what it is about the treatment you object to. You can always ask for a second opinion to discuss the treatment proposed. Your own GP can arrange this, or your consultant psychiatrist if you have one.

If you are under 18, the law is complex and it is best to seek specialist legal advice. It may be that you can consent on your own behalf, but this does not necessarily mean you have the same right to refuse. Others, such as your parents, guardian, the local authority or the court, may be able to consent on your behalf.

Part 2. Treatment without consent under the Mental Capacity Act 2005

What is the Mental Capacity Act 2005?

The Mental Capacity Act 2005 (MCA) contains the law that applies to anyone who lacks the mental capacity needed to make some or all of their own decisions. In certain circumstances, the MCA allows a decision to be taken by one person on behalf of another. It also allows individuals to plan ahead for a time when they might lose the capacity to make particular decisions. A person's capacity may be permanently affected (for example, if they have a form of dementia) or for a temporary period (perhaps because they are confused because of a short illness).

What does 'lacking capacity' mean?

The MCA says: "…a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain".

The phrase "in relation to a particular matter" highlights that the level of capacity needed by a person depends on the decision to be made. For example, a person probably needs less capacity to make a decision about everyday matters, such as what to eat, than to decide whether to accept medical treatment. Mental capacity must also be considered at a particular time – at "the material time". This is very important for people who experience mental distress. People who hear distressing voices, for example, may feel able to make a certain decision when they are not hearing the voices but not when the voices are at their most distressing.

Is there a test for mental capacity?

The MCA states that a person is unable to make a decision if he or she is unable to do one or more of the following things:

- understand the information relevant to the decision
- retain the information for long enough to be able to make a decision
- use or weigh up the information as part of the process of making the decision
- communicate the decision by any possible method, such as talking, using sign language, squeezing someone's hand and so on.

What if a person lacks the capacity to make a treatment decision?

If a person lacks capacity to make a decision about medical treatment, the person is unable to give valid consent.

The MCA allows people to plan for what should happen if they ever become unable to make certain decisions in the future. In particular, it allows people to make a **Lasting Power of Attorney (LPA)** or an **advance decision** (see 'Part 4: Making plans'). If a person has not made plans and becomes unable to make a particular decision, the MCA says that someone else may make that decision. This could be a friend, a relative, an informal carer, a professional carer, a doctor, a social worker or a nurse, for example. The MCA also protects a person from legal liability if he or she takes actions and decisions in connection with the care or treatment of a person who lacks the mental capacity to deal with their own care or treatment.

The health professional in charge of the treatment makes the decisions about whether the individual can give consent. That professional should discuss any issues with others involved in the patient's care and with the patient's family and close friends. If it is decided that the patient lacks the capacity needed to give

consent, the treatment can be given if it is deemed to be in the person's best interests. The MCA does not contain a definition of the term "best interests" but does set out a checklist of issues that should be considered by anyone taking an action or decision on behalf of someone else. Note: certain major treatments cannot be given without approval from the **Court of Protection**

3.2 Establish consent for an activity or action

Every adult must be presumed to have the mental capacity to consent or refuse treatment, unless they are

- unable to take in or retain information provided about their treatment or care
- unable to understand the information provided
- unable to weigh up the information as part of the decision-making process.

The assessment as to whether an adult lacks the capacity to consent or not is primarily down to the clinician providing the treatment or care, but carers have a responsibility to participate in discussions about this assessment.

Carers have three over-riding professional responsibilities with regard to obtaining consent.

- To make the care of people their first concern and ensure they gain consent before they begin any treatment or care.
- Ensure that the process of establishing consent is rigorous, transparent and demonstrates a clear level of professional accountability.
- Accurately record all discussions and decisions relating to obtaining consent

Valid consent must be given by a competent person (who may be a person lawfully appointed on behalf of the person) and must be given voluntarily. Another person cannot give consent for an adult who has the capacity to consent. Exceptions to this are detailed below.

Emergency situations

An adult who becomes temporarily unable to consent due to, for example, being unconscious, may receive treatment necessary to preserve life. In such cases the law allows treatment to be provided without the person in the care of a nurse or midwife consent, as long as it is in the best interests of that person.

Medical intervention considered being in the persons best interest, but which can be delayed until they can consent, should be carried out when consent can be given. Exceptions to this are where the person has issued an advanced directive detailing refusal of treatment.

Obtaining consent

Obtaining consent is a process rather than a one-off event. When a person is told about proposed treatment and care, it is important that the information is given in a sensitive and understandable way. The person should be given enough time to consider the information and the opportunity to ask questions if they wish to. Carers should not assume that the person in their care has sufficient knowledge, even about basic treatment, for them to make a choice.

The code supports involving people in the care giving processes. It clearly states:

“You must uphold people’s rights to be fully involved in decisions about their care.”

It is essential that they are given sufficient information to enable them to determine whether or not to accept or decline treatment and care. This right is supported in the code where it states:

“You must respect and support people’s rights to accept or decline treatment and care.”

If a person feels the information they have received is insufficient, they could make a complaint to the NMC or take legal action. Most legal action is in the form of an allegation of negligence. It is therefore essential that carers ensure that they:

“…share with people, in a way they can understand, the information they want or need to know about their health.”

In exceptional cases, for example, where consent was obtained by deception or where not enough information was given, this could result in an allegation of battery (or civil assault in Scotland). However, only in the most extreme cases is criminal law likely to be involved.

Who should obtain consent?

The nurse or midwife proposing to perform a procedure should obtain consent, although there may be some situations where this may be delegated to another.

When choosing to delegate the nurse or midwife must:

"… establish that anyone you delegate to is able to carry out your instructions.”

“… confirm that the outcome of any delegated task meets required standards.”

Usually the individual performing a procedure should be the person to obtain consent. In certain circumstances, you may seek consent on behalf of colleagues if you have been specially trained for that specific area of practice.

There may be occasions where nurses or midwives, although caring for the person, are not responsible for either obtaining consent or performing the procedure. In these cases the nurse or midwife is often best placed to know and to judge what information the person requires in order to make a decision

Carers are reminded of the importance of communication within the team and are advised that any concerns regarding a persons understanding of a procedure should be communicated appropriately. Such difficulties in understanding could be as a result of language differences. Interpreters may be required to assist in such cases. The code on these two points specifically states:

“You must keep your colleagues informed when you are sharing the care of others.”

“You must make arrangements to meet peoples language and communication needs.”

Forms of consent

A person in the care of a nurse or midwife may demonstrate their consent in a number of ways. If they agree to treatment and care, they may do so verbally, in writing or by implying (by co-operating) that they agree. Equally they may withdraw or refuse consent in the same way. Verbal consent, or consent by implication, will be enough evidence in most cases. Written consent should be obtained if the treatment or care is risky, lengthy or complex. This written consent stands as a record that discussions have taken place and of the person's choice. If a person refuses treatment, making a written record of this is just as important. A record of the discussions and decisions should be made.

When consent is refused

Legally, a competent adult can either give or refuse consent to treatment, even if that refusal may result in harm or death to him or herself. Carers must respect their refusal just as much as they would their consent. It is important that the person is fully informed and, when necessary, other members of the health care team are involved. A record of refusal to consent, as with consent itself, must be made.

The law and professional bodies recognise the power of advanced directives or living wills. These are documents made in advance of a particular condition arising and show the persons treatment choices, including the decision not to accept further treatment in certain circumstances.

Although not necessarily legally binding, they can provide very useful information about the wishes of a person who is now unable to make a decision.

Consent of people under 16

If the person is under the age of 16 (a minor), carers must be aware of local protocols and legislation that affect their care or treatment. Consent of people under 16 is very complex, so local, legal or membership organisation advice may need to be sought.

Children under the age of 16 are generally considered to lack the capacity to consent or to refuse treatment. The right to do so remains with the parents, or those with parental responsibility, unless the child is considered to have significant understanding and intelligence to make up his or her own mind about it.

Children of 16 or 17 are presumed to be able to consent for themselves, although it is considered good practice to involve the parents. Parents or those with parental responsibility may override the refusal of a child of any age up to 18 years. In exceptional circumstances, it may be necessary to seek an order from the court.

Child minders, teachers and other adults caring for the child cannot normally give consent.

The Age of Legal Capacity (Scotland) Act 1991 sets out the current position on the legal capacity of children, including giving or withholding consent to treatment. The law is broadly similar to that in England and Wales. However, one important difference is that parents consent cannot override a refusal of consent by a competent child. In Scotland a child under the age of 16 has the legal capacity to consent to his or her own treatment where, according to the Act…"in the opinion of the

qualified medical practitioner attending to him/her, he/she is capable of understanding the nature and possible consequences of the procedure or treatment."

Consent of people who are mentally incapacitated

It is important that the principles governing consent are applied just as vigorously to people who are mentally incapacitated. A person may be described as mentally incapacitated for a number of reasons. There may be temporary reasons such as sedatory medicines, or longer term reasons such as mental illness, coma or unconsciousness.

When a person is considered incapable of providing consent, or where the wishes of a mentally incapacitated person appear to be contrary to the interests of that person, nurses and

midwives caring for that particular person should be involved in assessing their care or treatment. It is important that carers are "aware of the legislation regarding mental capacity, ensuring that people who lack capacity remain at the centre of decision making and are fully safeguarded" (The code, 2008)

The courts have identified certain circumstances when referral should be made to them for a ruling on lawfulness before a procedure is undertaken. These are

- sterilisation for contraceptive purposes
- donation of regenerative tissue such as bone marrow
- withdrawal of nutrition and hydration from a patient in a persistent vegetative state
- where there is doubt as to the person's capacity or best interests.

The Adults with Incapacity (Scotland) Act 2000 and The Mental Capacity Act 2005, (England and Wales) allow people over the age of 16 to appoint a proxy decision-maker. This person has the legal power to give consent to medical treatment when the patient loses the capacity to consent. The Act also requires medical practitioners to take in to account, so far as is reasonable and practicable the views of the patient's nearest relative and their carer.

Mental Health Acts

For people detained under the relevant mental health legislation, the principles of consent continue to apply for conditions not related to the mental disorder. Carers who are involved in the care or treatment of people detained under the relevant mental health legislation, must ensure that they are aware of the circumstances and safeguards needed for providing treatment and care without consent. This information can be obtained from the relevant government health departments of the four countries of the United Kingdom.

3.3 Explain what steps to take if consent cannot be readily established

As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions.

You must always act lawfully, whether those laws relate to your professional practice or personal life.

Failure to comply with this code may bring your fitness to practise into question and endanger your registration.

Make the care of people your first concern, treating them as individuals and respecting their dignity

Treat people as individuals

- You must treat people as individuals and respect their dignity
- You must not discriminate in any way against those in your care
- You must treat people kindly and considerately
- You must act as an advocate for those in your care, helping them to access relevant health and social care, information and support

Respect people's confidentiality

- You must respect people's right to confidentiality
- You must ensure people are informed about how and why information is shared by those who will be providing their care
- You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising

Collaborate with those in your care

- You must listen to the people in your care and respond to their concerns and preferences
- You must support people in caring for themselves to improve and maintain their health
- You must recognise and respect the contribution that people make to their own care and wellbeing
- You must make arrangements to meet people's language and communication needs
- You must share with people, in a way they can understand, the information they want or need to know about their health

Ensure you gain consent

- You must ensure that you gain consent before you begin any treatment or care
- You must respect and support people's rights to accept or decline treatment and care
- You must uphold people's rights to be fully involved in decisions about their care
- You must be aware of the legislation regarding mental capacity, ensuring that people who lack capacity remain at the centre of decision making and are fully safeguarded
- You must be able to demonstrate that you have acted in someone's best interests if you have provided care in an emergency

Maintain clear professional boundaries

Mental Capacity Act

The Mental Capacity Act is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so. This could be due to a mental health condition, a severe learning difficulty, a brain injury, a stroke or unconsciousness due to an anaesthetic or sudden accident.

The act's purpose is:

- To allow adults to make as many decisions as they can for themselves.
- To enable adults to make advance decisions about whether they would like future medical treatment.
- To allow adults to appoint, in advance of losing mental capacity, another person to make decisions about personal welfare or property on their behalf at a future date.
- To allow decisions concerning personal welfare or property and affairs to be made in the best interests of adults when they have not made any future plans and cannot make a decision at the time.
- To ensure an NHS body or local authority will appoint an independent mental capacity advocate to support someone who cannot make a decision about serious medical treatment, or about hospital, care home or residential accommodation, when there are no family or friends to be consulted.
- To provide protection against legal liability for carers who have honestly and reasonably sought to act in the person's best interests.
- To provide clarity and safeguards around research in relation to those who lack capacity.

Under the Mental Capacity Act a person is presumed to make their own decisions "unless all practical steps to help him (or her) to make a decision have been taken without success".

Every person should be presumed to be able to make their own decisions. You can only take a decision for someone else if all practical steps to help them to make a decision have been taken without success. For example, someone might have the capacity to walk into a shop and buy a CD but not to go into an estate agent and purchase a property.

Incapacity is not based on the ability to make a wise or sensible decision.

How 'mental incapacity' is determined

To determine incapacity you will need to consider whether the person you're looking after is able to understand the particular issue that they're making a decision about. You need to consider if they have:

- an impairment or disturbance in the functioning of the mind or brain, and
- an inability to make decisions.

A person is unable to make a decision if they cannot:

- understand the information relevant to the decision,
- retain that information,
- use or weigh that information as part of the process of making the decision, or
- communicate the decision.

Making decisions for someone

If, having taken all practical steps to assist someone, it is concluded that a decision should be made for them, that decision must be made in that person's best interests. You must also consider

whether there's another way of making the decision which might not affect the person's rights and freedom of action as much (known as the 'least restrictive alternative' principle).

Best interests

The Mental Capacity Act sets out a checklist of things to consider when deciding what's in a person's best interests. You should:

- Not make assumptions on the basis of age, appearance, condition or behaviour.
- Consider all the relevant circumstances.
- Consider whether or when the person will have capacity to make the decision.
- Support the person's participation in any acts or decisions made for them.
- Not make a decision about life-sustaining treatment "motivated by a desire to bring about his (or her) death".
- Consider the person's expressed wishes and feelings, beliefs and values.
- Take into account the views of others with an interest in the person's welfare, their carers and those appointed to act on their behalf.

4. BE ABLE TO ENCOURAGE ACTIVE PARTICIPATION

4.1 Describe how active participation benefits an individual

Active participation is a way of working that recognises an individual's right to participate in the activities and relationships of everyday life as independently as possible; the individual is regarded as an active partner in their own care or support, rather than a passive recipient.

1. Fulfil your desire to connect

When you actively participate in a community, you experience your connection to other human beings. You share your ideas, bond with others who have similar interest, and get a sense that you are supported and accepted. Connecting with others deepens your sense of connection. Actively participating is a way to practice expressing your true Self and recognising that Self in someone else.

2. Build truer, deeper relationships

When involved, are you there to "inform yourself," or are you there to build relationships, or, foster relationships? As an active participant in an ongoing group, or even a one time event, you give people the opportunity to interact with you. They get to know you and realise that you're not just there for the contacts. It helps you to build trust. And trust leads to deeper, meaningful understanding of needs and requirements, relationships and friendships.

3. Establish yourself as an expert

As an active participant, means that you are in the conversation. If the opportunity presents itself to share professional information, you are in the loop already. You'll be involved and be part of or maker decisions that will aid your well-being and motivation to improve your life and your experiences.

4. Take ownership

Participating in a group in the surest way to gain ownership. You become a stakeholder, your voice is heard. Better than that, you are in a position to do something to make the changes you want to see. You own a piece of the pie.

5. Managing life changes

Active participants have involvement which is life changing and frees the individual up from some of the frustrations and angst that beset us all. It helps that others are involved and at the point of decision it is the individual who decides what is going to happen and how, within legal, moral and financial considerations

4.2 Identify possible barriers to active participation

Discrimination by others is a barrier to active participation

Discrimination means treating someone worse than other people for some reason.

In some situations, discrimination is acted on based on:

- age
- disability
- race
- religion or belief
- sex
- sexual orientation
- gender identity.

Other barriers include

- Refusal to co-operate
- Peer pressure
- Financial resources
- Time and distance
- Medication issues
- Lack of understanding
- Misunderstanding
- Poor advice and counselling
- Embarrassment
- Poor Transport arrangements
- Failure to inform
- Date, time discrepancies
- Forgetting arrangements
- Problems on the day
- Poor communications (no phone etc)
- Badly explained activities (individual doesn't understand)
- Over professional approach (individual confused by technical wording)
- Medical Illness (Short Term)
- Mental Illness (Short term)

BARRIERS TO ACTIVE PARTICIPATION: COMMUNICATION

Minimise any Barriers to Communication. Try a variety of approaches if the message is unclear.

Barriers being such as:

- Boredom or Impatience
- Threatening or Use of Harsh Language
- Negating or Devaluation of an Individual
- Jumping to Conclusions
- Judgmental Approach, Unwanted Advice, Arguing
- Distractions
- Interruptions
- Closed Questions
- Monosyllabic Answers
- Multiple or Overloading Questioning
- Mumbling
- Unspoken Unresolved Issues

4.3 Demonstrate ways to reduce the barriers and encourage active participation

Breaking Down Those Barriers

Always treat people the way you would wish to be treated if you needed the same form of action or advice as you would in that circumstance. Earn individuals trust and respect by acting in a professional way. Set High standards for yourself and follow the established method and Procedures. Your attitude and actions affect how people feel about themselves. Everything about the carer sends signals and affects the way the individual feel and react to them; the way carers stand and move, their appearance and their demeanour

Taking Steps to Break Down Barriers of Communication

- Openness
- Point out Discrepancies
- Facts
- Stay on Subject
- Be Specific / Example
- Key Words / Phrases
- Clarify
- Summarise
- Open Questions
- Treat As You Would
- Friendly Tone
- Body Language
- Time
- Interest
- Convey Warmth
- Empathy
- Respect, Listen, Non Judgemental
- Honesty Trustworthiness Reliability Truthfulness Dependability

GUIDELINES FOR EFFECTIVE COMMUNICATIONS

Communication must take place with employees at their level of understanding, using an appropriate manner, level and pace according to Individual abilities.

- Convey Warmth
- Show Respect with Active Listening and Without Passing Judgement
- Convey Empathy by Reflecting the Employee's Feelings
- Show Interest
- Take Time to Listen
- Be Aware of Body Language
- Use a Friendly Tone
- Treat the Employee as you Would Wish to be Treated
- Ask Open Questions
- Summarise at Relevant Points in Your Own Words
- Clarify as Required
- Use Key Words or Phrases
- Be Specific, Ask for Specific Examples
- Do not Allow the Conversation to Go Off the Subject
- Stick to the Facts
- Point Out Discrepancies

5. BE ABLE TO SUPPORT THE INDIVIDUAL'S RIGHT TO MAKE CHOICES

5.1 Support an individual to make informed choices

Carer ethics concerns itself with activities in the field of care. Carers ethics have the principles of beneficence (The state or quality of being kind, charitable, or beneficial.), non-malfeasance (Not to have misconduct or wrongdoing) and respect for autonomy (The condition or quality of being autonomous; independence). It can be distinguished by its emphasis on relationships, human dignity and collaborative care.

The concept of caring means that it tends to examine individual needs rather than 'curing' by exploring the relationship between the carer and the individual.

The progression of care has also shifted more towards the carer's obligation to respect the human rights of the individual and this is reflected in the code of practice devised by the general social care council.

Distinctive nature

Generally, the focus of care is more on developing a *relationship* than concerns about broader principles, such as beneficence and justice. Carer's seek a collaborative relationship with the individual in care. Themes that emphasises respect for the autonomy and dignity of the individual by promoting choice and control over their environment are commonly seen. This is in contrast to paternalistic practice where the health professional chooses what is in the best interests of the person from a perspective of wishing to cure them.

Carers seek to defend the dignity of those in their care. It is because carers having a respect for people and their autonomous choices. People are then enabled to make decisions about their own treatment. Amongst other things this grounds the practice of informed choice that should be respected by the carer.

The Principles of informed choice

- Services should be person centred in that they are flexible and responsive to need.
- Individuals continue to make a contribution to society and should be viewed as assets to society.
- Individuals want to live independently in their own homes or in a homely environment in their chosen community.
- Individuals want services that help them to help themselves.
- Individuals want local services to help them maintain their independence and safety in the community and promote good health.
- Services need to provided in a timely fashion as soon as possible once the need has been identified.
- Services will support informal care networks in terms of family, friends, and community.
- Individuals should be protected from harm, abuse, neglect and isolation.
- When they require treatment in an acute hospital setting they want:
    - the best quality treatment as close to home as possible
    - a smooth transition of care between community services and hospital and between hospital and community services.
    - to return home as soon as possible with appropriate support when required
    - access to rehabilitation services to maximise their level of independence
- Individuals want access to good quality information to enable them to make informed decisions about services they may need.
- Individuals want to retain control of decisions concerning their life and lifestyle.
- Admission to residential care will be made on the basis of positive and informed choice.

These principles are consistent with the focus on Independence, Participation, Care, Self-fulfilment and Dignity.

5.2 Use agreed risk assessment processes to support the right to make choices

Managing risks and safeguarding

'Giving people more choice and control inevitably raises questions about risk, both for individuals exercising choice over their care and support, and for public sector organisations who may have concerns about financial, legal or reputational risk.' ('Personalisation and support planning', DH, 2010, para 133)

'Personalisation and support planning' indicates two aspects of risk that need to be addressed in practice:

1. **Safeguarding,** where staff will need to:

- implement the organisation's procedures for safeguarding, including joint working agreements with partner agencies;
- work with other professionals and agencies to reduce risk and safeguard adults and carers;
- respond using the organisation's procedures to signs and symptoms of possible harm, abuse and neglect;
- take appropriate action when there are serious safeguarding concerns, seeking advice from line managers and accessing specialist expertise;
- work with services when there is any indication of child safeguarding concerns.

2. **Risk assessment and management**, where staff will need to:

- implement the organisation's procedures for risk assessment and management, including joint working agreements with partner agencies;

- use agreed approaches to the assessment and management of risks when working in situations of uncertainty and unpredictability;
- seek support when risks to be managed are outside own expertise;
- when necessary, work within the organisation's procedures for managing media interest in risk and safeguarding situations.

POLICY ON RISK ASSESSMENT

Policy Statement

The home recognises its responsibility to ensure that all reasonable precautions are taken to provide and maintain working conditions which are safe, healthy and compliant with all statutory requirements and codes of home, including the statutory duty on employers to conduct regular health and safety risk assessments.

The home is committed to ensuring the health, safety and welfare of its staff, so far as is reasonably practicable, and of all other persons who may be affected by our activities including individuals, their relatives and visitors.

The home fully complies with Department of Health guidance *Independence, Choice and Risk: a guide to best practice in supported decision making.*

Aim of the Policy

This policy is intended to set out the values, principles and policies underpinning this home's approach to risk assessment and health and safety.

Risk Assessment Policy

The following points constitute the policy of this home.

- a risk assessment should be undertaken, by a trained and qualified person, of the potential risks to individuals and staff associated with delivering any agreed package of care before the care or support worker commences work — where appropriate this should include risks associated with assisting with medication and other health-related activities and should be updated annually or more frequently if necessary
- the risk assessment should include an assessment of the risks for individuals in maintaining their independence and daily living within the home
- the manner in which the risk assessment is undertaken should be appropriate to the needs of the individual whose views, and those of their relatives or advocates, should be taken into account
- a separate moving and handling risk assessment should be undertaken, by a member of staff who is trained for the purpose, whenever staff are required to help a individual with any manual handling task, as required under the **Manual Handling Operations Regulations 1992**
- a comprehensive plan to manage the risks (including manual handling and the risks to individuals) should be drawn up, in consultation with the individual, their relatives or representatives; this should be included in the Individual Plan and kept in the home of the individual for home care staff to refer to, a copy should also be placed on the personal file kept in the agency office; this risk management plan should be implemented and reviewed annually or more frequently if necessary
- new risks which arise (including defective appliances, equipment, fixtures or security of the premises) should be reported by care workers to their line managers or supervisors or identified during regular reviews or the Individual Plan
- only staff who are both trained to undertake risk assessments and competent to provide the care should be assigned to emergency situations and where pressure of time does not allow a risk

assessment to be undertaken prior to provision of the care or support
(h) two people fully trained in safe handling techniques and the equipment to be used should always be involved in the provision of care when the need is identified from the manual handling risk assessment

- the name and contact number of the home responsible for providing and maintaining any equipment under the **Manual Handling Operations Regulations 1992** and the **Lifting Operations and Lifting Equipment Regulations 1998** should be recorded on the risk assessment
- any manual handling equipment provided should be maintained in a safe condition to use and be subject to regular inspections by the manufacturers, records of all such equipment and their maintenance schedules are kept in the central office; in this organization is responsible for ensuring that equipment is maintained adequately
- a responsible and competent person will be on call and contactable at all times when care and support staff are on duty
- staff should comply with the home's staff travelling policy.

Health and Safety Risk Assessments

The home recognises that risk assessments are a legal requirement under Regulation 3 of the **Management of Health and Safety at Work Regulations 1999** (MHSWR). The home believes that risk assessments should identify hazards and resulting risks to employees and other persons who may be affected by work activities. The home understands a hazard to be the potential for harm, and risk is the likelihood of that harm actually occurring and the severity of the harm (e.g. slight injury, major injury, death).

The home will fully implement Regulation 3 of MHSWR which requires employers to:

- make an assessment of risks to employees
- make an assessment of risks to others who might be affected by work activities such as individuals, contractors, visitors and the public
- clearly identify the measures needed to protect the persons in points 1 and 2 above
- review the assessment and make necessary changes if:
  - there is any significant change which affects risk (egg a new employee, machine or individual).
  - there is reason to think it is no longer valid
  - where there are five or more employees, keep records of:
  - the significant findings of the assessment
  - any group of employees identified by it as being particularly vulnerable.

The home will include the following as areas of potential hazard or risk:

- hazardous substances within the scope of the **Control of Substances Hazardous to** Health **Regulations 2002** (e.g. chemical hazards, drugs, sharps, body fluids, hazardous waste)
- and others not currently covered by COSHH (e.g. lead, asbestos and substances which are hazardous for reasons other than their toxicity, i.e. those which are flammable, or which enhance combustion, react violently, etc)
- manual handling and the moving of individuals
- use of display screen equipment (e.g. computers) electrical hazards work equipment and machinery workplace hazards (e.g. space, clutter, lighting, heating, ventilation, tripping hazards,
- safe access,
- inadequate sanitary facilities, e.g. toilets, drinking water)

- emergencies (e.g. fire, injuries requiring first aid, dangerous spillages, etc)
- violence or threats and abuse.

5.3 Explain why a worker's personal views should not influence an individual's choices

Personal Beliefs and Care Practice

1. 1. In good care practice, carers are advised that:
2.

- You must make the care of your individual client is your first concern you must treat your individual clients with respect, whatever their life choices and beliefs (paragraph 7).
- You must not unfairly discriminate against individual clients by allowing your personal views to affect adversely your professional relationship with them or the treatment you provide or arrange.
- If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the individual client and tell them they have the right to see another carer. You must be satisfied that the individual client has sufficient information to enable them to exercise that right. If it is not practical for an individual client to arrange to see another carer, you must ensure that arrangements are made for another suitably qualified colleague to take over your role.
- You must not express to your individual clients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress.

This supplementary guidance is intended to provide more detailed advice about how to comply with these principles. It also includes examples of specific scenarios on which we are regularly asked for advice. The examples are not exhaustive, and will be amended and updated as new issues are raised.

Serious or persistent failure to follow this guidance will put your position at risk.

Personal beliefs and the carer-individual client relationship

- Personal beliefs and values, and cultural and religious practices are central to the lives of carer's and individual clients.
- Individual clients' personal beliefs may be fundamental to their sense of well-being and could help them to cope with pain or other negative aspects of illness or treatment. They may also lead individual clients to ask for assistance which others may not feel are in their best clinical interests, or to refuse treatment which is.
- All carer's have personal beliefs which affect their day-to-day practice. Some carer's' personal beliefs may give rise to concerns about carrying out or recommending particular procedures for individual clients.
- This guidance explores the ways we expect carer's to approach some of the issues arising from their own personal beliefs and those of their individual clients. It attempts to balance carer's' and individual clients' rights - including the right to freedom of thought, conscience and religion, and the entitlement to care and treatment to meet clinical needs - and advises on what to do when those rights conflict.

- While we do not impose unnecessary restrictions on carer's, we expect them to be prepared to set aside their personal beliefs where this is necessary in order to provide care in line with the principles of good care practice.

Individual clients' personal beliefs

- Trust and good communication are essential components of the carer-individual client relationship. Individual clients may find it difficult to trust you and talk openly and honestly with you if they feel you are judging them on the basis of their religion, culture, values, political beliefs or other non-Care factors. For some individual clients, acknowledging their beliefs or religious practices may be an important aspect of a holistic approach to their care. Discussing personal beliefs may, when approached sensitively, help you to work in partnership with individual clients to address their particular treatment needs. You must respect individual clients' right to hold religious or other beliefs and should take those beliefs into account where they may be relevant to treatment options. However, if individual clients do not wish to discuss their personal beliefs with you, you must respect their wishes.

Examples of situations where individual clients' personal beliefs may affect care

Refusal of blood products by Jehovah's Witnesses

- Many Jehovah's Witnesses have strong objections to the use of blood and blood products, and may refuse them[1], even if there is a possibility that they may die as a result.
- You should not make assumptions about the decisions that a Jehovah's Witness might make about treatment with blood or blood products. You should ask for and respect their views and answer their questions honestly and to the best of your ability[2]. You may also wish to refer the medical practitioner to contact the hospital liaison committees established by the Watch Tower Society (the governing body of Jehovah's Witnesses) to support Jehovah's Witnesses faced with treatment decisions involving blood. These committees can advise on current Society policy regarding the acceptability or otherwise of particular blood products. They also keep details of hospitals and carer's who are experienced in 'bloodless' Care procedures.

Carer's' personal beliefs

- Your first duty as a carer is to make the care of your individual client your first concern. Individual clients are entitled to expect that you will offer them good quality care based on your clinical knowledge and professional judgement.
- You must not allow any personal views that you hold about individual clients to prejudice your assessment of their needs or delay or restrict their access to care. This includes your view about an individual client's age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status.
- You should not normally discuss your personal beliefs with individual clients unless those beliefs are directly relevant to the individual client's care. You must not impose your beliefs on individual clients, or cause distress by the inappropriate or insensitive expression of religious, political or other beliefs or views. Equally, you must not put pressure on individual clients to discuss or justify their beliefs (or the absence of them).
- Individual clients have a right to information about their condition and the options available to them. You must not withhold information about the existence of a care plan because carrying it out or giving advice about it conflicts with your religious or moral beliefs.
- Individual clients may ask you to advise on, or refer them for a care plan or procedure which is not prohibited by law or statutory code of practice in the country where you work, but to which you have a conscientious objection. In such cases you must tell individual clients of their right to seek

advice from a care manager with whom they can discuss their situation and ensure that they have sufficient information to exercise that right. In deciding whether the individual client has sufficient information, you must explore with the individual client what information they might already have, or need.

- In the circumstances where the individual client cannot readily make their own arrangements to see another appropriate carer, you must ensure that arrangements are made, without delay, for another carer to take over their care. You must not obstruct individual clients from accessing services or leave them with nowhere to turn. Whatever your personal beliefs may be about the procedure in question, you must be respectful of the individual client's dignity and views.
- You must be open with individual clients - both in person and in printed materials such as practice leaflets - about any treatments or procedures which you choose not to provide or arrange because of a conscientious objection, but which are not otherwise prohibited.
- If your post involves arranging treatment or carrying out procedures to which you have a conscientious objection, you should explain your concerns to your employer or registering body. You should explore constructively with them how to resolve the difficulty without compromising individual client care, and without placing an unreasonable burden on colleagues.
- You have an overriding duty to provide care for individual clients who are in need of Care Management, whatever the cause of that need. It is not acceptable to seek to opt out of treating a particular individual client or group of individual clients because of your personal beliefs or views about them.

5.4 Describe how to support an individual to question or challenge decisions concerning them that are made by others

You may wish to raise concerns about how an assessment was carried out. You may wish to challenge decisions about what care will be provided, including care put in place after a client is discharged from care. You may wish to challenge the amount that is being charged for services. If your complaint is on behalf of the person you care for, you must have their consent if they have the capacity to do so.

Firstly, a care can answer the issues of a care plan and treatments in the best but basic level to give the client an understanding of the issues and situation. The carer may then support the individual by expressing their concerns to a senior member of staff who can advise the carer to speak to the individual, or can speak to the individual themselves. The concerns may continue to be questioned to more senior staff, and may lead to answers given by outside professionals to give answers, i.e., doctors, social workers etc.

The carer may speak to family and friends on the individual's behalf, and they may seek advice as of the paragraph above.

Whatever the situation it is important to know that the individual has rights and have access to advice.

Where verbal solutions cannot be found, a carer may advise that a written complaint may be required, as the home has a complaints procedure:

COMPLAINTS

The home welcomes any Complaints about the services delivered or how to improve the care services provided. All complaints about the service provided within the home can be made verbally, in writing or by telephone and will be treated seriously.

Complaints can be made to the manager of the home, or the registering authority or other agency.

You have the right to make comment or complain about:

- A service you have received
- A Lack of service
- A plan or decision affecting you or someone close to you.

It is your right to have your complaint fully investigated. Unless we know of your concerns we cannot help you, so please let us know

You will find a complaints form in the managers office

Please use the form to tell us what you think of our services.

Carers who have been through making a complaint say it is always helpful to make a note of telephone calls. Write down who you spoke to, the time and a brief note about what was said.

COMPLAINTS POLICY

Policy Statement

The Home believes that if a client wishes to make a complaint or register a concern they should find it easy to do so. It is The Home policy to welcome complaints and look upon them as an opportunity to learn, adapt, improve and provide better services. This policy is intended to ensure that complaints are dealt with properly and that all complaints or comments by clients and their relatives, support workers and advocates are taken seriously.

The policy is not designed to apportion blame, to consider the possibility of negligence or to provide compensation. It is not part of The Home's disciplinary policy.

The Home believes that failure to listen to or acknowledge complaints will lead to an aggravation of problems, client dissatisfaction and possible litigation. The Home supports the concept that most complaints, if dealt with early, openly and honestly, can be sorted at a local level between just the complainant and The Home. If this fails due to either The Home or the complainant being dissatisfied with the result the complaint will be referred to the General Social Care Commission and legal advice will be taken as per necessary.

The Home adheres fully to its responsibilities to the individual.

Aim

The aim of The Home is to ensure that its complaints procedure is properly and effectively implemented and that clients feel confident that their complaints and worries are listened to and acted upon promptly and fairly.

Goals

The goals of The Home are to ensure that:

- clients, support workers, users and their representatives are aware of how to complain and that the home provides easy to use opportunities for them to register their complaints
- a named person will be responsible for the administration of the procedure

- every written complaint is acknowledged within five working days
- all complaints are investigated within 28 days of being made
- all complaints are responded to in writing by The Home within 28 days of being made
- complaints are dealt with promptly, fairly and sensitively with due regard to the upset and worry that they can cause to both staff and clients. The named complaints manager with responsibility for following through complaints for the Home is John Eaton

The Home believes that, wherever possible, complaints are best dealt with on a local level between the complainant and The Home. If either of the parties is not satisfied by a local process the case should be referred to the General Social Care Council

Complaints Procedure

Oral complaints

- All oral complaints, no matter how seemingly unimportant, should be taken seriously.
- Front line staff who receive an oral complaint should seek to solve the problem immediately.
- If staff cannot solve the problem immediately they should offer to get The Home manager to deal with the problem.
- All contact with the complainant should be polite, courteous and sympathetic. There is nothing to be gained by staff adopting a defensive or aggressive attitude.
- At all times staff should remain calm and respectful.
- Staff should not accept blame, make excuses or blame other staff.
- If the complaint is being made on behalf of the client by an advocate it must first be verified that the person has permission to speak for the client, especially if confidential information is involved. It is very easy to assume that the advocate has the right or power to act for the client when they may not. If in doubt it should be assumed that the client's explicit permission is needed prior to discussing the complaint with the advocate.
- After talking the problem through, The Home managers or the member of staff dealing with the complaint should suggest a course of action to resolve the complaint. If this course of action is acceptable then the member of staff should clarify the agreement with the complainant and agree a way in which the results of the complaint will be communicated to the complainant (i.e. through another meeting or by letter).
- If the suggested plan of action is not acceptable to the complainant then the member of staff or The Home manager should ask the complainant to put their complaint in writing to the Home and give them a copy of The Home's complaints procedure.
- In both cases details of the complaints should be recorded in the Complaints Book, the client's file and in the home records.

Serious verbal or written complaints

1. Preliminary steps:

- when a complaint is referred on to a The Home manager or is received in writing it should be passed on to the named complaints manager who should record it in the Complaint Book and send an acknowledgment letter within two working days; the complaints manager will be the named person who deals with the complaint through the process

- if necessary further details are obtained from the complainant; if the complaint is not made by the client but on the client's behalf, then consent of the client, preferably in writing, must be obtained from the complainant
- a leaflet detailing The Home's procedure should be forwarded to the complainant
- if the complaint raises potentially serious matters, advice should be sought from a legal advisor to The Home; if legal action is taken at this stage any investigation by The Home under the complaints procedure should cease immediately
- if the complainant is not prepared to have the investigation conducted by The Home they should be advised to contact the General Social Care Council and be given the relevant contact details.

2. Investigation of the complaint by The Home:

- immediately on receipt of the complaint The Home should launch an investigation and within 28 days The Home should be in a position to provide a full explanation to the complainant, either in writing or by arranging a meeting with the individuals concerned
- if the issues are too complex to complete the investigation within 28 days, the complainant should be informed of any delays.

3. Meeting:

- if a meeting is arranged the complainant should be advised that they may if they wish bring a friend or relative or a representative such as an advocate
- at the meeting a detailed explanation of the results of the investigation should be given and also an apology if it is deemed appropriate (apologising for what has happened need not be an admission of liability)
- such a meeting gives The Home the opportunity to show the complainant that the matter has been taken seriously and has been thoroughly investigated.

4. Follow-up action:

- after the meeting, or if the complainant does not want a meeting, a written account of the investigation should be sent to the complainant, this should include details of how to approach The General Social Care Commission if the complainant is not satisfied with the outcome
- the outcomes of the investigation and the meeting should be recorded in the Complaint Book and any shortcomings in The Home procedures should be identified and acted upon
- The Home should discuss complaints and their outcome at a formal business meeting and The Home complaints procedure should be audited by The Home manager every six months.

6. BE ABLE TO PROMOTE INDIVIDUALS' WELL BEING

6.1 Explain how individual identity and self esteem are linked with well-being

DEFINITIONS

The following definitions are aimed at fostering a common understanding.

Identity

Identity can be defined as an internalised, self-selected concept based on a combination of experiences inside and outside of the family. It is formed by selecting values, beliefs and concepts that are

representative of an individual's unique world. Identity includes religion, culture, language, sexuality, intellectual functioning, physical appearance, politics, history, and social environment. The identity of an individual develops and crystallises across their lifespan. It begins with a young child's awareness of significant others and an initial sense of self. It extends to a mature adult's integration and evaluation of their life accomplishments.

Whilst identity development occurs across the lifespan, it is particularly evident during adolescence where it becomes a focal point in the process of transition to early adulthood. Adolescents need consistent support and encouragement during this difficult period where they are attempting to consolidate their sense of identity.

Developing a sense of identity is a fundamental aspect of growing up. It is instrumental in achieving optimal psychological functioning and well-being.

Self-esteem

Self-esteem is a central and essential component in life satisfaction. Components of high self-esteem include happiness, security, affection, energy availability, alertness, calmness, clear-mindedness, singleness of purpose, lack of restraint and spontaneity. In contrast, low self-esteem is described as encompassing unhappiness, anger, feelings of threat, weariness, withdrawal, nervousness, disorganisation, conflict, feelings of restraint and self-consciousness Most individuals long to maintain their youth by keeping a fresh perspective in life, a positive outlook and attitude, keeping themselves fit and healthy and feeding their minds with intellectual stimulation. Some even go to the extent of pursuing artificial means of looking younger such as undergoing cosmetic surgery just so their looks will not reveal how old they really are.

Well-being[1]

Well-being is a complex construct that can be defined as the degree to which a person is fully functioning. It implies growing and developing to a level which reflects the best of one's potential. The process of achieving this can be culturally contextual but the ultimate feeling associated with well-being is consistent on a global level. It is an array of positive aspects of functioning which are promoted by attaining strong attachment relationships, acquiring age appropriate cognitive, social, and interpersonal skills as well as achieving an optimum health status.

Describe What You Can Do to Help People in Your Care Setting Keep Their Sense of Identity and Self-Esteem.

For the elderly, they need all the care, support and understanding they can get from the people around them because their advanced age limits their capabilities, leaving them feeling helpless and worse, useless. If before they were productive individuals, now, mostly ailing from certain illnesses, they have no choice but to depend on others to help them survive. In understanding and caring for the elderly, one not only needs to get to know them personally and be patient with their quirks and limitations, but also know about their developmental needs with careful research.

First of all, I will treat them with respect and accept them for who they are. I will not attempt to assist them in things I know they can manage on their own. That way, they will feel that they are still useful. Simple things like the basic activities of daily living such as dressing, grooming, cooking and general House-keeping.

Encouraging them to continue doing things that make use of their talents will indeed boost their self-esteem especially if these are appreciated by the people around them. If one is adept with a certain craft or has talent in performing music, then the necessary support shall be provided. Engaging the support of the significant people in their lives will tremendously help to raise a flagging sense of identity and self-esteem. What a joy is there than having all your loved ones in awe of the things you do especially well even if you believe you have lost your talent in such a magnificent craft!

Many elderly individuals suffer from depression due to the fact that they are already limited in their capabilities. Some need to undergo therapy just to get by and get on the process of aging. Managing behaviour is one effective approach that can indeed help them. People suffering from psychological problems are assumed to focus more on their flaws that pull them down than on their potentials that may spur them up to success. Much of our psychological problems are caused by frustrations due to our acknowledged human fallibility.

List Three Hinds of Rights People Have and One Way in Which You Would Ensure That Each Kind Was Met in Your Work.

- A person has the right to receive considerate care. Be considerate.
- A person has the right to have his needs met.
- A person has the right to be free from abuse

Any person deserves to be treated with utmost respect regardless of his background. No matter who they are or where they come from, they would appreciate being called by their names. Levelling with them about the care being providing, and involving them in their own care is a must. Adjusting my own language to them to understand clearly my explanations regarding their care is an effort I need to exert especially if they have some disabilities. If they are unable to understand me, then their representative must be informed accordingly.

They will receive equal treatment with others I may have under my care, nothing more, nothing less. However, with each one, I will strive to make that person feel special, as if he or she took top priority.
Needs to be met if he or she is under medical supervision, the intervention necessary, and the medication must be administered on schedule. Otherwise, they must follow all the health rules: exercise, eat a balanced diet, and get enough rest and sleep, not to mention brush, floss and gargle every day. They have to consult his dentist and doctor at regular intervals. If they need dentures or eyeglasses, make sure they fit and are comfortable.

In cases where abuse or neglect is suspected, these have to be reported to the proper authorities. No person deserves to be hurt and taken advantaged of and if someone I know has the symptoms of abuse, and then I am obligated to protect them by reporting the case to be further investigated upon.

List Three Codes of Practice or Policies in Your Setting that Would Be Important to Read When Making Sure You Respect People's Rights.

Safety First: Keep a Person Free from Harm by Preventing Injuries. Since elderly people may be prone to falls due to a less stable gait or maybe even the incapacity to move their way around, safety measures must be ensured to protect them. The environment must be kept accident-proof by installing facilities such as handrails, floors with rubber strips to avoid slips, furniture with rounded edges, etc. Staff or family members caring for the elderly must be vigilant in anticipating possible sources of accidents without being too paranoid. For example, if an elderly woman is awaiting a phone call, it would be wise to offer her a chair near the telephone instead of her rushing to it the minute it rings.

Open Two-Way Communication. Communication is essential to human Interactions especially with the elderly who need to still be in touch with others. My setting should encourage open communication. Caregivers should be available to talk, listen and respond to a person's thoughts and feelings and in turn, the elderly wards get to listen to their caregivers' thoughts, opinions and information about their health. Communication is not limited to positive feedback. Complaints of the elderly are also welcomed, acknowledged and acted upon by the staff.

Dignity: Treat Each Person with Respect at All Times. The Golden Rule of doing unto others what you want them to do unto you apply in every situation. Respect begets respect, and certainly the elderly deserve it. Be courteous and polite to them, giving them preferential treatment over younger, more able wards. Treating them gently, knowing they can be fragile in their old age will be much appreciated.

Allowing them their privacy by not barging in their bedrooms, intruding into their private time with the significant people in their lives, not touching their belongings or mail without their permission are ways of upholding their dignity as persons.

I am bound by my commitment to confidentiality that I keep information regarding my ward's case to myself and to those likewise entrusted with it such as immediate family members. Due to its confidentiality, there are times when I would need a great deal of self-control in keeping myself from divulging such information especially if I feel it would be useful. For instance, if the information tagged as confidential is the gravity of the person's disease, necessitating that the number of visitors be kept to a minimum, and then well-meaning people keep dropping by to see him and asking him how he is, I would be in a dilemma if I should divulge the truth or just keep mum about it as if everything is alright. I might just be able to refer them to the doctor or the immediate family and exit gracefully. I must be able to keep a poker face so that my feelings or thoughts will not be transparent to them.

List Five Laws or Codes to Do with Preventing Discrimination against People:

All human beings are born free and equal in dignity and rights.... Everyone is entitled to all ... rights and freedoms ... without distinction of any kind.... All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination ... and against any incitement to ... discrimination.... Everyone has the right to a standard of living adequate for ... health and well-being .. Including ... the right to security in the event of ... disability (The Universal Declaration of Human Rights).

This says it all. It upholds the dignity of all human beings and their right to be treated fairly. Levine's clinical work with students with learning disabilities has also indicated that a recognition of and capitalization on their specific strengths of mind fosters their development, whereas a focus on their specific weaknesses compromises their development. This would be a good guiding principle when dealing with the elderly. In doing so, their self-esteem is built up and they are empowered to push themselves towards their optimal potentials even in their advanced age (2002).

Identifying essential elements valued by settings upholding ant discriminatory practices as: Diversity and the valuing of all differenced. A setting whose practice is ant discriminatory will celebrate and value differences in identities, cultures, religions, abilities and social practices.

Self-esteem and positive group identity A setting will recognize the impact of discrimination, the social inequalities and their effect on the elderly and their families. Such a setting will identify and remove practices and procedures that discriminate. Fulfilment of individual potential A setting will value children and adults for their individuality and ensure a sense of belonging that promotes self-esteem. It will respect where each person comes from, what they achieve and what they bring to the learning situation. The full participation of all groups in society A setting will appreciate the importance of what is learned and what can be unlearned in the later years and recognise the wider aim of life skills, work and education to lay the foundations of a more just and equitable society

Practicing anti-discriminatory approaches involve a thorough understanding and acceptance of diversity. One needs to examine personal prejudices and work towards unlearning such prejudices and promoting positive values for everyone concerned: Gathering a repertoire of strategies to ensure settings are welcoming, nonthreatening and stimulating places to be where children and families are valued because of their differences and not in spite of them .Of course, constantly monitoring, evaluating and adjusting practice and procedures to be appropriate to a variety of cases must be strived for.

Give Three Examples of Types of Harm or Abuse that People You Care For Might Be At Risk of Suffering.

Neglect: some elderly may be considered by their family members as a burden to care for because they are not productive and therefore not contributing to the family anymore. Hence, they may be taken for granted as in forgotten to be bathed, fed, taken out to breathe fresh air, given medication for their illnesses, not brought to the doctor for check-ups, entertained or talked to leaving the poor elderly feeling abandoned an uncared for. The symptoms of neglect are evident in that they appear to be unclean, famished and malnourished, sickly and generally unhealthy.

Emotional Abuse: neglect can lead to emotional abuse in that the elderly's hurt feelings are not taken into consideration. On top of that, family members may be rude to them due to impatience at their slow movements or total dependence on them. They may be verbally abused especially when tensions run high in caring for them. Their emotional health is not given priority because for some, they may be thought of as useless and forgetful of episodes that cause pain.

Exploitation: the elderly may be taken advantaged on, especially in money matters. Younger, guile relatives may cheat them in handling their finances thinking these old folks will not remember details of financial transactions.

When Recoding Information About Abuse What Must You Try to Do and What Should You not Do?

Abuse can come in many forms as long as it harms or mistreats an individual on purpose. It can happen in all parts of society, and abusers may be male or female, of any age, may be members of any race, or practice any religion. I am aware that in my setting, I should be alert for signs of abuse directed towards the people I care for, as the abuser could even be someone they know very well. Should I have suspicions of ongoing abuse, I have the legal responsibility to report it to the proper authorities. Before doing so, I must gather enough evidence to support my claim. Recording observed signs of abuse and anecdotal evidence will indeed help in the investigation. If I suspect physical abuse, the signs manifested on my ward's body may be burns, bruises, reddened areas that do not go away, scratches, cuts or bite marks. Emotional abuse may be manifested in people who may not make eye contact, is withdrawn, sad or fearful or may shield himself. And a sexually abused individual may have bruises, scratches and cuts around the breasts, buttocks or genitals. The abused may have vaginal or rectal bleeding or may refuse personal care. However, an abused person may also not exhibit any of these signs, which will be difficult for me to prove that the abuse happened. He or she may even be very protective of his or her abuser for fear of being abused further, or may be because the abuser is a known and trusted person.

In any case, it would help if I share the information I have with my superiors or a very trusted member of my ward's family. I need to be careful of appearing judgmental or accusative of the suspected abuser because it may backfire to my ward again. Confidentiality is a key, and choosing the right people to divulge such information should be done with discernment.

Being in a disturbing situation, I believe that reporting the abuse may help my ward out of a dangerous situation. On the other hand, the abuser should also learn that controlling another person by harming him

or her will have dire consequences on himself. Hopefully, this will prevent him from further abusing others. Of course in reporting the abuse, I should refrain from implicating the abused by making it appear that it was he or she who told me. His or her protection and safety is of utmost priority.

In What Ways Can You Ensure You Work in an Anti-Discriminatory Way?

Ageism or the negative attitudes towards the elderly is a form of prejudice resulting in discriminatory behaviour against them. For example, in companies, older, experienced workers are encouraged to retire early because of the stereotypes regarding older people's abilities and productivity. Instead, the frame of mind I should have is to focus on people's skills and experience rather than age when delegating tasks. Another area where discrimination abounds is religion. I must keep an open mind and heart in acknowledging, accepting and respecting religions other than my own. Should my ward request for a religious service, then I must exert all efforts to arrange for one. Food restrictions on some religions must also be observed, such as not serving pork to Muslim wards. During the holidays, if I have Jews and Christians under my care, then we will celebrate both Hanukkah and Christmas. It can be a stretch giving in to requests related to religion, and even culture, but if I am to provide quality care, then I should be blind to differences and instead focus more on our similarities as human beings. Diversity must be embraced in order for harmony to prevail.

6.2 Describe attitudes and approaches that are likely to promote an individual's well-being

Promoting mental wellbeing at work

Why work is important to employees' mental wellbeing

The following definition of mental wellbeing is used in this guidance:

'Mental wellbeing is a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society.'

Mental wellbeing at work is determined by the interaction between the working environment, the nature of the work and the individual. Work has an important role in promoting mental wellbeing. It is an important determinant of self-esteem and identity. It can provide a sense of fulfilment and opportunities for social interaction. For most people, work provides their main source of income. Work can also have negative effects on mental health, particularly in the form of stress. Work-related stress is defined as 'the adverse reaction people have to excessive pressure or other types of demand placed upon them2'. Although pressure can motivate employees and encourage enhanced performance, when pressure exceeds an employee's ability to cope, it becomes a negative force in the form of stress.

Working environments that pose risks for mental wellbeing put high demands on a person without giving them sufficient control and support to manage those demands. A perceived imbalance between the effort required and the rewards of the job can lead to stress. A sense of injustice and unfairness arising from management processes or personal relationships can also increase stress and risks to mental health. Other stressful conditions include physical factors such as material hazards, noise, dust and dirt. Stress is not a medical condition, but research shows that prolonged stress is linked to psychological conditions such as anxiety and depression as well as physical conditions such as heart disease, back pain and headache.

Why employees' mental wellbeing is important to organisations' productivity and performance

Promoting the mental wellbeing of employees can yield economic benefits for the business or organisation, in terms of increased commitment and job satisfaction, staff retention, improved productivity and performance, and reduced staff absenteeism The costs associated with employees' mental health problems are significant for businesses and other organisations. These costs are associated with loss in productivity because of sickness absence, early retirement, and increased staff turnover, recruitment and training.
Evidence also shows that productivity can be reduced through the lower level of performance of employees who are at work but experiencing stress or mental health problems. This is known as 'presenteeism'.

Employment laws regarding equality, anti discrimination, health and safety, maternity and parental leave and flexible working. In addition the Health and Safety Executive's standards for managing work-related stress may provide a valuable tool in implementing this guidance6.

Wellbeing guidance

• Promote a culture of participation, equality and fairness that is based on open communication and inclusion.
• Create an awareness and understanding of mental wellbeing and reduce the potential for discrimination and stigma related to mental health problems.
• Ensure processes for job design, selection, recruitment, training, development and appraisal promote mental wellbeing and reduce the potential for stigma and discrimination. Employees should have the necessary skills and support to meet the demands of a job that is worthwhile and offers opportunities for development and progression. Employees should be fully supported throughout organisational change and situations of uncertainty.
• Ensure that groups of employees who might be exposed to stress but might be less likely to be included in the various approaches for promoting mental wellbeing have the equity of opportunity to participate. These groups include part-time workers, shift workers and migrant workers

Supervision in the workplace can ensure well-being. This is an example of a Supervision Policy and Form

SUPERVISION POLICY

The Manager/Owner who is the Person in Control has overall Responsibility for the actions and Activities that happen within the Home.

Actions and Activities may be delegated the others where knowledge, experience and appropriateness are applicable.

Each Individual is responsible for their actions and activities as defined within their Job Description.

The Home operates a Key Worker System and staff will be allocated residents for Care input. This means each member of staff will have specific responsibilities to certain residents but does not mean to the determent of others, so where there is a need and a carer is available are available, that client's needs are catered for.

At no time will any individual take on responsibilities beyond their role, experience or knowledge level.

Any issues that are not understood by the individual are to be passed to the appropriate person for guidance.

Managers will meet with staff on a regular basis and review their training, development needs and their progress within the Home.

Managers will meet on a regular basis and report on actions and activities and address any issues that need improving on.

Care staff will meet with Managers on a two monthly basis or more where appropriate to address any issues brought to light, and conversely bring to the attention of the Care staff any issues that may need discussion and improvement.

At any time, where issues are raised, individual one to one meetings will take place with the view for improvement in performance or training needs to resolve situations.

Each member of staff should know who their immediate Manager is and if there are issues they should be raised with that Manager. Where there are serious concerns that affect the welfare of a client then it may be necessary to inform the most senior Manager immediately. This must not be an excuse for not going through procedure.

An Organisational Chart is available to show the Management Structure of the Home and this is found in the office.

Where issues fail to be resolved, a Staff Improvement Advice Form will be used for corrective actions. Where the issues are deeper and more fundamental, Disciplinary Action may be taken to seek improvement. This may range from a Verbal Warning, to a Written Warning to Instant Dismissal in extreme cases.

The aim of supervision is to provide a regular opportunity for staff members with their manager to:

SUPERVISION APPRAISAL

PRINCIPLES TO BE DISCUSSED

- Reflect on content and process of their work

Discussed Yes [ ] No [ ]

- develop understanding and skills within their work

Discussed Yes [ ] No [ ]

- receive another perspective concerning their work

Discussed Yes [ ] No [ ]

- be valued and supported both as a person and as a worker

Discussed Yes [ ] No [ ]

- ensure that as a person and as a worker they are not left to carry unnecessary difficulties and problems alone

Discussed Yes [ ] No [ ]

- have space to explore and express personal views in confidence

Discussed Yes [ ] No [ ]

- be able to plan and utilise personal and professional resources

Discussed Yes [ ] No [ ]

- develop the ability to be pro-active rather than reactive

Discussed Yes [ ] No [ ]

- ensure job satisfaction and quality of work

Discussed Yes [ ] No [ ]

I have discussed the above issues with my Manager

Employee Sign_____ Manager_____ Date___/___/___

6.3 Support an individual in a way that promotes a sense of identity and self esteem

LOW ESTEEM

Low self esteem is not something that simply appears one morning. It is developed and nurtured over time. Every day we experience situations that either boost our self-confidence or tear it apart. The challenge for those of us who lack a strong identity is that once a poor self-image is accepted, we tend to make choices in our lives to support those beliefs. Or to put simply, once you have accepted the idea that you are worthless, most, if not all of your choices in life will be in harmony with that belief. Choices such as an abusive partner, disrespectful friends, or a dead-end job only serve to validate and compound an already fragile sense of worth. Suffering from *low self esteem* can become a vicious, never-ending cycle.

Some of the classic signs of low self-esteem are: consistent anxiety and emotional turmoil, always accentuating the negative, unable to accept compliments, overly concerned about what others think, don't trust one's own opinions, constantly depressed, socially withdraw, self-neglect, eating disorders, unable to take on challenges, always quitting and resigning, controlling, needy, success driven, arrogant, extremely self-defensive (someone who retaliates far worse than what would normally be expected), exaggerated perfectionism, and a constant need for validation and recognition. Someone may throw a lot of "pity

parties" as their unyielding thirst for validation, spotlight, and recognition helps them feel better. A person suffering from low self esteem may feel constantly worthless, and feel completely helpless to do anything to make his or her life better. They often feel defeated to think they can change other people for the better, let alone themselves, hence their personalities are driven inward, rather than outward.

Low self esteem is frequently seen in several different, and often serious conditions such as major depression, anorexia, body dysmorphic issues, "cutting", anti-social behaviour, domestic violence, hoarding, borderline, and numerous types of addictions- just to name a few. This means that the presence of extreme low self worth can be a sign of another serious condition in someone's life, and should always be taken seriously and not ignored.

Low Self Esteem Is More Common Than You May Think

According to the National Institute of Mental Health (NIMH), approximately one out of every 4 adults will suffer from a psychological disorder in any given year, the majority of for which low self-esteem is an underlying factor.

Poor self-image puts us at risk for eating disorders, teenage pregnancy, depression, suicide, criminal or violent behaviour, bullying, victimization, drug and alcohol abuse, spousal abuse, poor job performance, divorce, and disastrous relationships to name only a few. The good news however, is that just as self-esteem is developed during childhood, as an adult, you can learn to counter self-defeating behaviour. With self-esteem counselling and support, you can discover how to release your negative self-image and accept a more positive sense of self.

What Causes Low Self Worth?

As a child, parents are the biggest influence on self-esteem. Children who are consistently criticized, berated, yelled at or beaten by a parent quickly learn they are worthless. If a child is continually ignored, teased or ridiculed or if they are expected to be perfect all the time in order to be accepted, they eventually develop a poor self-image. If a child constantly fails at school or does poorly in sports, they will experience identity issues, especially when they reach their teens. How a parent deals with the situation is what directly impacts whether or not a child will develop a healthy self-image. **Low self esteem** can often occur as a result of a harsh or neglectful parent.

If you have feelings of worthlessness, it has probably manifested in one of the following ways. You may have taken on the role of the constant loser, the person who is always waiting for the other shoe to drop and is helpless to do anything about it. Self-pity provides an excuse to avoid taking responsibility for your life. You lack assertiveness and feel you must be in a relationship to be worthy. You are the typical underachiever.

You could also try to mask your low self-esteem by over compensating. You are the person who always appears happy. You are the highly competitive perfectionist who continually reminds others of your successes. Underneath however, you live in terror, worrying your true identity will be unmasked. You suffer from intense identity issues and tend to “burn out”.

Possibly, you go to the other extreme and act as though you simply “don’t care”. You tend to be angry and nothing anyone does for you is ever enough. You feel you are “unworthy” so you blame everyone else for your problems. You are controlling, the rule breaker and you have issues with authority, something that rarely ends well.

How To Improve Low Self Esteem and Negative Self Image

A healthy self esteem is developed during childhood, underscoring the great need in our society to ensure children are raised in a loving, yet sturdy environment guided by strong moral values. By your teens you will have already decided whether or not you are a "worthy" person. Identity issues are hard enough during this tumultuous time without the added burden of low self-image. So, it's no wonder so many adults grow up to feel they simply aren't good enough. Sometimes all it takes is one incident, in which you adapt an exaggerated and incorrect belief about yourself, to set off a lifetime of problems. Our choices are the biggest factor in how we lead our lives and to change our choices, we must first change the way we think about ourselves. This is no easy task, but with support and guidance from a self-esteem counsellor, you can learn how to create a new self-image. You don't have to become your negative beliefs.

Treatment For Low Self-Esteem

If you are suffering or know someone who suffers from a negative self-image, understand that this is a deep-rooted problem, and not something that will be fixed by a mere online article. Professional counselling is a very important avenue and resource that can peel back years of hurt and begin a new work towards a rewarding life.

These could include the belief that "I am never good enough", "there is nothing special about me", or "I never seem to be able to find direction or purpose in life." The emotions that are tied to these negative assumptions maintain a hold on an individual from feeling a sense of value and identity. By identifying and understanding events in life that contribute to low self worth and discovering a clear picture of a future without those assumptions, we are able to resolve these feelings and provide hope and release from harmful beliefs.

Low self worth is experienced in unique ways for each person, counselling determines what self-defeating behaviour is contributing to the maintenance of low self worth and lack of identity and challenges these thoughts and behaviours towards positive change. Further, working with the counsellor, individuals identify relationships that are contributing to low self esteem and work to develop healthy boundaries to reduce the negative impact on the individual's identity.

Most of us do our best to make sure that our children feel good about themselves but often, as adults, we tend to overlook that in ourselves. We may have started in life with high self-esteem, but every day life can erode our positive self image. It does not have to be extraordinary events that knock our good feelings out of the ring, even daily living experiences can take their toll. For example, the boss who never has and never will appreciate your work. Or, the favoured older sibling who managed to stay married to the same spouse forever and to have important scientific papers published (no, that one isn't me, I do have an older cousin with a great lake house and a paid off mortgage, though). The realisation that we are not going to be perfect parents (well, yes, that is me). And, then, there is always the aging process to pull the rug out from under. Gravity, wrinkles, greying hair, loss of muscle tone, and all the things that begin to go wrong with your body and your memory as you age, can take away even more of your self-confident.

Some people never had much in the way of self-esteem to begin with. You may have had a difficult childhood that made you feel bad about yourself. You may have had parents who were too busy earning a living or simply trying to survive to let you know how great you were and how much you meant to them. You may even have had mean parents or no available parents, so there was no one important in your life to tell you how important you were in theirs. Children can rarely go beyond the emotional boundaries set by their parents, at least not while they are still growing up. So, if you don't like yourself, your children will not learn how to like themselves. And, if none of you is confident and happy about who you are, then you will not feel entitled to seek each other out when you are in need.

Healthy self-esteem lets adults take healthy risks, so when the job goes, you feel good enough about yourself to jump into the job market and find another. Knowing that you are capable in that way gives your family a feeling of strength against the unknown. Healthy adult self-esteem also protects you from letting others treat you badly. That means that your children will see you give and expect respect and good treatment from others. They won't see you get symbolically pounded, they won't see you victimized, and they will see that you can recover from the torrents. When your children see you being strong, they know that their family is strong. Adult Self-Esteem Tips Others see us through the lens that we colour and shape. If we do not like ourselves, others will find fault as well.

Sometimes, our busy lives can erode our self-esteem even before we know it. While we are busy taking care of everyone else, our own needs get put aside until we are so full of unmet needs that we begin to think that is all we are. Just a constantly draining well of neediness that has no way of re-filling. We have to remember that we are important to our families, to our selves, and to the other people in our lives. We have to remember that we have value and that we deserve to look in the mirror and say "My goodness, that is a fine person looking at me today."

6.4 Demonstrate ways to contribute to an environment that promotes well-being

If you would like to increase your wellbeing, here are some things you might want to try.

- **Set personal boundaries**. Nothing drains us of self-esteem faster than letting other people walk all over us. It might be the boss who always makes you work late, it might be the teen who daily lists your faults (my life again), it might the spouse who loves you but can't remember your birthday, it might be the parent who still criticizes the way you fold your towels. Take a look at your life and determine where you need to say "Stop" and then stick with it.
- **Spend time with your children**. That's right, carve out some extra time in your busy week to have some fun time with your kids. There is nothing like seeing how much your children love being with you to make you realize how important and valuable your place in their world is.
- **Make a list of your accomplishments**. Every couple of months, write out everything you have accomplished. It does not have to be something huge, just the daily stuff of life, such as: got the plumbing fixed, finished report at work on deadline, gave spouse a wonderful birthday party, managed to give kids summer holiday despite limited budget. Those are the things that make up life. Tolstoy did a great job of writing War and Peace, but did he do anything else in that time period, or did his wife and his lover take care of the daily grind.? I bet those two women accomplished far more than he did, and I bet they were never thanked. You may never be thanked either, but you need to validate the things you do that keep your family going.
- **Try something new**. Self-esteem does not come to those who sit and wait. You have to get out there and try something in life. If the things you are currently doing don't make you feel good, then try something new. Take a course, learn to paint furniture, take up bowling, become an amateur rose grower. It doesn't matter what you try, just try something. Even if it doesn't work out, you can at least feel better for having tried.
- **Set the bar lower**. Many of us judge our own success by measuring ourselves against others (remember my cousin who owns the mortgage free lake house to die for?). Well, I will never have a house like hers and I will never pay off my mortgage, but that is because I am raising many children (none of whom are currently in jail), so that means something, doesn't it? Our small successes are just as valuable to our family and to the world as the major successes of others.

Get a good hairdresser or barber. Studies have shown that the first thing people notice in others is their hair. And, I bet that you know that when you look in the mirror, how your hair looks has a major impact on how good you feel about yourself. It doesn't matter if this is a superficial value, it is a value nonetheless, and a good hair cut can make you like yourself more. Take the time and the money from the family's resources to give yourself this boost. It will make everyone feel better, not just you. **Exercise.** You can exercise without changing your lifestyle. Just add a ten minute walk at night, or a couple of sit ups during the afternoon. This isn't about losing weight or building muscles, it's about getting those exercise induced 'feel good' hormones going again. Jettison the baggage. Take a look at your life and determine who needs to be in it with you and whose time is over. Sometimes we have friends, or even relatives, who have been important to us at one point, but whose presence has become a problem. You can maintain some part of the relationship, but take a look at the ways you need it to change, or if it is still worth retaining . **Spend time with friends**. There is nothing like being with people who like us to make us like ourselves. You don't have to drop your family responsibilities to carouse with your buddies, but you can find one event a month that is just you and a couple of friends. Maybe it is lunch outside of the office with colleagues with whom you have a special affection, or may be it is a movie night out with the girls (or guys) who have been friends long enough to really know you. Create the time and make sure your family knows that it is important that they cooperate in your attending. **Make friends**. For many of us, our busy-ness and the way we have to categorize each part of our life (parent, adult child, worker, soccer mom) has decreased our ability to make or keep friends. Try different ways to have friends. For example, set a date on the calendar to have a neighbourhood bar-be-que and send fliers out to all your neighbours. Follow up by asking them to bring something and getting R.S.V.Ps. Or, start chatting with someone who looks responsive at your church or social event group. Or, start talking to some of the other soccer moms and dads and see if you can strike up a friendship there. Is there someone at your exercise club (remember, you are going to exercise) who you think you have a lot in common with? **Keep your bedroom clean.** You may already do this, but many of us don't. We make sure that every other room in the house is clean and tidy, but we never get around to the place that is supposed to be our sanctuary at the end of the day. Make this room your priority. Keep it looking welcoming and pleasant. This is where you are you, where the pretence is dropped and where you unwind. So, make the space attractive, tidy, clean, and a place where you really want to end the day. **Throw out your old clothes**. You don't need reminders of what no longer fits, or of a lost youth. If you have outgrown an article of clothing, either by size or by age, then get rid of it. You can't make room for the best you that you are now, if you are hanging onto a version of you that no longer exists. **Get a pet that you like**. Often, we buy our pets because of what we think our children need. May of us think that our kids need an "Old Yeller" type of dog (one that doesn't have to be shot, of course), to teach them responsibility, or to watch over them, etc. But, the truth is it is generally the parents who take care of the animal. So, forgo the turtle that will eventually hibernate in the back of the closet and only come out once a year, and buy what you want. Some kind of dog or cat or even a lizard if that is what you like. Just so that it is honestly yours. I once read in a book that of all the memories that stick with a person through life, it is the memory of the look in the eyes of a faithful and loving dog that will sustain and comfort us in old age. Well, I hope you have more than that to comfort you in your twilight years, but for the present, get a pet that loves you unconditionally during all the times that no one else does. **Act as if you have high self-esteem**. If you can't feel good about yourself just yet, then act as if you do. That will cause other people to treat you better and then soon enough, you will begin to actually feel like you deserve their good treatment.

Improved Wellbeing

We want to know that social care is really making people's lives better.

This means we need to see clearly how well services are working.

We think all social care services should be planned and checked to make sure they help people. Services should help people: have better health take part and use their skills over their lives feel safe in the community have enough money to live on and take part in things going on in the community live in a clean and comfortable home have the help they need to look after themselves and feel good about themselves. have happier and more enjoyable lives have more choice and control be treated fairly and well and **More control**

We want people to have control of their own lives and make choices about how they live.

People should not just have to take the services they are offered. We want to give people more choice about the help they get. But we still need to make sure they are safe and well. People who use services should also have more say about how new services are planned.

Making risks and trying new things

Some people worry that if we give people more choice and control over their lives they might not look after themselves properly. They also worry that some people might take advantage of disabled people. But everyone has to try new things. You need to learn from your mistakes. Sometimes you need to take risks. If you always 'play it safe', it is hard to change your life for the better.

Social care workers should support you to keep you safe. They should also help you take risks and do things for yourself. But if things go wrong the social care workers often get the blame. We want to help people understand why taking risks can be a good thing.

Better information

To make choices, people need **better information** about services and equipment that could help them.
If people get the right information they can take more control over their lives. But it can be difficult for disabled people and their families to find out information. They do not know where to go. Information should be easy to understand. People should be able to get information indifferent languages or in other formats like large print or easy read summaries, like this booklet, if they want it. There should also be more information about services and equipment for disabled people. We want you to have the information you need without having to ask for help.

Better assessments

When someone comes to social services for help, social services do an assessment to decide what services that person will get. This means taking a close look at their lives and needs. At the moment assessments sometimes do not go well. People's ideas and feelings are not listened to. Or they are told that they cannot have the sort of help they want.

It is important to find out about people's thoughts and feelings. Even people with a lot of needs should have a say about how they live. Sometimes it can be hard to understand what they want. People supporting them should try as hard as they can to find out people's ideas and feelings. **There should be more information about services and who can have them.** This would mean people could work out for themselves what services they can get. Social workers would still be there to help.

Individuals should be protected and helped, regarding the issues below:

- **Abuse** Abuse is causing physical, emotional and/or sexual harm to an individual and/or failing/neglecting to protect them from harm
- **Active support** Support that encourages individuals to do as much for themselves as possible to maintain their independence and physical ability and encourages people with disabilities to maximise their own potential and independence
- **Danger** The possibility of harm and abuse happening
- **Harm** The effects of an individual being physically, emotionally or sexually injured or abused
- **Individuals** The actual people requiring health and care services. Where individuals use advocates and interpreters to enable them to express their views, wishes or feelings and to speak on their behalf, the term individual within this standard covers the individual and their advocate or interpreter
- **Key people** Are those people who are key to an individual's health and social wellbeing. These are people in the individual's life who can make a difference to their health and well-being
- **Others** Are other people within and outside your organisation that are necessary for you to fulfil your job role

Rights The rights that individuals have to:

- be respected
- be treated equally and not be discriminated against
- be treated as an individual
- be treated in a dignified way
- privacy
- be protected from danger and harm
- be cared for in a way that meets their needs, takes account of their choices and also protects them
- access information about themselves
- communicate using their preferred methods of communication and language

Risks Signs and symptoms of danger, harm and abuse,

- The likelihood of danger, harm or abuse arising from anything or anyone

Individuals need to develop and maintain relationships that promote the views, preferences and independence of **individuals** and **key people, and c**arers support individuals to communicate their views and preferences regarding their current and future health and well-being needs and priorities

Carers work with individuals identify the care and support:

- they can and wish to undertake themselves
- that can be provided through the individual's support networks
- that needs to be provided by yourself and **others** within and outside your organisation
- You provide **active support** to meet the holistic needs and preferences of individuals
- You carry out the activities for which you are responsible in ways that:
- promote individuals' rights and preferences
- complement and support the activities of individuals, key people and others within and
- outside your organisation

Carers support the rights of individuals and key people to access information and resources to meet their needs and preferences

Carers work to resolve conflicts, seeking additional support and advice in areas that are outside your competence to deal with
Carers support and respond appropriately to individuals and key people making comments and complaints about their care

Individuals are valued and ensure that the support given takes account of the their needs and preferences
Carers work with individuals and key people in ways that provide support that is consistent with individuals' beliefs, culture, values and preferences
Carers provide active support to enable individuals to participate in activities and maintain their independence
5carers support others with whom you work, to work in ways that:

- recognise and respect individuals' beliefs and preferences
- take account of individuals' preferences in everything they do
- acknowledge and respect diversity and difference

Carers reflect on, and challenge:

- your own assumptions, behaviour and ways of working
- the assumptions of others, their behaviour and ways of working
- procedures, practices and information that are discriminatory

All staff seek advice when they are having difficulty promoting equality and diversity
Carers use all available information to identify the **risks** of actual and likely **danger**, **harm** and **abuse** for individuals, key people and others with whom Carers work

Carers ensure that:

- Carers own practice and actions are sensitive to situations, issues and behaviour that may lead to the danger, harm and abuse of individuals and key people
- Carers provide necessary protection for individuals, balancing their rights and those of key people, and taking account of any restrictions placed upon anyone
- Carers recognise and challenge dangerous, abusive, discriminatory or exploitative behaviour appropriately

Carers recognise **signs and symptoms of danger, harm and abuse** and use Carers organisation's systems and procedures to report these

Carers develop relationships in which individuals are able to express their fears, anxieties, feelings and concerns without worry of ridicule, rejection or retribution
Carers respond appropriately to disclosures of risk of danger, harm and abuse, avoiding actions that could adversely affect the use of evidence in future investigations and court
Carers support individuals and key people to understand Carers responsibilities to:

- pass on information about actual and likely danger, harm and abuse
- protect them and others from danger, harm and abuse

Carers use supervision and support to enable Carers to cope with Carers thoughts and feelings about any suspected and/or disclosed danger, harm and abuse
Carers complete accurate, timed and dated records and reports, on suspicions of danger, harm and abuse:

- within confidentiality agreements
- according to legal and organisational requirements
- that avoid statements that could adversely affect the use of evidence in future investigations and court