



Health & Social Care Diploma Level 3

Units 7-9

Candidate

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Unit 7: Person-Centred Practice in Care Settings (J/650/2304)

What is Person-Centred Care?

The traditional model of care provision was institutional and regimented; the old approach has its admirers and worked well for a lot of people, but it also failed to address the individuality of people who were often on the margins of society.

People with poor mental and / or physical health were expected to fit in with services offered and it was often assumed that everyone with a particular condition required the same treatment.

A person-centred approach to care looks at what the individual needs and plans care provision to suit them. The individual is not just another body to be treated but is a human being who carers must work with to identify ways of meeting physical, emotional, spiritual and social needs.

Services that do not provide person-centred care are like conveyor belts in factories; they cannot cope with anything that doesn't fit the mould. People are all different and care provision must reflect that. A 50-year-old with early-onset Alzheimer's will have very different needs to a 90 year old with the same disease; why should they both be treated the same way?

Get together with someone who is different to you, perhaps an older family member, a friend or even a client, and both have a go at answering the questions below.

	Me	Them
Favourite type of music		
I relax by		
I usually get up at ...		
My favourite food is...		
My favourite hobby is...		
I like to watch...		
I am happy when I...		

Have a look at the table you have completed and consider whether if you lived together, you would both be happy being treated the same way. Could you eat the same foods? Do you both get up early or does one of you like a lie in? Could you agree on a programme to watch? If your answers are different, it is likely that you would both have very different expectations and priorities and would want these to be considered by service providers.

Framework for Change

Person-centred practices have been developed over the last quarter of a century or so in both the learning disability and dementia care fields. In the last decade government initiatives and policy have put person-centred approaches at the top of the agenda. Documents such as 'Valuing People Now: a new three-year strategy for people with learning disabilities'; 'Living Well with Dementia: A National Dementia Strategy' and 'New Horizons: Towards a shared vision for mental health' have all been issued by the Department of Health to provide guidance on caring for people with diverse needs in a person-centred way.

It is no longer acceptable for care providers to develop services for one particular 'type' of person; they must be flexible to respond to the needs of individuals. This does not mean that care services have to meet all needs of all people, but they do have to be able to adapt to the different needs of the individuals to whom they provide a service.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2009

The Health and Social Care Act set up the Care Quality Commission (CQC) and gave it the power to assess the quality of care delivered by registered providers. The CQC produced a document 'Essential Standards of Quality and Safety' which gave guidance for compliance with the new regulations and standards; they also issued advice on providing evidence to prove that clients' needs were being met appropriately.

Person-centred care is a fundamental part of the majority of the 16-core quality and safety standards. To meet the standards, care providers have to show that the client is at the centre of service provision; all areas of care are assessed in relation to their responsiveness to the needs of the individual clients.

The Human Rights Act 1998

Human rights legislation exists to protect all of us from the actions of public bodies like councils and NHS trusts. There are some rights which are particularly relevant to the provision of care, and they are summarised below:

- Article 2 – right to life
- Article 3 – protection from torture or inhuman or degrading treatment
- Article 5 – the right to liberty and security of person
- Article 6 – the right to a fair trial
- Article 8 - the protection of private and family life
- Article 9 – freedom of thought, conscience and religion
- Article 10 – freedom of expression
- Article 14 – freedom from discrimination

Collectively these rights mean that individuals in your care should be protected from abuse and undignified treatment; they should not be unnecessarily restrained or have their freedom of movement restricted. They must be able to complain about the treatment they receive and be supported to understand and defend their rights.

People receiving care have the right to maintain a family life and have their privacy respected and they must be allowed to practice and express their religious beliefs.

The Human Rights Act 1998 has been used to challenge health authorities' use of blanket policies such as 'no lifting'; these have been found to be unlawful as they do not allow for differences between individuals, they remove freedom of choice, and they may be discriminatory. (Ref *The Queen v. East Sussex County Council* 2003).

Equality Act 2010

This Act was intended to both simplify and strengthen existing legislation and to go further towards eliminating discrimination in British society.

There are now 9 'protected characteristics' which are:

- Age
- Disability
- Gender Reassignment
- Race
- Pregnancy or maternity
- Religion / Belief
- Marriage or civil partnership
- Sex
- Sexual orientation

The Act not only makes it illegal to discriminate against individuals it also protects them from harassment and victimisation and makes it a legal requirement for employers and the owners of premises to make 'reasonable adjustments' to support equal access for all to education, jobs, services and opportunities.

Person-Centred Values

To appropriately meet people's care needs you must know and understand them as individuals and adapt care provision accordingly. The individual becomes the most important part of a care partnership, working to find creative ways of maintaining their physical and mental wellbeing and improve quality of life.

Person-centred approaches to care are based on several core values which include:

- **Independence** – people must be encouraged to do as much as possible for themselves, carers must not ‘deskill’ them by doing too much for them. The care premises should be designed to encourage independent movement
- **Dignity** – all people are to be treated as competent adults and cared for in a way that maintains their self-respect
- **Privacy** – clients must have space to spend time alone with loved ones; their personal information should be protected and their dignity maintained when bathing or toileting
- **Rights** – as discussed above the human rights of clients are to be respected and protected
- **Choice** – the right to choose is not removed when someone is admitted to care; care providers must support clients to make decisions or to participate in decision making
- **Respect** – all clients are to be treated as competent adults; they are to be treated with respect regardless of physical frailty, mental capacity or behaviour. Respect does not have to be ‘earned’.
- **Partnership** – by viewing the provision of care as a partnership between the person who needs it and the person who provides it the relationship is made more equal and mutual respect is encouraged.
- **Individuality** – each person is different and their sense of self is to be supported

7.1

Write 350 words on how you promote the core values of the person-centred approach in your day to day

All care planning must have the individual at its centre from start to finish; they must have control of every aspect of the process including deciding how planning will be carried out and who will be involved. When the person cannot make their own decisions those made for them must reflect as closely as possible the choices they would have made themselves.

Involving the Right People

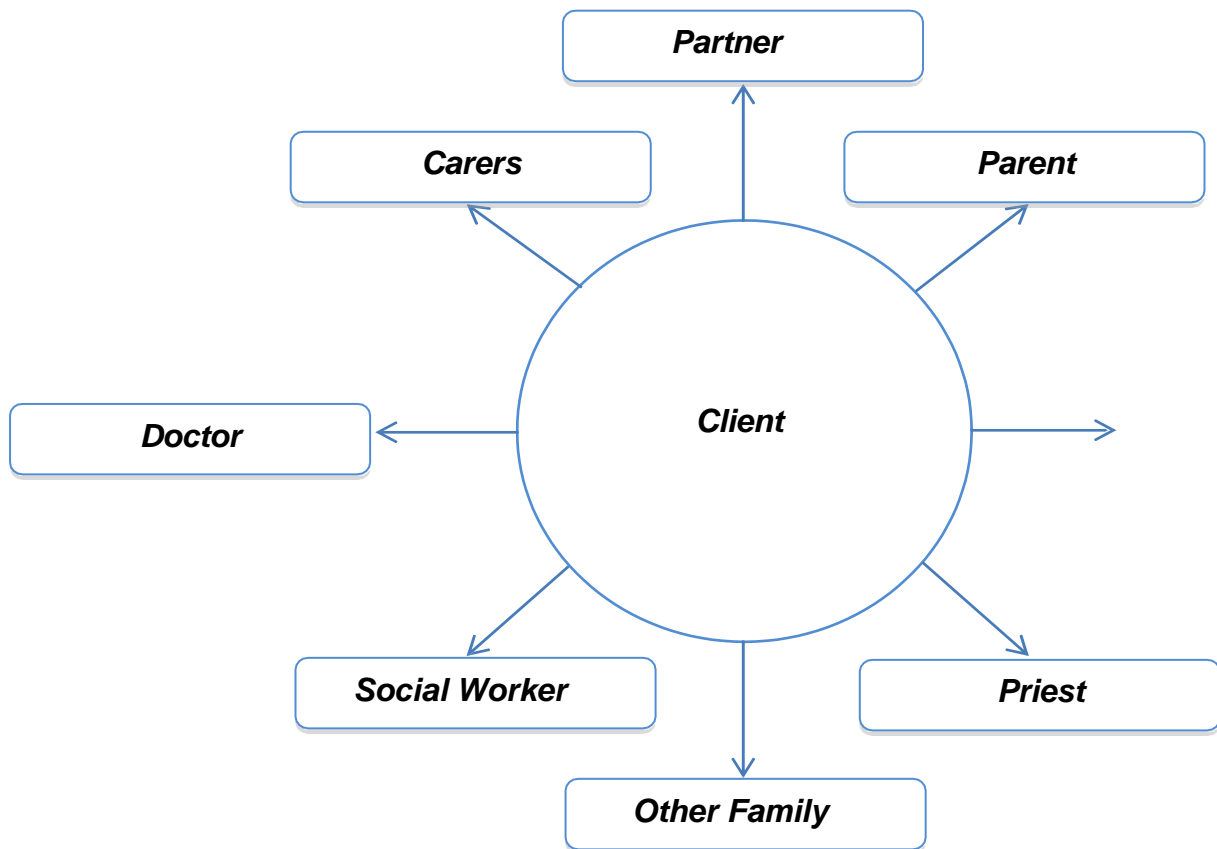
The relationship between care providers and the people they provide services for does not exist in isolation; care providers cannot and should not meet every need that the person has. An essential part of care provision is to support people to develop and maintain relationships within and beyond the care setting.

People who may need to be involved in care planning include:

- The client (always)
- Spouse / partner
- Family
- Friends
- Social worker
- Doctor
- Carers (whether paid or informal)
- Advocate

You must not make any assumptions about who is important to a person; they must be able to define their relationships in their own way. One way to identify people who should be involved in care planning is to draw a circle at the centre of a piece of paper with the client's name in it; they can then write people's names, or stick their photos, at various distances from their own name to illustrate their level of importance.

Example:



Advance Care Planning

Advance care planning is an end-of-life care approach that assumes that at some point before they die people will lose the ability to make decisions and to communicate with their carers. This type of care planning aims to identify and record clients' wishes about the following issues:

- Their beliefs, values and goals
- The type of care and treatment they would like, or wish to avoid
- Where they would like to die
- Who they would like to be with them when they die
- How they would like their body to be treated after death

- The kind of funeral they would like

Planning discussions should involve the client, their care providers, and any friends and family that the client wishes to involve. Plans need to be appropriately documented and made available to anyone who will be involved in the client's care

or treatment. This might include paramedics, doctors and specialist nurses as well as the staff providing day to day care.

By recording, and regularly reviewing, clients' wishes and preferences care providers are ensuring that they can make informed decisions based on 'best interests' if the client is unable to make decisions themselves. Situations when care providers or other health professionals need to make decisions on another's behalf include:

- When they are unconscious and require treatment
- When their mental capacity deteriorates and affects their ability to reason or understand information
- When the effects of alcohol or medication reduce their mental capacity
- When they are experiencing severe depression and lack the motivation to make decisions or take actions to meet their own needs (i.e. they are self-neglecting)

Recording

Information gained from care planning sessions must be appropriately recorded in a way that allows it to be communicated to the client and those involved in their care while protecting sensitive information from being accessed by people who have no reason to see it.

Maintaining confidentiality of clients' personal information is an important part of your responsibility to them; they must be confident that their details are kept safe and secure.

Records which may be used to support important decisions, such as whether to give medical treatment, should be read, signed and dated by the client to show

that they are up to date and correct.

Reviewing

Care plans must be reviewed on a regular basis to ensure that they are always relevant and that they are altered to reflect changes which occur. At the end of care planning sessions, the client, carers and others involved should agree a date to assess the success in implementing the plan and to identify whether changes are necessary.

Active Participation

The principle of active participation is essential to the provision of person-centred care. All clients are to be encouraged to take an active role in planning for their own care needs, identifying ways in which their mental and spiritual wellbeing can be supported and influencing changes to the environment in which they live.

By enabling clients to actively participate in making decisions about all issues that might affect them you help to ensure the following:

- Needs are met in ways that suit individuals' cultural, religious etc. requirements
- Care needs are less likely to be overlooked
- People feel empowered to voice their own opinions and know that these will be given due consideration
- People know that they can speak out about practices that they feel to be discriminatory or otherwise abusive
- The environment reflects the diversity of the individuals within it reinforcing each one's sense of self and demonstrating that everyone is of equal value

Meeting Diverse Needs

Residential care premises are often called 'homes'; this word should conjure up images of comfort, familiarity and warmth but all too often it represents institutionalisation and neglect.

The challenge facing all care providers is that their premises have to represent 'home' to a group of people who may put very different meanings on the word. Some may see their home as a private sanctuary, somewhere to escape from other people and spend time alone; for others it's a space full of noise and people where different generations come together to celebrate the good times and be comforted in the bad.

If these people are to share a space that space will have to take all of their needs into account. The following considerations are important:

- Relationships in the home must be based on tolerance and mutual respect – staff and clients alike must be educated and informed about equality and diversity and the home's commitment to these principles
- Privacy must be respected – all clients must have their own private space; it is appropriate for staff to knock before entering bedrooms
- Shared spaces should have a well-defined purpose and offer a choice – there should be places where conversation is encouraged and places where people can go to sit quietly
- Televisions / radios should only be on when people actually want to watch or listen to them; they are for the benefit of clients not staff
- Everywhere should be clean, tidy and free of offensive odours
- Décor and furniture should be appropriate for the client group – there may need to be special consideration for the needs of people with conditions such as dementia; visual difficulties or physical disabilities

Influencing Care Provision

As we looked at in the previous unit all clients are to be involved in all aspects of service provision. From recruiting staff, to redecorating rooms or deciding when hot meals are to be served it is important that the needs of clients are the main concern.

This may seem like an impossible task, and you may wonder how clients can be involved in areas like staff recruitment, but it's important that you keep an open mind and develop new ways of working that are inclusive and responsive to changing client needs.

Allowing clients to be involved in creating adverts for new staff and the interview process helps them to feel more in control of, and engaged with, their care provider.

It gives them a personal involvement in the future development of staff members and helps to ensure that staff and clients will be compatible.

Clients may sit on interview panels or contribute questions to be asked; they may suggest certain attributes that they would like people to have or give their opinion of candidates' interpersonal skills.

Being Creative

In moving away from traditional models of care providers have found that they need to be creative about how they provide services in order to be responsive to client needs in ways that are affordable, and that staff can achieve.

For example:

- Caterers need to find out when clients would prefer to have their main meal of the day and look at ways in which food can be available at all times for people who don't have the same habits. Involving clients in growing and preparing foods and contributing to menu planning helps them to feel that they have a personal stake in the food provision and means that they are more likely to have a positive attitude to mealtimes
- Getting to know clients as individuals helps staff to develop good relationships with them and makes it more likely that they will recognise and respond to their personal needs
- Identifying skills that staff and clients could use to benefit everyone can help people to feel valued and can be a low cost way of encouraging activities and providing mental, physical and emotional support. For example, people who know how to cut hair or apply make-up could run pamper sessions; skills such as sewing or painting can be taught to others or used to decorate the home or make items to sell.

Person-centred management

Person-centred approaches can benefit all businesses, not just care providers. It's becoming more common for employers to adopt flexible practices that encourage staff retention and improve job satisfaction.

For example:

- Shift patterns take into account the needs of different staff groups so that, for example, mothers can work around school hours
- Staff relationships are based on cooperation rather than hierarchical structures – people are supported to work to their strengths and develop their weaknesses; everyone's opinion counts
- In assessing staff performance managers seek input from colleagues and clients as well as supervisors
- Staff and clients are matched where possible, for example, clients would be asked to suggest particular qualities that they would like their key worker to possess to improve compatibility

7.2

Write 400 words on the positive effects on a person-centred approach and what it could achieve for your client

A series of 20 horizontal dashed lines for writing.

Unit 8: Importance of Choice and Independence in Care Settings **(K/650/2305)**

Protecting Choice and Rights

Adults in need of care have the same rights and power of choice as the rest of the population; they may, however, face daily challenges as people make assumptions about their physical and mental capacity based on their age, appearance or medical conditions.

It's important that you empower your clients to be in control of their own lives by understanding their individual abilities and how they are best able to make, or participate in making, decisions about their life and issues which affect them.

The Mental Capacity Act 2005

The Mental Capacity Act 2005 was designed to protect the rights of potentially vulnerable adults who might otherwise be prevented from making their own choices and decisions.

Before the Mental Capacity Act was introduced there was no way of ensuring that people who required care and support were being treated as competent adults. It is all too easy to make assumptions based on a person's behaviour or medical history and to believe that it will be in their best interests for you to act or make decisions on their behalf.

The Act is based on five key principles which together ensure that individuals are respected as competent adults; given every opportunity to make their own decisions and choices; treated fairly without prejudice or discrimination and supported to be as independent as possible.

The Statutory Principles

1. A person must be assumed to have capacity unless it is established that he lacks capacity
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success

The active participation of clients is an essential part of:

- Care planning
- Decision making
- Future planning of service provision

Regardless of their mental capacity all clients should be able to contribute in some way to all issues affecting them; including, but not limited to:

- Reviews of their care
- Assessments of quality of services
- Daily decisions such as what to wear / what to eat
- Longer term planning of care and health needs
- Financial plans
- Staff recruitment
- Activity planning
- Redecoration of premises
- Changes to the way services are provided
- Menu planning / catering arrangements

What is the Mental Capacity Act?

The Mental Capacity Act 2005 was designed to protect the rights of potentially vulnerable adults who might otherwise be prevented from making their own choices and decisions. You should understand how the Act will affect your working practices, how by complying with it you are protecting the best interests of your clients and what you will need to do to demonstrate your compliance to the Care Quality Commission.

It is now law that ALL adults must be assumed to have the capacity to make decisions and take actions for themselves unless after being provided with appropriate support and information it can be shown that they do not.

If it is decided that a person lacks capacity, then decisions must be taken in their best interests, and they must be involved in the process as far as possible.

Before the Mental Capacity Act was introduced there was no way of ensuring that people who required care and support were being treated as competent adults. It is all too easy to make assumptions based on a person's behaviour or medical history and to believe that it will be in their best interests for you to act or make decisions on their behalf.

What Decisions are Covered by the Mental Capacity Act?

The Act covers all types of decisions that clients may need to make from what to eat for breakfast to whether to have major surgery; however, not all decisions have to be treated the same, the requirements for assessing and recording will depend on the significance of the decision and the nature of the client's difficulty making it.

Be aware that significance must be judged on an individual basis and that while you can never assume that a client lacks capacity care records may include general advice about their 'normal' decision making abilities and preferences.

Certain decisions can never be made on another person's behalf either because they are personal or because other laws apply. These include:

- Sexual consent
- Consent to marriage / civil partnership
- Consent to divorce / dissolution
- Consent to put a child up for adoption.
- Discharging parental responsibility
- Voting

Assessing Capacity

A person must be assumed to have capacity unless it is established that he lacks capacity.

Whenever the term 'a person who lacks capacity' is used it means a person who lacks the ability to make a particular decision or take a particular action for themselves at the time that it needs to be taken.

If you believe that a person may lack capacity to make a decision you should carry out a two-stage assessment. Stage one is known as the diagnostic test, stage two is a functional test.

Diagnostic Test

For the Mental Capacity Act to apply to an individual they must have a disturbance of their mind or brain which is affecting their ability to make a decision. This could be permanent or temporary and may be a single condition or a combination of factors acting together.

Factors include:

- Conditions associated with forms of mental illness
- Dementia
- Significant learning disabilities
- Long term effects of brain damage
- Physical / medical conditions that cause confusion, drowsiness or lack of consciousness
- Delirium
- Concussion following head injury
- Symptoms of alcohol / drug use
- Inability to communicate: Coma Unconsciousness 'locked in' syndrome

When recording your assessment, you would write down what you believed to be causing the disturbance; this will be enough to comply with the code of practice. You are not expected to make a formal diagnosis.

Functional Test

Following on from a diagnostic test if you believe that a client has a disturbance of the mind or brain which may affect their ability to make decisions you must

then assess whether they actually lack competence by deciding whether they are unable to do one or more of the following:

1. Understand information given to them about the decision
2. Retain the information for long enough to make the decision
3. Weigh up the information i.e. consider the pros and cons
4. Communicate their decision

Competence must be assessed properly according to the specific requirements of the diagnostic and functional tests in order to ensure that you are not acting on prejudices or assumptions. The code of practice accompanying the Act states that 'A person's capacity must not be judged simply on the basis of their age, appearance, condition or an aspect of their behaviour.'

The terms used are carefully chosen to cover a wide range of different interpretations; 'appearance' could mean the facial characteristics associated with Down's syndrome or the presence of multiple facial piercings; 'condition' could relate to physical disability, mental health, illness or drunkenness; and 'aspects of behaviour' could range from making obscene gestures to refusing to speak.

Bear in mind that the way a person looks, or acts may make them seem more competent, not less. If a person is smartly dressed and speaks politely and correctly, we may believe they are talking sense even if they are not.

We have been talking about you assessing people's competence, but we haven't yet discussed when 'you' should do this. Bearing in mind that all adults should be assumed competent you will only carry out an assessment when you have reason to believe that they are not.

In general terms, where there is doubt about an individual's competence, it should be formally assessed every time a decision needs making or action needs taking. The person who carries out the assessment will be whoever is suggesting a choice or proposing an action and, if they assess the individual as lacking competence, they will become the 'decision maker'.

The decision maker could be you, or any other person involved with the individual in a professional capacity.

Examples of decisions you may need to assess capacity for:

- Does the client want a bath
- What will they wear
- What are they going to eat
- Choice between activities
- When they will go to bed

Other people who may make assessments:

- Doctors ref medical treatment
- District nurses about dressing change consent
- Social worker about a place to live

Decision makers receive legal protection (see unit 4) as long as they base their decisions on the best interests of the client. For acts of care / treatment you must have 'reasonable belief' that the client lacks capacity to agree to an action or decision. 'Reasonable' steps must have been taken to establish that the person lacks capacity and must also establish that any action being taken is in their best interests.

Clients' care plans may include information about their ability to make their own choices and decisions and should have details of any support they need to understand, process and communicate information. However, this does not mean that they do not need any further assessments; reviews should be carried out regularly and formal assessments should be completed and recorded in any of the following circumstances:

- When planning care and support
- When any significant decision needs to be made (significance must be judged on an individual basis)
- When the consequences of the decision will have a significant impact on the client's life (e.g. what medical treatment to have, money management)

- When a decision maker's choice or course of action may be challenged

When assessing an individual's competence to make a decision it will not be enough to just say 'well I asked him what he wanted, and he didn't seem able to tell me, so I went ahead and decided for him.' You must be able to show that you have done everything possible to help the client understand their choices and to make a decision for themselves.

When assessing a client's capacity you may need to:

- Understand the nature and effect of the decision to be made – this may require access to documents and background information
- Access relevant information to support your assessment e.g. medical records
- Get professional advice regarding an individual's medical condition or method of communication

The functional stage of the capacity assessment requires you to judge whether clients are capable of doing four separate things which we will now look at in order.

1. Understand information given to them about the decision

Care plans should include details of any barriers to communication and the type of support that the individual might need to understand information and to communicate their feelings and responses.

Communication guidance

- Ask people close to the individual how best to communicate with them
- If necessary, use simple language or pictures / signs
- Use the right volume and speed – avoid jargon and words that the person may have difficulty understanding
- Break down information into short sentences – allow time for the person to process one instruction / idea at a time
- Repeat information whenever necessary

- Be aware of cultural / ethical / religious factors that shape thinking / behaviour / communication
- Consider using a professional interpreter who will faithfully translate what the client says. A family member might censor complaints or say what they think the person means
- Consider whether an advocate might improve communication

2. Retain the information for long enough to make the decision

When you have done all you can to make sure that your client understands the decision they are making you must then decide whether or not their understanding lasts long enough to make their choice. To find out if they have retained what they have been told you could ask them questions or ask them to put the information into their own words.

The actual length of time the information needs to be retained for will depend on the significance of the decision and the likely consequences if the decision has been forgotten before it has taken effect. For example, if a client is choosing their lunch they don't have to retain the information for long to make their selection but, if by the time food is served they have forgotten they may decide they want something else and become upset if this isn't possible. In this situation it would be best to either shorten the time between choosing and serving or to provide the client with a memory aid such as a card with their choice printed on it.

3. Weigh up the information i.e. consider the pros and cons

As well as being able to understand the information they are given, individuals must also be able to understand what the consequences of a choice or action will be. The client must have been given all relevant information in an unbiased way in order to choose the course of action that is right for them. They may also want to consider the way that their decision or action may affect those close to them. Although your focus as a carer must always be on what is best for the client, they will be influenced by their relationships with other people. For example, they may want to do something because it will make their loved ones happy and it is their right to do this as long as it has been their own free choice.

4. Communicate their decision

Carers and other health professionals are expected to make every effort to interpret clients' speech, gestures and, if necessary, behaviour. If a person is capable of communicating in any way whatsoever, they must be given every opportunity to do so.

Alternatives to speech as methods of communication include:

- sounds
- behaviour including challenging
- pointing
- signs
- drawings
- blinking
- facial expression

Records

To meet the Care Quality Commission's requirements (Mental Capacity Act 2005 Guidance for Providers) your records of assessments and decision making should show the following:

- How the client was helped to make a decision for themselves, and how effective this was
- How much the person is able to understand information relevant to the decision
- Whether the person can remember information for long enough to make the decision
- How well the person can weigh up the pros and cons
- How the person can let others know what their decisions are and how well they can do this

Carrying out and recording assessments may require you to access, discuss and write down personal information about clients. To ensure that you comply with both the General Data Protection Regulation and your duty of confidentiality ensure you do the following:

- Protect information from being accessed by people who have no need or right to know it – lock written information in filing cabinets, use passwords on computers and only discuss personal information in private areas
- Think carefully before passing on information to others, for example when involving family members. Get the client's consent to discuss their personal business, or, if this is not possible, only communicate what is necessary to people who need to know
- Only record accurate, relevant information

8.2

Write 500 words on why the mental capacity act helps clients, what negative influences it can have on independence and how carers can promote independence while following the act:

The Health and Safety at Work (etc) Act (HSWA) 1974

The Health and Safety at Work Act was the first piece of legislation designed to cover **all** types of work and working environments. It is described as a framework, or skeleton, act because it gives general guidance on many issues, but further legislation was required to add detail and give specific responsibilities for controlling risks.

Under the Act your employer must:

- Provide you with written policies and procedures for safe working
- Ensure that the environment you work in and the equipment you use are safe and well maintained
- Handle substances safely
- Provide you with information, instruction, training and supervision
- Ensure that you have appropriate welfare facilities e.g. toilets and drinking water You must:
- Use equipment and carry out tasks following your employer's safe working procedures and any training and information you have been given
- Work in a way that reasonably protects your health and safety and that of other people
- Co-operate with your employer on health and safety issues
- Report health and safety concerns to an appropriate person

The key to meeting the requirements of health and safety law is risk assessment; this helps you to identify hazards of work and to decide how best to control them. So, for example:

- in order to handle substances safely employers need to identify hazardous substances and ways of making them safer
- to work in a way that reasonably protects your health and safety you must be able to recognise hazards and know how to reduce them

Fire Safety Regulations, Regulatory Reform (Fire Safety) Order 2005

Control of Substances Hazardous to Health Regulations (COSHH) 2002

Health and Safety (First Aid) Regulations 1981

Manual Handling Operations Regulations 1992 (MHOR updated 2004).

Each of these is based on a risk assessment approach; instead of telling employers that they must use particular control measures or pieces of equipment, they ask that employers make their own decisions about what is right for their workplace and their type and size of business. Employers are allowed to be the experts on their own business and, as long as they can show that they have reduced risk to acceptable levels using appropriate methods they will be meeting their legal duties.

Examples of using risk assessment to meet the requirements of these 4 pieces of legislation include;

- Identifying clients who will be at increased risk if a fire starts and creating their own personal emergency evacuation plan (peep)
- Determining which cleaning materials may cause skin problems and introducing gloves to manage the risk
- Estimating how many, and what type, of accidents and medical emergencies may occur and using this information to stock first aid kits
- Determining the specific assistance needs of a client and introducing suitable equipment

Even in the most risk aware workplaces accidents still happen and these must be appropriately reported and recorded. Make sure you are familiar with the accident book or forms used and that you know how and when to complete them. Certain incidents must be reported to the Health and Safety Executive under the following regulations:

Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations enable enforcement agencies to monitor workplace accidents and ill health. Among other things, they can then identify common types of accident; see which types of workplace experience which types of illness and injury; and track the spread of infections.

Employers and managers have a duty to report certain incidents either by telephone (fatalities and major incidents only) or online (www.hse.gov.uk/riddor); reportable events include:

- Accidental death
- Accident resulting in more than 7 days absence from work
- Certain diseases / illnesses (a full list is accessible from the RIDDOR website)
- Injuries to non-employees requiring immediate medical attention
- Near misses (incidents that could have caused serious injury but didn't e.g. a hoist sling tearing while in use)
- Events such as fires or collapse of buildings

Getting Started

Formal risk assessments should be done by employers and managers who are competent; this means that they should:

- Understand the risk assessment process and have been trained to carry them out
- Have experience of their working environment and the type of work activities that go on in it
- Be able to identify appropriate control measures and weigh up the costs and benefits of implementing them
- Know the legal framework for Health and Safety at work
- Be able to communicate their findings

Formal risk assessments follow a 5-step process which we will look at individually; the steps are:

1. Identify the hazards
2. Decide who might be harmed and how
3. Evaluate the risks and decide on precautions
4. Record your findings and implement them

5. Review your assessment and update if necessary

Informal Risk Assessments

Informal risk assessments do not have to take this step-by-step approach; they are concerned only with identifying hazards, recognising how harm might be caused and to whom, and deciding on control measures to reduce the risk. Informal risk assessments are done 'on the go' while the hazardous task is being planned and carried out.

You almost certainly carry out informal risk assessments on a daily basis; if you didn't you would be lucky to get through the day in one piece. Every day examples include using the 'green cross code' to cross the road and using the 'mirror, signal, manoeuvre' sequence, when driving a car.

You may think that you do these things without thinking, and sometimes that's probably true, we are all guilty of operating on autopilot at times. However, when we act without thought we're in danger and we do things like stepping into the road without looking or turning into oncoming traffic.

The more we do something, the more natural the thinking process becomes and the less aware we are that we are doing it. So, while a child will stand at the side of the road and talk themselves through the process of checking for traffic, an adult will look both ways and make the necessary calculations much more quickly.

Experienced carers become quicker and more competent at carrying out tasks because they have done them many times before and they have developed safe techniques; however, experience can also introduce risks as with repetition comes complacency. If you have done something 99 times you don't expect to have difficulty doing it a hundredth time and you may miss the fact that something in the situation has changed and you need to alter your actions to allow for it.

Task

- What has to be done?
- What do we want to achieve?
- What is likely to be involved?

Individual (you)

- Am I capable, competent and confident that I can do this?
- Do I have the training and experience to do it safely?
- How am I feeling today, am I fully fit?
- Am I dressed appropriately (comfortable clothing, not too loose or too tight; sensible shoes)

Load (inanimate)

- How big is it?
- Is it easy to hold?
- How heavy?
- Does it have sharp edges?
- Is it unstable?

Environment

- Is there space?
- What's the flooring like?
- Have I got to go through doors / upstairs? How difficult will this be?
- Are there bits of furniture in the way?
- Will there be people about?
- Is the lighting adequate?

8.3

Write 250 words on all the different risk assessments you have to follow in your role:

Unit 9: Equality, Diversity, Inclusion and Human Rights in Care Settings (M/650/2307)

Equality is simply defined as the state of being equal; in terms of employment and the provision of services it can be seen as ensuring that everybody is treated in the same way. To give people equal rights, opportunities and status we have to identify and overcome barriers that put some people at a disadvantage.

'Equal' does not mean 'the same' and it's important to appreciate the difference. If everybody was treated the same, we may be failing to provide appropriate, person-centred care. Employers who treat all staff the same may feel they are being fair, but they could well be discriminating against some and depriving them of equal opportunities.

Diversity is 'the state of being different'; it may be challenging but diversity should be regarded positively as something to be promoted and celebrated. It's an old cliché that the world would be a boring place if we were all the same, but people who are open to new experiences and curious about other people's ways of life do seem to experience a more interesting life.

People's values and beliefs are shaped by their backgrounds and experiences; to provide appropriate care you must understand and respect the people you support and the way in which their needs will be affected by their individual characteristics.

It is impossible to provide quality care without due regard to equality and diversity. Care providers have a social, moral and legal duty to ensure that the people they support are treated equally and fairly. To achieve this, organisations and individual carers have to recognise that everyone must be treated as an individual.

All clients should be treated with dignity and respect regardless of their lifestyle, beliefs or background. It may require greater investment and effort to achieve equality for some people, but this is not an excuse for prejudiced and discriminatory attitudes.

Barriers to Equality

Many people are vulnerable to discriminatory treatment because they lack the physical and mental strength to protect their own interests or because their options are restricted, for example, because they cannot afford to find another care provider or because there is a limited choice of service provider accessible to them.

Everyone deserves to have the same opportunities and equal treatment when buying services or being paid to work; to support this right and to prevent people from being exploited by service providers and employers; the government creates legislation.

The most recent **The Equality Act 2010** brings together and strengthens over forty years' worth of anti-discrimination legislation, including:

- The Sex Discrimination Act 1975
- The Race Relations Act 1976
- The Disability Discrimination Act 1995
- The Equal Pay Act 1970

The Act aims to uphold the rights of all parts of society to access employment opportunities and benefit from public and private services and facilities. It challenges the direct discrimination which occurs when people are openly denied services or jobs and the indirect discrimination caused by unfair restrictions or conditions.

The Equality Act introduces 9 'protected characteristics', these are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief

- Sex
- Sexual orientation

It is an offence to discriminate against people because of these characteristics or to treat them less fairly. So, for example:

- A woman cannot be paid less than a man doing the same job
- A person in a wheelchair cannot be charged extra for public transport
- Hotels cannot refuse to put unmarried couples in double rooms
- Employers cannot impose unnecessary height restrictions as men and women would be affected differently as would people of different racial backgrounds

The Act makes it illegal to discriminate against someone because of:

- One of the 9 protected characteristics
- Their association with someone who has a protected characteristic
- The belief that they have a protected characteristic

Harassment and Victimisation

The Equality Act is intended to protect people from harassment and victimisation as well as discrimination.

Harassment and victimisation are essentially forms of bullying. There are three types of harassment which are unlawful under the Equality Act:

- Harassment related to a relevant protected characteristic.
- Sexual harassment.
- Less favourable treatment of (an individual) because they submit to or reject sexual harassment or harassment related to sex.

Victimisation is defined in the Act as:

Treating someone badly because they have done a 'protected act' (or because you believe that a person has done or is going to do a protected act).

A 'protected act' is:

- Making a claim or complaint of discrimination (under the Equality Act).
- Helping someone else to make a claim by giving evidence or information.
- Making an allegation that you or someone else has breached the Act.
- Doing anything else in connection with the Act.

The law requires service providers and employers to take a proactive approach to equality and prevention of discrimination, harassment and victimisation. This means that they can't just react to complaints or problems; they must actually make an effort to identify possible issues and address them before anyone is affected. So, for example, business owners should ensure their premises are fully accessible before they start trading and bodies like the NHS should carry out research into and gain feedback from different groups when they are developing new services.

Supporting Equal Opportunities

As well as The Equality Act 2010 care providers must also meet the requirements of The Health and Social Care Act 2008; guidance for this can be found in The Essential Guide to Quality and Safety issued by the CQC.

'The registered person must...take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have'

Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2009

In their guidance for inspectors (Equality and Human Rights in the Essential Standards of Quality and Safety: an Overview) the CQC state that they are looking for evidence that care providers aim for:

- Equality of access to care and support
- Equality of outcomes from care and support
- Equality of opportunity to participate and contribute fully in society

Equality of Access

Access could mean physical access to facilities or areas of a building, or it could be access to information about care and treatments available. Where barriers to access exist, reasonable steps must be taken to overcome them; for equality you should aim to allow independent access. For example, you might say that a wheelchair user could be carried up steps into a building, but this would be an unacceptable solution as it would be undignified and would leave the individual relying on others.

The Equality Act asks for 'reasonable adjustments' to be made to enable access for people with disabilities; this is not limited just to people who use wheelchairs. People with sight problems, conditions such as dementia or learning disabilities may face their own challenges when moving around. Ease of movement, and the ability to find your way around, has a significant impact on independence.

Less obvious issues to be considered include:

- How do different flooring materials affect the ease with which wheelchairs will move?
- How are people with conditions such as dementia affected by different patterns / positioning of mirrors etc?
- Are there alternatives to worded signs to help people who have difficulty reading?
- If colours are used to define facilities or to show the way, are they useful to people who are colour blind?
- Are there grab rails or other supports in appropriate positions?
- Are there signs at lower levels for wheelchair users and older people who may have become bent with age?

Equality of Outcomes

The CQC should not be able to find evidence that certain groups achieve better results than others. Here's an example of discrimination evidenced by inequality of outcome:

A 2000 study of the management of elderly blunt trauma victims in Scotland found that significantly more of the elderly died than would be predicted. Once admitted to A&E, older patients were less likely to be admitted to intensive care, less likely to be managed in a resuscitation room and less likely to be transferred to a regional neurosurgical care centre. (Ageism and Age Discrimination in Secondary Health Care, 2009)

Equality of Opportunity

Some people choose to distance themselves from society and take pleasure in not conforming. However, there are many people who are denied opportunities to access public facilities, participate in community events, influence political decisions or contribute to society. Factors influencing people's opportunities include:

- Poverty
- Lack of education
- Language barriers
- Lack of access
- Cultural differences
- Ignorance of diversity
- Disenfranchisement (lack of the right or opportunity to vote)

A disabled person, for example, may be unable to vote if there are not suitable alternatives to visiting a polling station. A teenage single mother may feel that she is excluded from child services advertised with pictures of couples and more mature women.

Protecting Rights

Equality is only possible if we accept that everyone has the same rights. The core principles of human rights are fairness, respect, equality, dignity, autonomy and participation for all.

The Human Rights Act 1998

Human rights legislation exists to protect all of us from the actions of public bodies like councils and NHS trusts. There are some rights which are particularly relevant to the provision of care, and they are summarised below:

- Article 2 – right to life
- Article 3 – protection from torture or inhuman or degrading treatment
- Article 5 – the right to liberty and security of person
- Article 6 – the right to a fair trial
- Article 8 - the protection of private and family life
- Article 9 – freedom of thought, conscience and religion
- Article 10 – freedom of expression
- Article 14 – freedom from discrimination

Protecting Personal Information

It's part of a carer's duty of care to clients that they must protect their personal details. Information recorded in people's care and health records can be of a highly sensitive nature; people must not be exposed to risk of harm or ridicule through a lack of respect for confidentiality.

All records should be completed in plain English to be as accessible as possible, stick to facts and use non-judgemental language.

Before the Freedom of Information Act 2000, which gave people the right to see anything written about them, professionals often used jargon and abbreviations to make in jokes and express their opinions about the person concerned.

This kind of record making was deliberately excluding. There are stories of doctors using amusing abbreviations to pass on their opinion of the lifestyles of patients to their colleagues. It has been rumoured that UBI stands for unexplained beer injury, GPO is good for parts only and LOBNH is lights on but nobody home; these may have amused the doctors, but they label the patient and may affect the treatment they receive from other health carers in the

future.

Celebrating Diversity

If care practices and environments are not flexible to meet different needs and expectations people can end up feeling like excluded outsiders in what should be their home.

Carers need to be aware of differences in people's approach to personal hygiene; toileting; eating; grooming; and medical care. Providing care in an inappropriate way can cause offence and ignorance is not an acceptable excuse.

If they have not got the knowledge or skills necessary to meet an individual's needs shouldn't be afraid to ask for help. If appropriate they should be honest with the person they are caring for and ask them to explain their requirements or, perhaps, ask one of their family members to teach you what to do.

Culture of the Workplace

There is a difference between being protected from discrimination and being made to feel truly welcome and involved. The first can be achieved in a purely impersonal way while the second allows everyone in an organisation to feel that they are part of it, that they can influence the way it operates and that they are valued.

The management must set a good example to follow and policies, procedures and working practices should reflect a zero-tolerance attitude to discriminatory attitudes and bullying behaviours.

Offensive language and inappropriate behaviour must be challenged immediately and effectively. Staff should go through appropriate disciplinary procedures whilst clients should be given opportunities to agree their own 'codes of conduct' and to discuss acceptable ways of speaking and behaving in **public** areas.

Staff and clients should be given information and education to improve their understanding of diversity issues; this should reduce the likelihood of people causing offence through ignorance and can help to develop mutual respect between individuals.

It is important to know that with rights come responsibilities, and clients should be no exception to this. To achieve an environment where diversity is celebrated, and people are encouraged to express themselves as individuals, it is important for clients as well as staff to act appropriately.

Carers should not have to put up with insulting behaviour or language, their employers have a duty to protect them. If a client abuses or uses discriminatory language towards other clients, this is a safeguarding issue and must be taken seriously and dealt with appropriately.

Most importantly employers must see diversity, equality and inclusion as positive ideals to be promoted and celebrated. Training and development should be taken seriously and not viewed as 'tick box' exercises for legal compliance.

Encouraging Feedback

The best way of finding out whether clients feel happy with the care they receive is to ask them. Organisations should have ways of gathering information that are useful for your client group. Carers might have residents' meetings, hand out satisfaction surveys or just sit down with clients and have a chat but whatever they do should be recorded and acted upon.

When the CQC carry out their inspections they look for evidence that care providers are responsive to clients' needs and that they are constantly working for better outcomes for everybody i.e. they are aiming to improve people's physical and mental wellbeing. Records such as minutes of meetings with details of action taken in response to feedback are an excellent way of showing that you are taking an appropriately person-centred approach.

Care providers' complaints procedures must be clear and well communicated; comments and complaints should be seen positively as opportunities to improve. Carers should not be afraid of feedback from clients.

When a complaint has been made anonymity must be maintained to prevent victimisation of the individuals involved.

Staff Recruitment

The diversity of the client group should be reflected in the people who care for

them. Carers should be both male and female and come from a range of cultural and racial backgrounds.

A good manager will find staff with varied qualities and skills to meet client needs in different ways. Employees should feel valued for the unique qualities they bring to the work role and should be encouraged to develop their strengths and work on their weaknesses.

Clients should be involved in every stage of staff recruitment including advertising positions, interviewing and decision making. If possible, a client representative should be present on interviewing panels, but if it's not possible then clients should have the opportunity to contribute questions to ask prospective employees.

Relationships

Supporting clients to participate in recruitment helps them to feel more in control of their lives. The relationship between a carer and a client has to be a very personal one; clients must feel as comfortable as possible with the people who bathe and toilet them.

Where communication barriers exist it is up to carers to remove them so that individuals are not unnecessarily confused about what is going on around them or excluded from activities and conversations because they have difficulty understanding them.

Carers need to have excellent communication skills; the way you communicate and interact with the individuals you care for will have a significant impact on their quality of life. Individuals who are highly dependent on others to meet their basic needs will be most affected by poor communication and a lack of interaction.

Although it is human nature to find some people more 'likeable' than others this cannot be reflected in the care delivered. Care provision must reflect client needs **not** the personal feelings of carers.

Helping People to Feel Included

As both employer and service providers, homes must not only meet the requirements of the Care Quality Commission to provide person centred care,

but a home must also meet the obligations of the Equality Act to challenge and remove discrimination of any kind whilst promoting inclusion for all.

A care environment is both home and workplace so there must be a suitable balance between its functional needs (e.g. room to move hoists, wheelchair access) and the social and psychological needs of the individuals who live or work in it (e.g. 'homeliness'; familiarity).

Involving Clients in Shaping the Care Environment

To improve the likelihood that the care environment is suitable for the people who live within it, clients should be involved in all decision-making processes. So, whether you are redecorating the lounge; purchasing new books or games; or landscaping the garden clients' opinions should count.

Gaining input from clients when creating plans or making decisions may not be as straightforward as asking them; different people will need to be involved in different ways, for example:

- Plans could be put forward at residents' meetings and different options discussed
- Clients could be shown pictures/ fabric swatches / colours and asked to comment on them
- Care managers could look at profiles of their clients and identify suitable options to reflect a range of needs
- Family members and other loved ones could be asked for opinions and advice
- Surveys and feedback forms could be used to identify areas in need of change or improvement
- Clients could use a suggestion box to put forward ideas
- Client representatives could attend trade shows and industry events to get ideas and see what's available

Empowering Clients

Issues of equality, diversity and inclusion affect all aspects of care provision from the way staff are recruited, to the way people's personal hygiene needs

are met. Care providers must take positive action to prevent discrimination and to promote the rights of individuals to be themselves.

Judgemental attitudes have no place in care and care workers must be able to respect the values and beliefs of others even if they don't share them. They should be open to new experiences and new ways of doing things and never stop learning.

People living in care environments need to be supported to achieve their full potential and experience maximum quality of life; to this end the people who care for them must promote independence and a sense of self. They have to see the individual in terms of their abilities and work with them to identify and achieve both long term, and short term goals.

To help clients to achieve and / or maintain a sense of self care workers need to:

- Help them to be confident
- Reinforce their individuality
- Enable them to express themselves
- Help them to access information and educational opportunities
- Encourage them to try new things
- Protect them from discrimination and abuse

9.2

Write 500 words on how equality & diversity can help improve a clients wellbeing while also thinking of your own experiences.

A series of 28 horizontal dashed lines for writing.