# Working in Health and Social Care 2

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# Getting to know your unit

**Assessment**

You will be assessed by a written exam set and marked by Pearson.

In this unit, you will be introduced to the roles and responsibilities of health and social care practitioners and the organisations they work for. You will see how a wide range of roles, including doctors, nurses, physiotherapists, occupational therapists, social workers, youth workers, care workers and other professionals, work together to ensure that the individual needs of vulnerable people are met.

You will learn how standards in this area are set and monitored and reflect on the role of professionals in this sector in supporting people with health and social care needs.

## How you will be assessed

You will be assessed by a paper-based examination, lasting for 1 hour 30 minutes and worth 80 marks. The examination will consist of four sections. There will be short- and long-answer questions. The questions are intended to assess your understanding of how health and care services and health and care practitioners can meet the needs of a range of service users who need professional support. Each section will relate to a different service user group, for example the frail elderly, people with learning disabilities, people with mental health problems or people with long-term illnesses. The questions will make connections between the organisations and professionals that contribute to care and provide opportunities to discuss the challenges associated with providing high-quality health and care provision.

Throughout this unit, you will find assessment practices to help you to prepare for the exam. Completing each of these will give you an insight into the types of questions that may be asked and, importantly, how to answer them.

Unit 2 has four assessment outcomes (AO), which will be included in the external examination. Each assessment outcome also has some 'command words' associated with it – see Table 2.1 for a list of what these command words are asking you to do.

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The assessment outcomes for the unit are:

**AO1** Demonstrate knowledge of service user needs, roles and responsibilities of workers and working practices within the health and social care sector.

Command words: Identify.

Marks: 2 marks.

**AO2** Demonstrate understanding of service user needs, roles and responsibilities of workers and working practices and procedures in the health and social care sector.

Command words: Describe.

Marks: 4 marks.

**AO3** Analyse and evaluate information related to the roles and responsibilities of health and social care workers and organisations and how workers and organisations are monitored and regulated.

Command words: Explain.

Marks: 6 marks.

**AO4** Make connections between the roles and responsibilities of health and social care workers and organisations, how workers and organisations are monitored and regulated and how multidisciplinary teams work together to meet service user needs.

Command words: Discuss.

Marks: 8 marks

**Table 2.1:** Command words used in this unit

| Command word | Definition – what it is asking you to do |
|---|---|
| Identify | State the key fact(s) about a topic. The word 'outline' is very similar. |
| Describe | Give a full account of all the information available, including all the relevant details of any features, about a topic. |
| Explain | Make an idea, situation or problem clear to your reader by describing it in detail, including any relevant data or facts. |
| Discuss | Write about the topic in detail, taking into account different ideas and opinions. |

This table contains the areas of essential content that learners must be familiar with prior to assessment.

| Essential content | |
|---|---|
| **A** | The roles and responsibilities of people who work in the health and social care sector |
| **B** | The roles of organisations in the health and social care sector |
| **C** | Working with people with specific needs in the health and social care sector |

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## Getting started

Sheila is nearly 90 and is now quite frail. She lives alone in a ground floor flat and uses a wheelchair indoors. Sheila is on a very low income. Identify and list the health and care services that might be available locally to help her live independently. After completing this unit, see if you can add more services to your list.

# A The roles and responsibilities of people who work in the health and social care sector

**Key terms**

**General practitioner** – a doctor who does not specialise in a specific branch of medicine but provides ongoing treatment and preventative care in the community for a variety of medical problems that may be experienced by individuals of all ages.

**Preventative care** – care and education that aims to ensure people remain healthy, and are aware of factors that can lead to illness and poor health. It includes screening and vaccination programmes.

## Roles of people who work in health and social care settings

### Doctors

When people are feeling unwell, their first (or primary) point of contact with the medical profession will normally be a **general practitioner (GP)**. GPs provide ongoing care for people in the community. This includes:

- caring for people who are unwell, including carrying out simple surgical procedures
- providing **preventative care** and health education for service users.

GPs are increasingly based in local health centres, working with other doctors and a range of health and care professionals such as nurses, health visitors and counsellors. GPs may refer people to hospital specialists (consultants) or other care professionals for further assessment and treatment such as X-rays or blood tests, or to social workers for social care support.

The principle responsibilities of doctors in treating illnesses are to:

- diagnose an individual's illnesses and ailments
- discuss and agree an individual treatment plan
- prescribe appropriate medication or treatment
- monitor the impact of the agreed treatment.

The preventative care and health education services provided include:

- vaccination programmes for people of all ages
- health education and advice on issues such as smoking, alcohol consumption and healthy eating.

**Research**

List the range of preventative care and health education services provided at your GP's surgery. Share this information with the other members of your group. Are there any significant differences in different areas?

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Hospital doctors provide specialist medical care. In the UK and the Republic of Ireland, **consultant** is the title of a senior, hospital-based doctor who specialises in a particular field of medicine and manages complex cases. To provide this care, the consultant normally leads a team, or firm, of more junior doctors. This includes newly qualified doctors and more experienced doctors (known as registrars). Consultants are normally known by the name of their specialist field, for example:

- cardiologists specialise in treating heart disease
- psychiatrists specialise in treating mental health problems
- oncologists specialise in treating cancer
- paediatricians specialise in treating children
- geriatricians specialise in treating older people.

**Key term**

**Consultant** – a senior doctor, normally based in a hospital, who provides specialist expert healthcare support in their area of expertise.

## Nurses

Nurses are the largest group of professionals working in the health services. There are many opportunities to specialise and to reach senior levels within the profession, including the role of nurse consultant or **nurse practitioner**.

- Adult nurses work with adults of all ages, who may have a wide range of physical health conditions. They may be based in hospitals, clinics or GP practices, or work for specialist organisations such as the armed forces. Many adult nurses work with people in their own homes. Adult nurses will often plan individual care, carry out healthcare procedures and treatments and evaluate their effectiveness. They also work to promote good health by running clinics and health education programmes on topics such as giving up smoking or weight loss.
- Mental health nurses are nurses who specialise in mental health work in a range of settings. These may include psychiatric units in hospitals, community healthcare centres, day care settings, residential homes and prisons. Mind, the charity that supports people with mental health problems, estimates that each year one in four people in the UK will experience mental health problems. Remember that most people who experience mental health problems are cared for in the community, not in hospitals.
- Children's nurses or paediatric nurses work with children with a very wide range of conditions. A children's nurse works closely with the child's parents or carers. This is to ensure that, as far as possible, the care provided meets their social, cultural and family needs, as well as addressing their health issues. Children's nurses may work in hospitals but also support children at home.
- Learning disability nurses work mainly with individuals with learning disabilities living in the community rather than in hospitals. This may include supporting people in schools and workplaces, people living at home with their families and people who live in specialist residential settings. They aim to work with people with learning disabilities and their carers to maintain the person's physical and mental health, provide specialist healthcare and support them to live as fulfilling and independent a life as possible.
- District nurses care for people of all ages, supporting them in their own homes or in residential homes. District nurses work closely with family members and other carers. They assess the patient's needs and also the care and support needs of their 'informal' carers. District nurses most commonly care for older people, people with disabilities and people recently discharged from hospital.
- Neonatal nurses work with newborn babies, including babies who are born prematurely. They work in specialist hospital settings and in the community. The neonatal nurse works very closely with the baby's parents and actively encourages them to take a practical role in their child's care.

**Key term**

**Nurse practitioner** – provides expert consultancy service to patients and their carers. They contribute to the management and development of the care provision. They also undertake research and contribute to the education and training of other members of staff.



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An adult nurse talking to a patient

- Health visitors provide support for families in the early years of their children's life, normally from birth to the age of five. They offer support on health issues and minor illnesses, and advice on feeding and weaning. They carry out routine checks on the child's development and support parents in meeting the developmental needs of their children. Health visitors see the children and their carers in their homes, at clinics, at the GP practice and sometimes at a nursery or in other community settings.
- Practice nurses work in GP practices. In small practices there may be only one practice nurse, but increasingly they are part of a larger team of practice nurses. Practice nurses' responsibilities vary according to the GP practice but will normally include taking blood samples, carrying out child immunisation programmes and administering vaccinations for people travelling abroad. Practice nurses often provide **health screening** for men and women, and family planning advice, if they are qualified to do so.
- School nurses are usually employed by the NHS but may be employed directly by a school. They provide a variety of services, including developmental checks, administering immunisation programmes and providing health education programmes.

**Key term**

**Health screening** – the process of checking for the presence of disease in individuals who have no signs or symptoms of the illness. For example screening for the presence of cervical cancer for women or testicular cancer for men before they have any symptom of the disease.

## Midwives

Midwives play a central role in supporting women through all stages of pregnancy, providing both **antenatal** and **postnatal** care. This includes helping families prepare for parenthood and delivering babies in the maternity departments of hospitals and in patients' homes.

Midwives may be based in hospital maternity units but an increasing number of midwives work in the community, providing support at local clinics in GP practices, in women's homes and at children's centres.

**Key terms**

**Antenatal care** – care provided for a mother and her baby before the birth of the baby.

**Postnatal care** – care provided for a mother and her baby after the birth of the baby.

## Healthcare assistants

Healthcare assistants are sometimes known as nursing assistants or auxiliary nurses. They work under the guidance and with the support of qualified healthcare professionals. They may work in GP practices, hospitals, nursing homes and other

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community healthcare settings. Most commonly healthcare assistants work alongside qualified nurses, but they may also work with midwives in maternity services. Duties carried out by healthcare assistants include:

- taking and recording a patient's temperature and pulse
- weighing patients, and recording the result
- taking patients to the toilet
- making beds
- washing and dressing patients
- serving meals and assisting with feeding when necessary.

## Social workers

Social workers provide help and support for people of all ages through difficult times in their lives. They aim to ensure that the most vulnerable people are safeguarded from harm and to help people live independent lives. Social workers support children, people with disabilities, people with mental health problems and the frail elderly.

Increasingly, social workers specialise either in providing services for adults or in providing services for children and young people.

- Adult services include services for older people, adults with disabilities, people with mental health problems and people who have learning difficulties. They support people living independently and those in residential care. They work very closely with the service users' families and carers.
- The children and young people's services provide support for children and their families. They play a key role in ensuring that children are safe and protected from abuse. If children are at risk from harm, social workers take measures to ensure that the children are removed to a safe place. This may, in extreme circumstances, include removing them from their home and family. Social workers also work in residential children's settings and manage fostering and adoption procedures. They provide support for young people leaving care and young people at risk of being in trouble with the law.

## Occupational therapists

Occupational therapists work with people of all ages who are having difficulty in carrying out the practical routines of daily life, for example washing and bathing, housework, cooking or getting to the shops. These problems may be the result of a disability, physical or psychological illness, an accident or the frailty of older age. The occupational therapist will agree specific activities with an individual that will help them to overcome their barriers to living an independent life. Occupational therapists may work in people's homes, GP practices, residential and nursing homes, prisons, social services and other council departments and in hospitals.

## Youth workers

Youth workers generally work with young people between the ages of 11 and 25. They aim to support young people to reach their full potential and to become responsible members of society. They work in a range of settings, including youth centres, schools and colleges. They may be employed by the local council but youth workers are also employed by a range of religious and other voluntary organisations. Youth workers are not always based in a particular building, especially if they are working with young people on the streets.

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Typical youth work activities include:

- delivering programmes relating to young people's concerns, such as smoking, drugs, binge drinking, relationships and dealing with violence
- organising residential activities and projects
- running sports teams
- initiating and managing community projects with young people
- working with parents to support the healthy development of their children.

Youth work covers a wide range of activities

## Care assistants

Care assistants provide practical help and support for people who have difficulties with daily activities. This may include supporting older people and their families, children and young people, people with physical or learning disabilities or people with mental health problems. Care assistants work in a wide range of settings, such as in clients' homes, at day care settings, in residential and nursing homes and in supported or sheltered housing complexes. Their exact duties will vary according to the needs of the clients, but could include:

- helping with personal daily care, such as washing, dressing, using the toilet and feeding
- general household tasks, including cleaning, doing laundry and shopping
- paying bills and writing letters
- liaising with other health and care professionals.

Sometimes care assistants will work with only one person, providing intensive support to enable them to manage everyday life.

**Key term**

**Supported housing** – shelter, support and care provided for vulnerable people, to help them live as independently as possible in the community.

## Care managers

Care managers have a key leadership role within residential care settings. They manage the provision of residential care for:

- adults and young adults with learning difficulties
- older people in residential care or nursing homes
- people in **supported housing**
- people receiving hospice care.

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Care managers are responsible for the routine running of the residential care setting, including appointing suitable staff and managing staff teams, managing the budget and ensuring that the quality of care meets the standards required by the sector. Care managers will manage and supervise the duties of the care assistants working in their setting.

## Support workers

The support worker role is closely linked to the healthcare or nursing assistant role discussed earlier. Support workers, however, may work under the supervision of a range of health and care professionals, including physiotherapists, occupational therapists and social workers. Family support workers, for example work with and support social workers. Once the social worker has identified what is needed, the support worker may work closely with the family to help implement the plan. They may provide support with parenting skills, financial management or domestic skills.

**Reflect**

Consider the range of health and care workers who support people at your work placement. There may be professionals or volunteers who are not included in this unit. The list is not exhaustive! Can you think of other professionals who might promote your clients' or patients' health and wellbeing further?

Keep a list to help you prepare for the exam.

**Research**

In groups, use the internet and other up-to-date resources to identify the entry qualifications for a health and social care role and the main responsibilities of professionals working in the health and care services. Each group member should research a different job and share their results. You may want to present your work as a chart to help with revision.

### Case study

#### Caring for Imran

Imran has multiple sclerosis. He uses a wheelchair both at home and when he goes out. Imran has a very caring family who are determined that they should look after him at home. He needs help with washing and dressing, he cannot feed himself any longer and he is incontinent.

**Check your knowledge**

1. Identify the range of care professionals who might support Imran and his family in caring for him at home.
2. Briefly describe the contribution that each of the healthcare professionals you have identified may make to Imran's care and comfort.
3. Discuss your work with other members of your group. Have you missed anything?
4. Present your work in a table.

This will help you prepare for your exam.

**PAUSE POINT** Describe the key roles and responsibilities of a range of health and care practitioners.

**Hint** Close the book and list the key health and care practitioners that have been discussed.

**Extend** Briefly describe the roles and responsibilities of each practitioner.

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## Responsibilities of people who work in health and social care settings

In this section, you will consider the day-to-day responsibilities of people working in health and social care settings. You will examine the strategies that are in place to ensure that the care services promote the health and wellbeing of service users and meet the standards required by the health and care sector.

**Key terms**

**Policies** – detailed descriptions of the approach, and often the specific procedures that should be followed, in caring for clients.

**Procedures** – written instructions that outline the expected and required routines that care staff must follow in specific situations, for example reporting accidents or administering medicines, in order to implement agreed policies.

### Following policies and procedures in health and social care settings

Health and social care organisations have guidelines that describe the working procedures that should be followed to ensure that the care provided meets service users' needs. **Policies** and **procedures** aim to ensure that all staff and volunteers work within the law and to the highest professional standards.

The specific policies in place in a care setting will vary according to the client groups served and the particular function of the setting. These policies may include:

- health and safety policy
- equality and diversity policy
- medication policy
- **safeguarding** policy
- Disclosing and Barring Service (DBS) referral policy
- death of a resident procedures
- complaints policy.

**Key term**

**Safeguarding** – policies to ensure that children and vulnerable adults are protected from harm, abuse and neglect and that their health and wellbeing is promoted.

**Research**

When you are on work placement, ask your supervisor for a copy of one of their policies. Summarise the policy and explain to the rest of your group how it is used to promote the health and wellbeing of the people you support.

Make notes during other people's presentations in order to gather information about as many policies as possible.

**Reflect**

Think about the range of policies in place at your work placement setting. Are all staff familiar with them? Are the policies always implemented? What action is taken if staff or volunteers do not follow the official procedures?

Make a note of your answers to help you with your revision.

### Healing and supporting recovery for people who are ill

There are clearly many different strategies that may be used to support the recovery of people who are ill. The precise support needed will depend on the service user's condition and also their wider social and personal needs.

The range of treatments and care procedures used in healthcare settings may include:

- **Prescribing medication**, this has traditionally been the doctor's role. However, some nurses have undergone additional training and taken on the role of nurse prescriber. Some other healthcare practitioners, such as dentists, chiropodists and physiotherapists, may prescribe some medications in certain circumstances.

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**Research**

Visit the Pharmaceutical Services Negotiating Committee website and research who can prescribe medications and in what circumstances.

- **Surgery**, which may play a significant part in supporting an individual's recovery from illness and other physical disorders. For example, cancerous tumours such as breast lumps may be removed by surgery if cancer is diagnosed at an early stage. Older people may require joint replacement surgery, such as hip or knee joints. Health and care workers in the community have an increasingly important role in supporting people recovering from surgery. This may include visits from the district nurse to monitor progress and provide specific treatments, including changing dressings. Physiotherapists and occupational therapists, where necessary, support mobility and promote independence in carrying out daily living activities. Social workers may provide additional emotional support and ensure that the patient is accessing the services available. Home care workers may provide practical help in the home, including preparing meals where this is seen as necessary.
  A patient's recovery will continue after discharge from hospital. Community support is particularly necessary as there is a trend to discharge people as soon as possible following surgery.
- **Radiotherapy**, is treatment using high-energy radiation. Treatment is planned by skilled radiotherapists working alongside a team that includes radiographers and specially trained nurses. Although radiotherapy is often used to treat cancer, it can be used to treat non-cancerous tumours or other conditions, such as diseases of the thyroid gland and some blood disorders. Patients may need support from their GP on completion of the treatment to ensure full healing. Common side effects of some forms of radiotherapy include itchiness and peeling or blistering of the skin.
- **Organ transplant**, involves either moving a body part or organ from one person's body to another's (known as an allograft) or from one part of a person's body to another location in their own body (known as an autograft). The purpose of the transplant is to replace the patient's damaged or absent organ. Organs that can be transplanted include the heart, kidneys, liver, lungs, pancreas and intestines. The most commonly performed transplants are the kidneys followed by the liver and the heart. A living donor can give one kidney, part of their liver and some other tissues, such as bone marrow. However, other transplants come from donors who have recently died, so in the recovery period following surgery the person receiving the transplant may need the support of a counsellor.
  Highly skilled surgeons and their teams will carry out the transplant. However, many more care professionals will be involved in preparing the individual physically and mentally for surgery and caring for the person following their transplant. For example, specialist nurses, physiotherapists, occupational therapists, counsellors and social workers may provide post-operative support.
- **Support for lifestyle changes**, changing the pattern of daily routines and habits that are damaging to health can be very challenging, but may be very important in improving a person's health. Counselling and the support of **self-help groups** may be crucial in implementing and sustaining lifestyle changes. For example, introducing a more healthy diet, taking more exercise, reducing the amount of alcohol consumed and stopping smoking. Healthcare professionals, such as GPs, practice nurses and district nurses, can assist individuals to set up self-help groups, for example by allowing them to meet in a room in a GP practice.

**Key term**

**Self-help groups** – groups formed by people who share a common issue that they wish to address. The members provide advice, support and care for each other. For example, Alcoholics Anonymous is a self-help group for recovering alcoholics.

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- **Accessing support from specialist agencies**, many specialist agencies support and promote the health and wellbeing of service users, especially those who have specific illnesses or disorders. Healthcare professionals can inform their service users about these agencies, some examples include:
  - Age UK – provides services and support to promote the health and wellbeing of older people.
  - Mind – provides advice and support for people with mental health problems and campaigns to raise awareness and improve services for people with mental illnesses.
  - YoungMind – is committed to improving the mental health of children and young people, through individual support and through campaigning for improved services.
  - The Royal National Institute of Blind People (RNIB) – supports people affected by sight loss, both people who are partially-sighted and those who are blind.
  - Alzheimer's Society – provides information and support for people living with dementia, their families and their carers. It also funds research and promotes awareness of this condition.

**Research**

Investigate one specialist organisation or agency that provides specific advice and support for the people cared for at your work placement setting. Write a short report of the aims, objectives and key activities of the organisation. Email this to other members of your group.

**PAUSE POINT** Close the book and list the range of policies in place in health and social care settings.

**Hint** Think about the policies in place at your work placement setting.

**Extend** Briefly describe the main requirement of one policy at your work placement setting.

## Enabling rehabilitation

The purpose of a **rehabilitation** programme is to enable a person to recover from an accident or serious illness and to live, as far as possible, an independent and fulfilling life. These programmes are particularly important after someone has a heart attack or a stroke, or following an accident that has significantly reduced their mobility or their reaction speed. Rehabilitation programmes may also be a central part of treatment for people who have a mental illness. The specific programme will vary according to the person's physical and psychological needs and their home and family circumstances, including the level of support from their family, friends and carers. Rehabilitation may include support from physiotherapists, occupational therapists, counsellors or **psychotherapists**.

**Key terms**

**Rehabilitation** – the process of restoring a person to good health following surgery, an accident or other illness, including recovery from addiction.

**Psychotherapy** – type of therapy used to treat emotional and mental health conditions, usually by talking to a trained therapist one-to-one or in a group.

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It may also include using **complementary therapies**. Complementary therapies are not considered **conventional medical treatment**, and so may not be available as part of an individual's NHS care.

**Discussion**

Consider the range of support that may assist the rehabilitation of an elderly woman who lives alone and has not left her house since she had a burglary. Which health and care professionals might support her to live a more fulfilling life? What strategies could they use?

**Key terms**

**Complementary therapies** – a wide range of treatments designed to treat the whole person rather than the symptoms of their disease. For example, acupuncture, aromatherapy and reflexology.

**Conventional medical treatment** – also called orthodox treatment. A system of treating an individual's symptoms and diseases by using drugs, radiation, or surgery administered by medical doctors and other healthcare professionals (such as nurses, pharmacists, and therapists).

## Providing equipment and adaptations to support people in being more independent

A vast range of equipment is available to support people to remain independent when carrying out their routine daily activities. There are many reasons for people needing temporary or permanent assistance with mobility or other activities of daily life and their needs are usually assessed by a physiotherapist or occupational therapist. Other healthcare professionals, such as doctors or nurses, may refer a service user to a physiotherapist or occupational therapist for assessment. Care assistants and health care assistants often provide ongoing support in using equipment effectively and adaptions to increase a service user's independence.

### Equipment to increase mobility

At the simplest level, mobility appliances allow people to be more physically active and more independent in carrying out daily routines. For example, people with arthritis, people who have broken a limb or are recovering from surgery or a stroke, or who have a progressive disease such as multiple sclerosis, motor neurone disease or muscular dystrophy or are simply ageing and have less strength in their bones and muscles. Mobility aids include:

- walking sticks
- walking frames, including tripods and tetrapods
- wheelchairs, manual or electric
- adapted shopping trolleys
- stairlifts
- adapted cars, or other motorised transport.

### Appliances that support daily living activities

Individuals may need a range of other appliances to support daily living activities and to promote their independence. These could include:

- special cutlery with thick, light handles that are easy to hold for people with arthritis
- feeding cups or angled straws for drinks
- egg cups and plates with suctioned bottoms
- special gadgets to help people who can only use one hand to take the lids off jars and tins, and others to help with peeling potatoes and buttering bread, kettles on tipping stands and adapted plugs to help with using electrical appliances
- special dining chairs and armchairs adapted to meet individual needs
- bathing aids such as walk-in baths and showers, bath and shower seats
- raised toilet seats for service users who find it difficult to sit down and stand up again

A raised toilet seat is helpful to people who have reduced mobility

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- adapted computer keyboards and, where necessary, screens to support people with a range of physical conditions, including epilepsy, arthritis and visual impairments.

Some people with chronic conditions may need highly sophisticated equipment in their home to manage an independent life. For example, people with chronic bronchitis, emphysema or a coronary heart condition may need oxygen cylinders at home and people with kidney failure may need dialysis equipment.

**Key term**

**Assistive technology** – any tool or strategy used to help people with disabilities complete their studies successfully and reach their potential.

### Technology and other resources that support educational achievement

**Assistive technology** and a very wide range of other resources are available to support people with disabilities and other illnesses to meet their educational potential. These include:

- adapted computers to meet the needs of visually impaired and blind people
- availability of signers and other communicators for hearing-impaired and profoundly deaf people
- ensuring wheelchair access to all learning spaces
- additional time in examinations for learners who are dyslexic
- enlarged text for people with poor vision.

**Research**

Investigate the range of adaptive equipment available to support someone:

- with arthritis in their hands and fingers
- who uses a wheelchair
- who has a degenerative eye condition and is partially sighted.

Which healthcare professionals might be able to help them find the adaptive equipment they need? How might the equipment be paid for? Would they have to buy it themselves?

## Providing personal care – including washing, toileting and feeding

Keeping clean, enjoying a meal and using the toilet when needed are tasks and activities that most people are able to take for granted and do for themselves. However, when people become either physically or mentally ill, or they have a disability, these everyday activities become a challenge. There are clearly important reasons, in terms of physical wellbeing, why people should be clean, eat well and be able to use the toilet when necessary. Dealing with these very personal areas of life has an impact on self-esteem and general confidence. It cannot be overemphasised how important it is for health and care workers to approach these intimate areas of a person's daily life with thoughtfulness and sensitivity.

Carers must discuss usual routines and preferences in terms of personal hygiene and diet with clients. For example, when washing the client may prefer a bath to a shower, or a thorough wash to either of these. Most people would prefer to take personal responsibility for these tasks and wash in private. Independence should be encouraged, but where specific help is needed the client's dignity and privacy should be preserved. Toilet and bathroom doors should be closed and shower curtains drawn. You should follow the policies and procedures of your setting to ensure the safety and dignity of your service user while carrying out these intimate tasks.

**Key term**

**Domiciliary care** – care provided in the service user's own home. This may include district nurses, home care workers and health visitors.

**Domiciliary care** workers, who provide support for people living in their own homes, will often provide personal care of this type. In a residential home care assistants will provide this support and in hospitals it will be a regular task for health care assistants working on the ward.

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A wide range of equipment is available to extend the independence of people in terms of their personal hygiene and to support carers providing personal care. Equipment includes:

- walk-in baths
- showers suitable for the use of wheelchair users
- non-slip bathmats
- bath and shower seats
- hand rails
- bath lifts and hoists
- adapted taps
- bedpans and commodes
- female and male urinals.

An adapted bathroom

Healthcare professionals must also be aware of and respect religious and cultural differences related to personal cleanliness, for example:

- Muslims and Hindus normally prefer to wash in running water rather than have a bath
- Muslims and Hindus often prefer to use a bidet rather than use paper after using the toilet
- Sikhs and Rastafarians do not normally cut their hair
- Hindus and Muslims would strongly prefer to be treated and supported by someone of the same sex.

Eating and drinking is vital for life itself, but meal times are also a social activity and ideally an enjoyable occasion. Dining areas should be clean and a pleasing environment. Most people in care settings are able to feed themselves. However there will be clients who experience difficulties because of their physical condition, because they are confused, or because they are emotionally unsettled. They may be depressed or unhappy in the setting and find it difficult to eat.

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**Key terms**

**Halal** – an Arabic term meaning permissible or allowed. Used in the context of preparing food according to Islamic law set down in the Quran, for example how animals are killed and meat prepared for consumption.

**Kosher** – means suitable. Used in the context of food preparation and consumption according to Jewish dietary laws. Covers permitted and forbidden foods, for example not cooking or eating milk and meat products together.

**Gluten** – a protein found in wheat and some other grains. When people with coeliac disease eat gluten they experience an immune response that attacks their small intestine causing symptoms such as abdominal bloating, pain and diarrhoea.

Some people will be capable of feeding themselves with minimal assistance and often using specially designed eating and drinking equipment, such as those referred to earlier in the unit, will allow them independence.

Many people have specific dietary requirements. This will sometimes be related to religious belief, sometimes to physical disorders and sometimes to personal choice, for example:

- vegetarians do not eat fish, meat or meat-based products – this could include jelly
- vegans do not eat meat or any animal-related products, including eggs, cheese, cow's or goat's milk
- Muslim and Jewish people do not eat pork and they require their meat to be killed and prepared for consumption in a particular way, Muslims eat **halal** products and Jews **kosher** foods
- Hindus and Sikhs do not eat beef
- people with coeliac disease require a **gluten**-free diet
- other people have specific allergic reactions to particular foods – allergic reactions to nuts, strawberries, dairy products and shell fish are particularly common.

**Reflect**

Use a catalogue or the internet to see the wide range of adaptions and equipment available to support people to wash, use the toilet and eat and enjoy their meals. Think about the people at your placement. Would these adaptions help them?

Make notes so that you can describe key equipment and its purpose. You may need to do this in your final assessment.

## Supporting routines of service users in the context of their day-to-day family life, education, employment and leisure activities

Earlier in this unit, the specialist support provided by a wide range of health and care professionals was discussed. Although many health and care staff have expert knowledge and high-level skills in particular areas, they will also try to address the wider personal needs that may emerge while working with their service users. This could include, for example a nurse not just attending to a service user's physical needs but also being aware of their wider social, emotional, spiritual and educational needs. Addressing these may be just as important for a speedy and successful recovery as the medical interventions and physical care that needs to be delivered and monitored.

**Key term**

**Informal care** – care and support provided by relatives and friends, normally unpaid and in addition to the care provided by professional health and care providers.

In attending to the needs of the 'whole' person, health and care professionals will want to support clients in developing and maintaining a fulfilling and satisfying daily life. This will involve being aware of the community in which their client lives, their work, their family circumstances, their general financial position and their interests, hobbies and aspirations. It also includes being aware of the support provided by family, friends and neighbours, who are often referred to as **informal carers**. These wider considerations can be as important to a person's recovery as medicines and other clinical interventions.

**Link**

You can find out more about caring for the whole person, or holistic care, in the section on Holistic approaches, and also in *Unit 10: Sociological Perspectives*.

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**Discussion**

Consider how far the care provided at your placement, or at any other care setting with which you are familiar, supports routines that develop good links with families, and promotes opportunities for extending education, employment and leisure activities. Discuss your thoughts, knowledge and experience with other members of your group.

**PAUSE POINT** Close the book. List items of adaptive equipment that service users may use to be as independent as possible in daily life.

**Hint** Think about the various things people have to do throughout the day, eg get up and dressed, wash, eat, travel etc.

**Extend** Explain the impact of using this equipment in promoting health and wellbeing.

## Assessment and care and support planning, involving service users and their families

As was discussed earlier in this unit, health and care professionals' skills are wide ranging and cover many specialities. However, despite the differences in skills, experience and specialist knowledge, all health and care professionals are likely to take a similar approach to planning and evaluating care. Often referred to as the care planning cycle (see Figure 2.1), this approach involves:

- assessing the individual healthcare needs of their service users
- agreeing a care plan that promotes the service user's health and wellbeing
- evaluating the effectiveness of the care implemented.

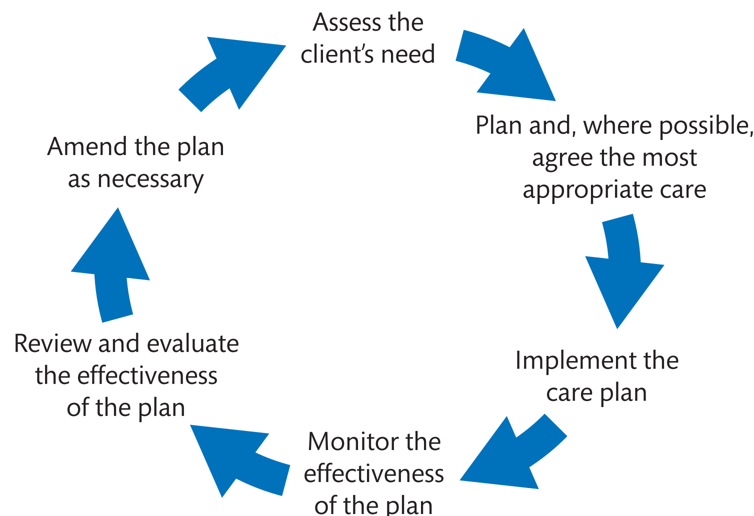


**Figure 2.1** The care planning cycle

The process is cyclical, interventions and changes may be introduced at any point in the process. Adjustments may be necessary, for example in response to changes in the client's health or social circumstances, the resources that are available, the specific expertise of the staff or multi-disciplinary team or changing levels of support from informal carers.

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When planning care, professionals will assess needs and agree the appropriate care with the service user and where appropriate with family members and other informal carers. Informal carers often contribute to the reviews and evaluations of care provision and to discussions about alternative strategies.

**Research**

Read a care plan for a service user at your work placement setting. How closely does the process at your setting match the care planning cycle presented in this unit? Did the planning and review involve informal carers or other members of the service user's family?

## Specific responsibilities of people who work in health and social care settings

People working in health and care settings are required to work to high professional standards. They are required to follow agreed policies and procedures and actively promote the health and wellbeing of those in their care. This is underpinned by a value system, which includes commitments to:

- promoting anti-discriminatory practice to ensure that care services meet the needs of all people regardless of their religion, culture, ethnic background, disability or other personal differences
- empowering individuals, enabling them to take control of their lives and the decisions that relate to their treatment and care
- ensuring the safety of staff, and of the people for whom they care
- maintaining confidentiality and privacy
- promoting good communication between carers, and between carers and their clients.

These principles of good practice are the care value base, established by the Care Sector Consortium in 1992. They are found in the **code of practice** of all health and care professions, for example:

- the General Medical Council (GMC) sets and monitors standards of behaviour for doctors
- the Nursing & Midwifery Council (NMC) sets and monitors standards of behaviour for nurses and midwives
- the recently formed Health and Care Professions Council (HCPC) sets and monitors standards of behaviour for social workers and for a range of other health professions, including physiotherapists, occupational therapists, paramedics and speech therapists.

**Key terms**

**Code of practice** – standards of behaviour and professional practice required of health and care practitioners, set and monitored by professional bodies such as the GMC, NMC or the HCPC.

**Anti-discriminatory practice** – care practice that ensures that individual and different needs of clients and patients are met regardless of their race, ethnicity, age, disability, sex or sexual orientation, and that prejudices and unfair discrimination are challenged.

**Prejudice** – preconceived opinions or fixed attitudes about a social group that are not based on reason or evidence. Prejudicial attitudes may lead to active discrimination.

### Promoting anti-discriminatory practice

#### Implementing codes of practice and policies that identify and challenge discrimination in specific health and social care settings

**Anti-discriminatory practice** is a core value and principle that guides the work of health and care professionals. It is based on legal requirements as outlined in the Equality Act 2010. It underpins the polices and practices of care settings, and in the codes of practice of all care professionals. Anti-discriminatory practice aims to ensure that the care needs of service users are met regardless of differences in race, ethnicity, age, disability or sexual orientation, and that the **prejudices** of staff or other service users are appropriately challenged.



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Legislation exists (for example, see Figure 2.2) to ensure that vulnerable groups of people are not discriminated against.

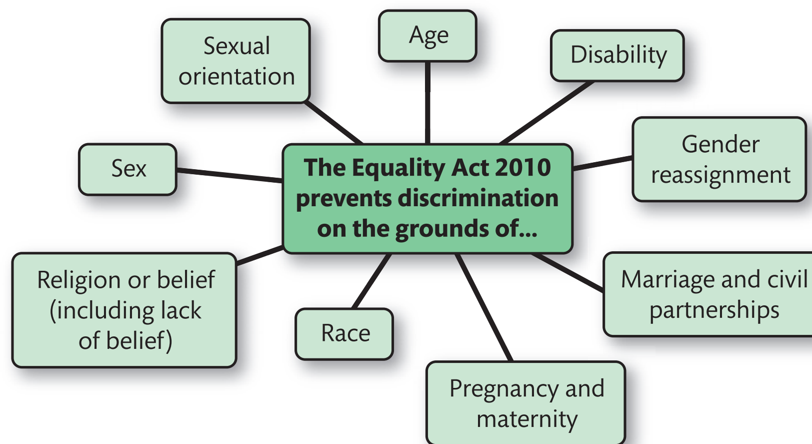


**Figure 2.2** The Equality Act 2010

All citizens in Great Britain (England, Wales and Scotland) have legal protection through the courts. In Northern Ireland, the main legislation protecting workers against discrimination is the Employment Equality (Age) Regulations (NI) 2006 and there is separate legislation for each area of discrimination:

- Employment Equality (Age) (Amendment) Regulations (NI) 2006
- Employment Equality (Age) (Amendment No.2) Regulations (NI) 2006
- Employment Equality (Age) (Amendment) Regulations (NI) 2009
- Employment Equality (Age) (Repeal of Retirement Age Provisions) Regulations (NI) 2011.

The Human Rights Act (1998) applies to all parts of the United Kingdom (England, Scotland, Wales and Northern Ireland). The Act guarantees rights to people cared for by 'public authorities' to be treated equally, with fairness, dignity and respect. Public authorities, or organisations, include hospitals, GP practices, social service departments, schools and colleges and many care and nursing homes.

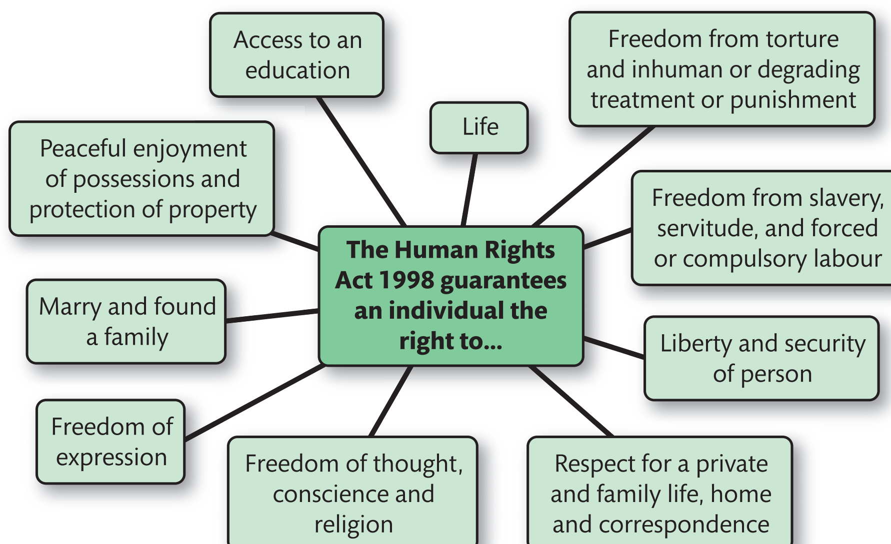


**Figure 2.3** The Human Rights Act (1998) guarantees rights to individuals

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**Reflect**

Think about a situation where you think that you were discriminated against. How did this feel? How did you react?

Make a note of your thoughts and reflections.

### Adapting health and social care provision for different types of service users

Despite the legislation that underpins the policies, procedures and codes of practice governing professional practice and the care provided in health and care settings, the world is not free from prejudice and discrimination. Unfair treatment is a daily experience for many people in society. Furthermore, anti-discriminatory practice is more than ensuring that a service user's legal rights are in place. In care settings anti-discriminatory practice involves promoting equal opportunities for all and challenging discrimination at work. This requires health and care workers to:

- address their own prejudices and adapt their behaviour to ensure that clients' needs are met, whatever the client's ethnic background, age, disability or sexual orientation
- understand and meet the individual needs of all service users, including people from diverse cultures, people belonging to a wide range of religious groups, people who are gay or whose sexuality is unclear, people who have a physical disability, a learning difficulty, a communication problem or people with a mental health problem
- celebrate the contribution that a wide and diverse range of people can bring to the setting, and to society
- actively challenge both intentional and unintentional discrimination against clients and patients
- ensure that the setting is a welcoming and accessible environment for all
- compensate for the negative effects of discrimination in society.

In order to ensure that service users' individual needs are met provision has to be adapted according to their needs, for example:

- to ensure that people who use wheelchairs have full access to and movement within the setting, ramps may be needed, doors may need to be widened, toilet facilities adapted and kitchens and dining rooms arranged to allow for easy movement
- if a service user has a hearing impairment, it may be necessary to use written and visual communication more often than spoken, ensure that a quiet area is available for important conversations and meetings and maybe employ a signer or interpreter to ensure that communication channels are clear
- for service users who speak little or no English, information may need to be available in a number of different languages to meet individual needs
- in a multi-cultural setting, dietary requirements will need to be met and religious and cultural festivals respected and observed.

**Link**

Go to *Unit 10: Sociological Perspectives* section C, to find more information about discrimination and the impact of inequalities on health and wellbeing.



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**Discussion**

Identify three ways that provision is adapted at your work placement to meet a service user's needs. Are there other adaptions that should be made to ensure that all needs are met? Discuss your findings and those of other members of your group.

Make notes of the range of adaptions used. Try writing your notes as a table to help with your revision.

## Empowering individuals

The importance of fostering and supporting the **empowerment** of service users in health and care settings can often be overlooked. Empowerment means ensuring that service users take a full part in discussions and decisions about their personal care and treatment and that, where possible and appropriate, they are included in discussion of overall policy and provision at the care setting. Empowering service users will help to ensure that meeting individual needs is at the heary of the service provision.

**Key term**

**Empowerment** – supporting people to take control of their lives and futures by taking a full part in discussions and decisions about their care and treatment.

### Promoting individualised care

Empowerment enables service users to understand the choices that they can make about their care, to contribute to the decision-making and to take control of their lives. In health and care settings, particularly when service users are feeling unwell or anxious about their future, there can be a tendency to allow the experts to take over and for the service user to just 'do as they are told'. This can lead to service users losing confidence and becoming passive and over-dependent on their care workers.

In most situations, practitioners are required to gain their client's consent before carrying out a care procedure, a treatment or making arrangements for a client's care. If service users are empowered, they will be fully involved in discussion about and planning of their care, and they will fully understand the options open to them. It will ensure **individualised care**, with the service user at the heart of the service.

**Key terms**

**Individualised care** – care provision tailored to meet the particular and specific needs of each service user.

**Self-esteem** – a person's sense of self-respect; the confidence a person has in their own worth and value.

**Multi-cultural society** – a population made up of people from a variety of different ethnic backgrounds and cultural traditions.

### Promoting and supporting individuals' rights to dignity and independence

Empowering service users means that they are more likely to be treated as individuals. Their needs and preferences will be known and respectfully considered. This provides a context in which their rights to dignity and independence, discussed earlier in this unit, are promoted, which will contribute to boosting their **self-esteem**.

### Providing active support consistent with the beliefs, cultures and preferences of service users

Health and care provision in a **multi-cultural society** must address the specific needs of people from diverse backgrounds. The beliefs, languages, traditions, diets and customs of service users will be many and varied. This makes for a stimulating social setting. Diversity can be fun and should be celebrated through sharing festivities and enjoying a wide range of food and music, for example. It can also present challenges for care providers. For example:

- if service users speak little or no English, information will need to be presented in a range of languages, translators may be necessary and support may need to be given to access English lessons
- there may be a need to provide a wide range of foods for people with different religious requirements, for example Jews and Muslims do not eat pork, Hindus and Sikhs do not eat beef and many Buddhists are vegetarian
- religious observances may need to be considered, for example Muslims will need a prayer room and opportunity to pray up to five times a day, Roman Catholics may want to attend Mass on Sundays and other holy days, Jews may want to attend the synagogue on Saturdays.

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A professional carer must be aware of individual differences and ensure, through discussion and planning, that the importance of these needs to the service user are fully respected and are not ignored. If service users are empowered, they will contribute to the planning of their own care and to the policies and procedures at the healthcare setting.

**PAUSE POINT** Can you explain why empowering service users will promote their health and wellbeing?

**Hint** Define the term empowerment.

**Extend** Explain the strategies used at your work placement setting to empower service users. What more could be done?

### Supporting individuals who need health and social care services to express their needs and preferences

Of course not all service users will have the confidence or personal skills to participate fully in their care. Some may need specific support to enable them to explain their needs and preferences, or to take part in meetings. This support could be provided by:

- translators and interpreters
- signers
- advocates
- family and friends.

Translators and interpreters are concerned with communicating meaning from one language to another. This is obviously essential for many people where English is not their first language, but also includes communication between people using sign language and those using spoken English, for example translating British Sign Language or Makaton to spoken English. Signers play a key role in ensuring that people with hearing impairments can fully participate in meetings and communicate their preferences and care needs.

Sometimes people with communication problems need somebody else to speak for them in meetings, complete forms or write letters for them. For example, the increasing proportion of the population who suffer from dementia, people with a learning difficulty or people who have suffered brain damage following an accident, may not be able to communicate their needs and preferences. In these circumstances, an **advocate** may speak for the client and express their views. In the care sector advocates are often volunteers. They aim to gain the trust of service users who have communication difficulties and find ways of communicating with them to represent their views to the carers. Family and friends can often play a key role in ensuring that the service user's needs are understood and met.

**Key term**

**Advocate** – a person who speaks for someone else and represents their views and preferences.

### Promoting the rights, choices and wellbeing of individuals who use health and care services and balancing their rights with those of other service users and staff

It will not always be straightforward to provide a service user with the care or treatment of their choice, even when their preferences are clear and apparently reasonable.

There may be a conflict between:

- the equally valid preferences of one service user and that of another – for example conflicts arising from the choice of music or other leisure-time activities in the sitting room



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- the client's right to choice and protecting their personal safety – for example a person suffering from dementia may wish to live independently in their own home but if they are not able to use the cooker and the oven safely, this may pose fire risks and other dangers to themselves and others
- the different rights that service users have – for example the right to confidentiality and the right to protection from harm, if a service user discloses incidents of sexual or physical abuse
- the respect for the cultural or religious values of a service user and promoting their health and wellbeing – for example Jehovah's Witnesses do not believe in blood transfusions, and a blood transfusion may be essential for their own or their children's survival.

## Case study

### Helping Marjorie

Marjorie is more than eighty years old. She lives in a two-bedroomed terraced house, built just before the First World War. She has always enjoyed good health. In fact she has never been in hospital and rarely visits her GP. She lived for many years with her partner, Jean, who died 10 years ago.

Marjorie has always been very independent and continued to be so after Jean died. Neighbours say she is proud and won't accept help.

However, Marjorie is now very frail and has had a number of falls in the house, and this has made her very anxious about going out. She can't do much in the kitchen and scalded herself recently when making a cup of tea. Marjorie has been reluctant to get help from social services, but has accepted a homecare worker, Mandy, who visits twice a day. Marjorie has cooked meals delivered to ensure she has sufficient nutritious food.

People speak very highly of Mandy, but Marjorie thinks she is unreliable and is convinced she reads her letters and other private correspondence. It seems that before very long Marjorie will need residential care. She has no children and nobody to help her make decisions about her future.

**Check your knowledge**

1. Identify six hazards for Marjorie in her house when she is at home on her own.
2. Complete a risk assessment for the six hazards and calculate the level of risk.
3. What strategies could be put in place to minimise these risks?
4. If Marjorie is really concerned about Mandy's professional standards, who should Marjorie contact?
5. If Marjorie is to move to long-term residential care, which professional would take a key role in arranging this?
6. What approach should be taken to ensure that when planning this move Marjorie maintains her dignity and right to choice, that she feels empowered, safe and retains her independence?

Write your answers in full. This case study could be very useful in preparation for the final examination.

## Discussion

Can you identify situations at your work placement setting where there are conflicts between the valid preferences of one service user and another? How are these conflicts resolved? Discuss your experiences with other members of your group.

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## Dealing with conflict in health and social care settings

Tension and conflict between service users, and between service users and their carers, is sadly very common. Challenging behaviour could be defined as any behaviour that puts the service user or anybody else in the setting at risk, or significantly affects their quality of life. This may include excessive rudeness, aggression, self-harm or disruptiveness. Professional carers and other staff should be trained to deal with conflict. Conflict may erupt in any care setting, such as in GP practices, hospital wards, residential care homes for the elderly, residential care homes for young adults, residential care homes for people with disabilities or when providing domiciliary care. Conflict may develop between service users and their doctors or nurses, between care workers and their clients, and between the service users themselves or their informal carers. If you are a domiciliary care worker, for example and work alone there should be a **lone workers' policy** in place with specific guidance for dealing with any situation where you feel vulnerable, such as dealing with conflict and aggressive behaviour.

**Key term**

**Lone workers' policy** – guidance and procedures aimed at ensuring that people working on their own are safe. This is particularly important when providing domiciliary care. Lone workers' policies are in place principally to protect the carer from harm but will also provide additional protection for service users.

When dealing with conflict, a range of skills are needed (see Figure 2.4).

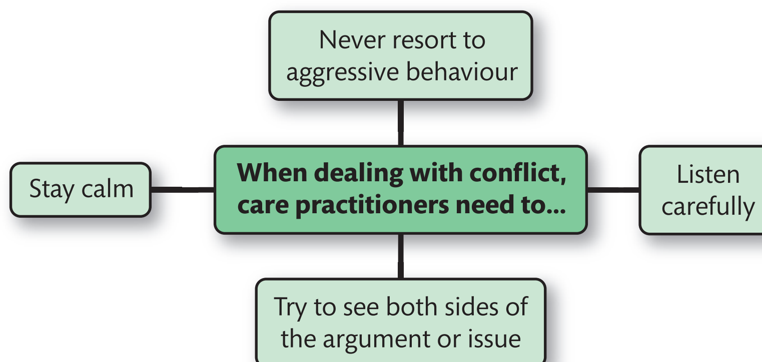


**Figure 2.4** Skills required when dealing with conflict

If it seems that the situation may lead to violence, wherever possible:

- make sure that you know where the doors or other exit points are
- remove anything that could be used as a weapon
- allow the aggressor personal space, do not stand too close to them
- summon help as soon as possible, by using a panic alarm, shouting for help or by phoning the police or security.

**Research**

Ask your manager or supervisor at your work placement for a copy of the policy that deals with conflict at the setting.

If you have observed incidents of conflict or aggression, describe how closely the procedures were followed. Remember to ensure that confidentiality is respected and all names are changed.



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**PAUSE POINT** Close the book and see whether you can define (i) anti-discriminatory practice and (ii) empowerment.

**Hint** Think about the range of people who might access health and social care.

**Extend** Explain how a health and care provider can promote anti-discriminatory practice and describe its likely impact on service provision.

## Ensuring safety in health and social care settings

### Risk assessments

It is the responsibility of employers to ensure the health and safety of all who work for their company or organisation. Employers are also responsible for the safety of volunteers, learners on work placement and all visitors, including those visitors providing technical or professional services, for example plumbers, electricians and visiting care professionals. The Health and Safety at Work Act (1974) governs the requirements of employers and employees to ensure that they maintain a safe working environment for all.

Employers must:

- ensure that the organisation has a robust health and safety policy and that there is someone with official responsibility for health and safety at the setting
- undertake a **risk assessment** to identify the **risks** and **hazards** at the workplace, and take action to reduce the likeliness of harm or injury
- provide up-to-date information on health and safety issues
- provide health and safety equipment to carry out all procedures and treatments
- provide health and safety training
- keep a record of all accidents and incidents.

**Key terms**

**Risk assessment** – identifying and evaluating the possible consequences of hazards and the level of risk that the hazard will cause harm.
**Risk** – the likelihood, high or low, that a person will be harmed by a hazard.

**Hazards** – anything that could potentially cause harm, such as climbing stairs, wet floor surfaces, trailing electricity cables, the disposal of waste or bathing a service user.

Employees must:

- take reasonable care of their own safety and that of others in the workplace, including service users, colleagues and visitors
- cooperate with their employer to carry out the agreed and required health and safety procedures of the workplace
- not intentionally damage health and safety equipment at the setting, for example hoists and lifts.

When employers carry out risk assessments, they examine all the procedures and activities that take place in their organisation and assess the level of risk involved. In a care home, for example this will range from risks associated with routine care procedures to organising social events and taking service users on outings. The responsibility for carrying out the risk assessment will often be delegated to a senior member of staff or a supervisor, for example a senior care assistant in a residential home may have responsibility for assessing the risks associated with the bathing of a new resident. It is the responsibility of the care home manager to ensure that the senior care assistant has had the training to carry out this task.

Even seemingly harmless household items can be hazardous for frail elderly people

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## Step by step: Carrying out a risk assessment

5 Steps

1. Identify the hazards at the setting, or in carrying out an activity.
2. Identify those at risk, including service users, staff, volunteers and other visitors.
3. Evaluate the level of risk – usually rated on a scale of 1 to 4, with 1 being the lowest level of risk.
4. Identify ways to limit the risk – this will include specific actions to minimise risk.
5. Review measures taken to minimise the risk.

When assessing the level of risk that may arise from a particular hazard, a guide similar to Table 2.2 could be helpful.

**Table 2.2** Assessing the level of risk

| Score | Likelihood of risk | Score | Severity of the injury |
|---|---|---|---|
| 1 | Most unlikely to happen | 1 | If it did happen the harm would be negligible and could be dealt with by an untrained person, eg applying a plaster. |
| 2 | Unlikely to happen | 2 | Slight injuries, eg catching a cold or the need for a few stitches. |
| 3 | Likely to happen | 3 | Serious injuries, they may be physical or psychological and may take months or years to heal. |
| 4 | Very likely to happen | 4 | Could be permanent disability or even death. |

The risk rating for a particular activity or procedure can be helpfully expressed numerically by multiplying the rating for the likelihood of the risk happening by the severity of the likely injury that could arise.

Risk rating = likelihood of risk × severity of the injury

Rating 1 or 2 = a minimal risk rating – the existing practice would be seen as adequate.

Rating 3 or 4 = a low risk rating – the existing practice should be reviewed to lower the level of risk.

Rating 6 or 8 = a medium risk rating – this should lead to specific action to improve safety.

Rating of 9, 12 or 16 = a high rating – this must lead to immediate action to improve safety and the activity should be stopped until proper measures are in place to reduce the risks identified.

Taking service users with a mild learning difficulty on a bus, for example, would normally be considered low risk because the likelihood of harm is low. It is rare for such service users to come to harm on public transport. Of course in the unlikely event of an accident, the harm could be serious. However, if the same group were going swimming, the risk may be higher and the potential harm could lead to death.

### Research

Ask to see a risk assessment that has been used at your work placement for taking service users on an outing. Do you think it identifies the key hazards? Do you agree with the level of risk identified? Would the measures taken lessen the risk of harm?

Summarise the key points of the risk assessment using a grid similar to Figure 2.5.

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**Discussion**

As a group, complete a risk assessment form for the risk of frail elderly service users falling on stairs (you could use a form similar to that shown in Figure 2.5). Are you able to agree on the level of risk and the measures that should be taken?

Keep copies of your risk assessments to help you with your revision.

| Potential hazard | Who is at risk | Existing measures to minimise risk | Risk rating | Preventative measures | Responsibilities (identify the job role) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Figure 2.5** Example of a form that could be used to carry out a risk assessment

### Safeguarding and protecting individuals from abuse

If a child or vulnerable adult shares information that raises concerns about their personal safety, or they disclose that they are being abused, you should follow the setting's safeguarding policies. As an employee or volunteer, you should listen carefully and avoid asking questions. Let the service user tell their story in their own way and in their own words. In this instance, you will have to explain to the service user that the information must be shared with somebody more senior. All care settings will have a designated safeguarding officer who will take over responsibility for investigating the claim or accusation. The safeguarding officer will ask you to provide a written record of what you have been told.

**Reflect**

Read the safeguarding policy at your work placement setting. If some areas are unclear or you are confused, ask your supervisor or manager to explain the procedures for you. Write down in your own words what you are required to do if a service user discloses abuse.

### Protecting service users, staff and volunteers from infection

Working in a care environment requires all staff and volunteers to ensure that they maintain a clean and hygienic working environment and minimise the likelihood of passing on infection. In order to keep yourself and service users safe from infection, you must ensure that you are familiar with the policies and procedures in place at your setting to minimise the spread of infection. Procedures are likely to include the following requirements.

- Washing your hands before you start work and before you leave work, before eating, after using the toilet and after coughing or sneezing and before and after you carry out any personal care, particularly if this involves contact with body fluids, **clinical waste** or dirty linen. Alcohol hand rubs are a further effective and swift procedure to ensure that hands are clean and provide further protection from contamination.
- Safe handling and disposal of sharp articles such as needles and syringes to avoid needle-stick injuries and to ensure that infection is not passed on through viruses carried in the blood or bacteria.

**Key term**

**Clinical waste** – waste contaminated by blood, urine, saliva or other body fluids, which could be infectious.

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- Keeping all soiled linen in the designated laundry bags, or bin, and not leaving it on the floor. Soiled linen should always be washed in a designated laundry room. When handling soiled laundry a protective apron and gloves should be worn. Hands must be thoroughly washed after handling soiled linen. Separate trolleys should be used for soiled and clean laundry to avoid cross-contamination and the spread of disease.
- Wearing protective disposable gloves and aprons when you have contact with body fluids, or when you are caring for someone with open wounds, rashes or pressure ulcers, for example.
- Cleaning all equipment according to the agreed procedures of your setting.
- Wearing protective clothing for any activities that involve close personal care or contact with body fluids.

### Control and disposal of substances harmful to health

To protect all service users, staff and visitors from harm and infection, you must ensure that **hazardous waste** is disposed of properly. This includes disposing of protective clothing, syringes, soiled dressings, nappies, incontinence pads and bodily fluids.

**Key term**

**Hazardous waste** – waste containing substances that can cause serious harm to people or equipment, including soiled dressings and items contaminated with bodily fluids, explosives, flammable materials and substances that poison or destroy human tissue.

There are different disposal requirements for different types of substances and equipment. This includes cleaning fluids, harmful vapour and fumes. The Control of Substances Hazardous to Health (COSHH) Regulations (2002) provide guidance approved by the Health and Safety Executive for the safe disposal of hazardous waste. The policies and procedures used in your care setting will be based on this guidance.

In care settings, different coloured bags are often used to ensure the safe and efficient disposal of hazardous waste. Table 2.3 shows examples of waste disposal that are widely used.

**Table 2.3** Examples of types of waste and appropriate methods of disposal

| Type of waste | Method of disposal |
|---|---|
| Clinical waste, eg used bandages, plasters or other dressings | Yellow bag: waste is burned in controlled settings |
| Needles and syringes | Yellow 'sharps' box which is sealed: waste is burned in controlled settings |
| Body fluids, eg urine, vomit or blood | Flushed down a sluice drain: area must then be cleaned and disinfected |
| Soiled linen | Red laundry bag: laundered at the appropriate temperature |
| Recyclable equipment and instruments | Blue bag: returned to the Central Sterilisation Services (CSSD) for sterilising and reuse |

**Source:** adapted from Nolan, Y (1998) *Care NVQ Level 2*, p.78.

**Safety tip**

Check the approved procedures for disposing of substances harmful to health at your work placement setting.

### Reporting and recording accidents and incidents

There are particular illnesses, diseases and serious accidents that health and care providers must officially report. These are called 'notifiable deaths, injuries or diseases' and are covered by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) (2013). Notifiable illnesses include diphtheria, food poisoning, rubella (German measles), tuberculosis (TB) and notifiable incidents occurring at work include broken bones, serious burns and death.

However, less serious accidents and incidents must also be recorded. If somebody slips on a wet floor or trips over the trailing straps of a shoulder bag a record must be made,

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regardless of whether or not there is an injury. Providers of health and care services use an accident form to report the details of all accidents and incidents, which are then recorded in an accident book. These reports are required by law and are checked when care settings are inspected.

**EXEMPLAR ACCIDENT FORM**

About the person completing the form:

**Full name:** ____________________

**Job title:** ____________________

**Signature** ____________________

About any witnesses:

**Full name:** ____________________

**Job title/Status** ____________________

**Signature** ____________________

About the injured person:

**Name:** ____________________

**Home address:** ____________________

**Post code:** ____________________

**Home tel no:** ____________________

**Date of birth:** ____________________ **Age:** __________

**Gender:** ____________________

About the accident:

**Date of accident:** ______ / ______ / ______

**Time of accident:** ______ : ______ **hrs**

**Location of accident:** ____________________

**Injury** (e.g. fracture) ____________________

**Part of the body injured:** ____________________

About the type of accident:

**What happened? (tick if applies)**

- ☐ Equipment failure
- ☐ Slip on wet surface
- ☐ Tripped over object
- ☐ Injured while moving something
- ☐ Fell
- ☐ Trapped by something collapsing
- ☐ Inhaled gas/fumes
- ☐ Electric shock
- ☐ Asphyxiation
- ☐ Assault
- ☐ Exposure to fire
- ☐ Struck by moving object
- ☐ Other

**Describe the accident using factual information:**

About prevention of a recurrence:

**Can you identify any way the accident could have been prevented?**

**Date form completed:** **Review date:**

Figure 2.6 A sample accident form

## Provision of first-aid facilities

The provision of first aid in health and care settings is governed by the Health and Safety (First-Aid) Regulations (1981). Provision for first aid should be 'adequate and appropriate'. What is deemed as adequate and appropriate will vary from setting to setting. It is proposed that from September 2016 all newly qualified early-years practitioners will be required to complete paediatric first-aid training.

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All first-aid incidents occurring in care settings must be recorded, either in the accident book or by completing the setting's accident form. The report should include:

- the name of the casualty
- the nature of the incident/injury
- the date, time and location of the incident
- a record of the treatment given.

These records must be truthful and accurate. They may be used in courts of law, particularly if the casualty is claiming compensation for injury, or if there is an accusation of criminal negligence.

### Complaints procedures

All care organisations must have complaints procedures and these are also checked when the setting is inspected. Complaints should not be regarded as a purely negative activity but rather as a source of information that will help improve the service. Complaints procedures vary in different organisations but will follow a very similar format. If a service user, a member of staff or a volunteer complains, they have a right to:

- have their complaint dealt with swiftly and efficiently
- have a proper and careful investigation of their concerns
- know the outcomes of those investigations
- have a judicial review of the facts, if they think the action or the decision is unlawful
- receive compensation if they have been harmed either physically or psychologically as a result of the situation about which they are complaining.

**PAUSE POINT** Identify the responsibilities that care providers have to ensure the safety of service users, staff and visitors at their settings.

**Hint** Think about all the potential hazards in your care setting. How likely is an accident and what could be the consequences?

**Extend** Complete a risk assessment for organising a simple birthday party for a service user at your setting.

## Information management and communication

Health and social care organisations hold a wide range of diverse information about service users. This ranges from mundane concerns about preferred TV programmes or planned holiday arrangements to very personal and sensitive information, including addresses, telephone numbers, family details, information about criminal convictions and health issues. It is important that service users are able to trust that their personal information is treated as confidential, and only shared with people who have a legitimate reason to know about their circumstances and preferences.

### The Data Protection Act 1998

The Data Protection Act (1998), which came into force in March 2000, sets out the rules governing the processing and use of personal information in health and social care settings and in many other organisations, including credit agencies, clubs and many other organisations that hold information about their members. The act covers information stored electronically on computers, mobile phones and on social media sites. It also covers most paper-based personal information. It is against the law to have photographs of service users without their permission.

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**Research**

What is the policy at your work placement setting about using photographs of service users for publicity or other purposes?

Share this with other members of your group.

Always make notes from activities such as this and keep them in the correct section of your file. This is good practice to support preparation for your final examination.

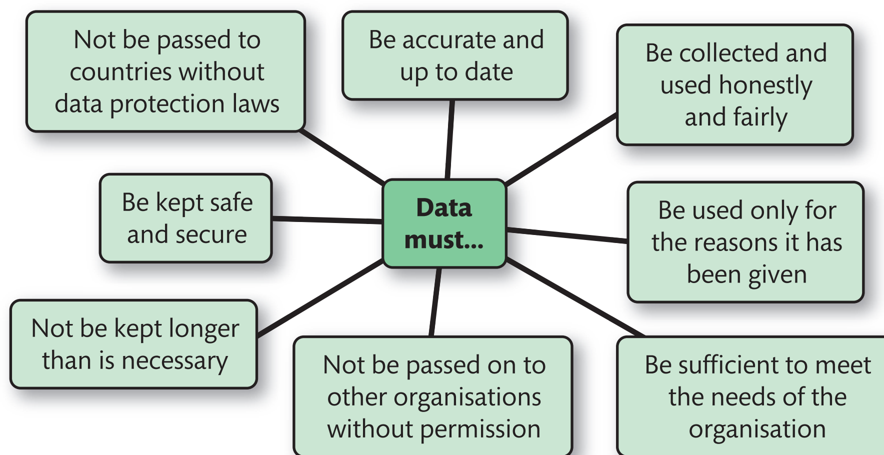


**Figure 2.7** The Data Protection Act (1998) has eight key principles

## Recording and storage of data

The Act covers the policies, procedures and systems for:

- Storing information – confidential information should be stored in locked filing cabinets, in a locked room. Information held electronically should be protected by a secure password.
- Accessing information – members of staff in the organisation who are allowed access to this information should be clearly identified. Staff should never have access to personal information that they do not need to know. Where information is stored electronically, only the relevant staff should have personal access passwords.
- Sharing information – information should only be shared with other professionals who have a need and a right to know it.

## Legal and workplace requirements

- The principles and requirements of the Data Protection Act (1998) and the requirement for confidentiality are within the policies and procedures of all health and social care settings. They are also embedded in the codes of practice of the professional bodies that regulate health and care staff, discussed earlier in this unit, such as the General Medical Council, Nursing & Midwifery Council and the Health and Care Professions Council.
- All employees and volunteers in organisations have a responsibility to ensure that the confidentiality of service users' information is protected. They also have a duty to actively promote respect for confidentiality throughout the setting. If they spot weaknesses in the procedures, for example the location of offices where personal care is discussed, they should feel confident to suggest improvements in the systems and arrangements. This is necessary to ensure the safety and security of service users and to respect their right to the confidentiality of personal information.

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### Confidentiality, safeguarding and legal disclosure

All personal records must be kept safely and securely and used only for the purpose that they are intended for. They must not be available to people who do not have a valid professional need to know the details. If a child or vulnerable adult discloses to any member of staff or volunteer that they are at personal risk or that they are the subject of abuse, the setting's safeguarding policies should be followed. In this situation, you will have to explain to the service user that their disclosure will be shared with a senior member of staff who will then support them. The safeguarding officer at the setting will then take over responsibility for dealing with the concerns.

## Accountability to professional organisations

As you have seen, the standards of professional practice expected of professionals working in health and care settings are regulated and monitored by a range of professional bodies, including the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and the Health and Care Professionals Council (HCPC).

The specific regulations vary according to profession. However, each professional organisation monitors the:

- level and content of the initial education and training of members of their profession
- ongoing professional development and the requirement to keep up to date, and to complete further training – often called continuing professional development (CPD)
- standards of professional practice in their everyday work
- standards of personal conduct, both at work and in leisure time.

### Codes of professional conduct

Professional organisations publish codes of practice for members which must be followed. If a member is accused of failing to meet the standards set, this will be investigated and, in extreme circumstances, the member can be removed from the professional register and barred from professional practice.

The professional organisation's regulations outline the formal procedures that will be used following a complaint or concern about the qualifications or professional practice of its members. This will include specific procedures to investigate unprofessional practice reported by professionals about their colleagues, known as **whistleblowing**.

**Key term**

**Whistleblowing** – a situation in which an employee reports poor or dangerous practice at their workplace to the press or to another organisation outside of their work setting, for example the GMC, NMC or HCPC, in order to bring about change for the better.

### Revalidation procedures

Each of the professional bodies requires its members to complete regular CPD in order to remain on the register. This may include, for example:

- training on the use of new procedures or new treatments
- training on the use of new equipment
- providing evidence that a registered person reviews and learns from their own practice.

CPD requirements will always include evidence that members have current and up-to-date understanding of safeguarding regulations.

### Safeguarding regulations, raising concerns and whistleblowing

In April 2015, a Care Certificate was introduced for newly appointed health and social care workers who are not members of the regulated professional bodies that were discussed earlier, that is the GMC, the NMC and the HCSC.

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Employees who would normally complete this new programme include health or social care assistants, support workers and homecare workers.

The Care Certificate is not a statutory requirement, it is voluntary, and would normally be used alongside the specific induction programme for a work setting. It does, however, provide an identified set of standards that health and social care workers should follow in their daily working life. Employers are expected to implement the care certificate for all new starters from April 2015. They will be required to meet its standards before they can work with patients. It replaces the Common Induction Standards (CIS) and the National Minimum Training Standards (NMTS).

The code of conduct incorporated into the new certificate requires that healthcare support workers and adult social care workers in England:

- are accountable, by making sure they can answer for their actions or omissions
- promote and uphold the privacy, dignity, rights, health and wellbeing of people who use health and care services, and that of their carers, at all times
- work in collaboration with colleagues to ensure they deliver high-quality, safe and compassionate healthcare, care and support
- communicate in an open and effective way to promote the health, safety and wellbeing of people who use health and care services, and of their carers
- respect a person's right to confidentiality
- strive to improve the quality of healthcare, care and support through CPD
- uphold and promote equality, diversity and inclusion.

## Multi-disciplinary working in the health and social care sector

Different care professionals often work together as a team to promote the health and wellbeing of their service users. For example, the care manager of a residential home may work with GPs, district nurses and physiotherapists to meet the needs of their residents. Social workers with responsibility for children may work with the health visitor, the school nurse, school teachers and the educational psychologist to meet the children's needs. These teams may include not only the health and care workers discussed earlier in the unit but also representatives from voluntary organisations. The emergency services, including the police and the education services, may also be represented. When professionals co-operate in this way by working together as a team, it is called a **multi-disciplinary team**.

**Key term**

**Multi-disciplinary team** – a team in which health and care workers from different professional backgrounds and with different work roles, plan, implement and monitor an individual's care.

### The need for joined-up working with other service providers

If a service user is known to and supported by a number of different agencies or professionals, it is essential that those carers work as a team. There have been a number of high-profile cases of child abuse, for example the abuse and tragic death in February 2000 of Victoria Climbié while in the care of her aunt, and the death of Baby P (Peter Connelly) in 2007 following months of abuse. Part of the reason for the death of these children was identified as a lack of 'joined-up working'. Both children lived in the London Borough of Haringey. The professionals and the agencies working there did not pass on crucial information.

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### Involving service users, carers and advocates in the multi-disciplinary team

At formal team meetings it will be expected that, where possible, the service user will be present, their advocate, translator and/or interpreter will be there, informal carers will be invited along with all other professional staff who contribute to the support, planning and evaluation of the care provided. The service user's presence and/or their representatives is crucial to ensure the empowerment of the client or patient. It is the key opportunity for the service user to express their views and preferences and to contribute to the planning and delivery of their support.

### Holistic approaches

The work of a multi-disciplinary team ensures that a **holistic approach** is taken to planning and implementing a care programme. It means health and care professionals must not only provide their specialist support but also see this in the context of the wider needs of the service user. At a care planning meeting the physical, social, emotional, spiritual and intellectual needs of the service user will be considered. The care plan must meet the needs of the 'whole person'.

**Key term**

**Holistic approach** – an approach to care that addresses the individual's physical, social, emotional and spiritual health, so addressing the needs of the whole person.

**PAUSE POINT** Can you list and describe the impact of using specialist equipment to promote health and wellbeing?

**Hint** List all the different health and care practitioners who provide support at your work placement setting.

**Extend** How do they ensure that there is good communication between them in planning and delivering care?

## Monitoring the work of people in health and care settings

### Line management

In addition to working in interdisciplinary teams as discussed in the previous section, people who work in health and care settings normally also work in hierarchical organisations and their work is monitored by senior members of staff. For example, in a care home, the care assistants will be managed by the care manager who will allocate tasks and set the routines and standards for the setting. The care manager will expect employees to follow these routines and meet the standards set. In a larger setting, there will often be senior care workers who manage a team of care assistants on behalf of the manager. In an early-years setting, for example, the nursery manager will manage the early-years' practitioners at the setting and in a reception class the nursery teacher will manage the early-years educator. If staff performance falls short of the practice expected, it will be the **line manager's** responsibility to address the issues with the staff concerned and take the appropriate action. In the first instance this may be an informal

**Key term**

**Line manager** – person responsible for managing the work of an individual or of a team in an organisation, usually the position they hold will be at least one level above the person/people they manage.

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conversation or warning. If the concerns are serious or there is no improvement in performance more formal action may be taken which could finally lead to suspension or dismissal.

A range of adults work with young children

## External inspection by relevant agencies

All health, care and early-years settings in the United Kingdom are regularly inspected by independent, government-financed agencies. For example in:

- England, health and care provision is inspected by the Care Quality Commission (CQC)
- Northern Ireland, health and care provision is inspected by the Regulation and Quality and Improvement Authority (RQIA)
- Wales, care provision is inspected by the Care and Social Service Inspectorate Wales (CSSIW) and health by Healthcare Inspectorate Wales (HCIW)
- Scotland, on 1st April 2011 the work of the Care Commisioner passed to a new body, the Care Inspectorate; regulation of independent healthcare has passed to Healthcare Improvement Scotland.

Early years and education services are inspected by:

- Ofsted, in England
- the Education and Training Inspectorate (ETI), in Northern Ireland
- Her Majesty's Inspectorate for Education and Training in Wales
- Education Scotland, in Scotland.

## Whistleblowing

Whistleblowing is when a member of staff is aware that the quality of care at their workplace is dangerously poor and reports this to bring about change. They may inform the press or another, usually powerful, organisation outside the setting in which they work such as the police or a professional body. Whistleblowers may be employees at any level and working in any part of the organisation as a care worker, an administrator or a manager.

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### Service user feedback

Settings will have a range of different systems for ensuring that service users and their families, friends or other informal carers can formally comment on the strengths and weaknesses of the service that they receive. This may include:

- regular meetings for service users to report concerns and to share ideas for the improvement of provision
- at a large setting, there may be a committee that represents all service users, for example a parents and carers association at a pre-school setting
- a suggestions box
- service users may request a private meeting with a manager or governor of a setting
- service users reporting good practice or areas of concern to the external agencies – for example Ofsted, CQC or CSSIW. If organisations responsible for inspecting settings receive complaints this may lead to a prompt and often unannounced inspection of the care setting.

### Criminal investigations

In extreme circumstances, such as cases of sexual, physical, financial or emotional abuse, or in other circumstances in which it is suspected that criminal law has been broken, the police may investigate. There have been high-profile cases where care staff have been found guilty and imprisoned following criminal investigations, for example following a Serious Case Review of the Winterbourne View residential home. This may also lead to health and care workers being removed from their professional register and being barred from professional practice.

#### Assessment practice 2.1

Aziz was born in Pakistan, and came to England in the 1960s. He is a devout Muslim and has a large, caring family. However, he now needs some additional help. He has chronic bronchitis, he doesn't have a very good appetite and he is beginning to lose his balance when walking into town.

1. Identify two health professionals who might be involved in Aziz's care.
2. Describe the role of the two professionals in delivering healthcare.
3. Explain how the care provision may need to be adapted to meet Aziz's cultural needs.
4. Discuss how Aziz may be supported in planning for his future.

# B The roles of organisations in the health and social care sector

## Roles of organisations in providing health and social care services

Health and social care services are provided and managed by a wide range of organisations. Some services are directly funded and delivered by government or public sector organisations, such as the National Health Service and local authority social work support. Many other services are provided by independent charitable

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organisations, such as Shelter, Barnardo's and the Samaritans. Services are also provided by a growing number of private companies, such as Bupa or Priory Group Hospitals. These are profit-making businesses that deliver health and care services.

## The public sector

The public sector organisations that provide health and social care services are financed and directly managed by the government. For example, the National Health Service is a public sector service. It is primarily funded by taxation and a smaller proportion of funds come from National Insurance contributions. The majority of the services available are free to service users when they need them, but they do pay for them through their regular tax and National Insurance contributions. The public sector health services and systems of organisation in the four countries that make up the United Kingdom generally work independently of each other, but there is no discrimination when individuals/service users move from one part of the UK to another. The four organisations are:

- National Health Service England (NHS England)
- Health and Social Care in Northern Ireland
- NHS Scotland
- NHS Wales.

The range of services that the National Health Services in the four countries provide includes:

- **Primary health care** is provided by GPs, dentists, opticians and pharmacists. Primary health care services are normally accessed directly by the service user when needed.
- **Secondary health care** includes most hospital services, mental health services and many of the community health services. These are normally accessed via the GP, who makes an appropriate referral to a consultant or other healthcare specialist, such as a hospital physiotherapist, a psychologist or community nurse, and requests an appointment for further examination or specialist treatment. Members of the public and the emergency services have direct access to the accident and emergency services of hospitals.
- **Tertiary health care** provides specialist, and normally complex, services. For example specialist spinal injury units or hospice support. Referral to these services is by health professionals who have identified the need.

### NHS Foundation Trusts

In England, hospitals are managed by hospital trusts, most of which are now **NHS Foundation Trusts**. Foundation trusts were established in 2004. Although their services are largely financed by government, they are independent organisations. NHS Foundation Trusts are managed by a board of governors, which may include patients, staff, members of the public and members of partner organisations. The aim of the NHS Foundation Trust is to move decision-making from a centralised NHS to local communities, in order to respond to local needs and wishes. Trusts that have not achieved foundation status are still managed centrally.

Mental health services may be provided through your GP, or support may be needed from more specialist service providers, for example counsellors, psychologists or psychiatrists. More specialist support is normally provided by Mental Health Foundation Trusts. Mental Health Foundation Trusts are managed by the community, including people who use the mental health services. Patients, their families

**Key terms**

**Primary health care** – care provided by doctors, dentists and opticians, for example.

**Secondary health care** – care which includes most hospital services, normally accessed via the GP or other professional.

**Tertiary health care** – specialist and often complex care provided in highly specialised units and hospitals, for example spinal injury units.

**NHS Foundation Trusts** – health services, largely financed by government that manage the delivery of hospital services, many mental health services and community health services in England.

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and friends, local organisations and local residents can become members of the foundation. The members elect governors who have responsibility for the quality and range of care provided.

The services provided by a Mental Health Foundation Trust include provision of psychological therapies, the support of psychiatric nurses and very specialist support for people with severe mental health problems.

Community Health Foundation Trusts work with GPs and local authority social services departments to provide health and care support. The services provided by the trust may include:

- adult and community nursing services
- health visiting and school nursing
- physiotherapy and occupational therapy and speech therapy services
- **palliative**/end of life care
- walk in/urgent care centres
- specialist services, such as managing diabetes, sexual health or contraceptive services.

**Key term**

**Palliative care** – specialist care for people with serious illnesses, which aims to provide relief from symptoms and to reduce stress for patients and their families.

The aim of the Community Health Foundation Trust is to provide care for service users that will enable them to live as independently as possible in the community, rather than in settings such as hospitals or residential care.

### Adult social care

Adult social care provision is for people over 18 years of age who have disabilities, mental health problems or who are otherwise frail, due to age or other circumstances and who are unable to support themselves without specific and planned assistance.

Adult social care services are the responsibility of local authority social service departments. The support provided can take many forms, including:

- care in the service user's own home – such as help with cooking, cleaning, shopping and a wide range of other personal daily needs
- day centres to provide care, stimulation and company
- sheltered housing schemes
- residential care for older people, people with disabilities and people suffering from mental illness
- respite care or short-term residential care provided principally to give families caring at home a rest and a break from their responsibilities
- training centres for adults with learning difficulties.

In some parts of the country, care trusts have been established that are responsible both for the NHS mental health services and the local authority provision for people with mental illnesses. Primary Care Trusts (PCTs) were launched in April 2000 and fully established across the country in April 2002, to provide better continuity of care between the NHS provision and the social care support necessary for people with mental health problems.

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Adults receive support in a range of settings

### Children's services

Children's services are the responsibility of local authorities. Their aim is to support and protect vulnerable children and young people, their families and also young carers. The local council's children's departments are required to work in close collaboration with other care providers, and crucially with the NHS and the education services.

Support for children and their families can include:

- services to safeguard children who are at risk from abuse or significant harm, including sexual, physical, emotional harm or neglect
- day care for children under 5 years old, and after-school support for older children
- help for parents and carers with 'parenting skills'
- practical help in the home
- support of a children's centre
- arrangements for fostering and adoption.

### GP practices

General practitioner (GP) practices are often the first point of access to health and care provision. GPs have an extensive knowledge of medical conditions, including a wide range of physical disorders, and they also offer preventative healthcare. GPs work in local communities. Their role is to make initial diagnoses and to refer individuals, if necessary, to a specialist for further investigation and treatment. However, GPs increasingly work as members of multi-disciplinary teams, which may include nurses, health visitors and healthcare assistants. They also work closely with other agencies, including the education services, local authority social services and also the police. The GP and their team aim to use a holistic approach to care.

GP practices are funded from central government as part of the National Health Service. They are funded according to their assessed workload from their patients. This takes into account:

- the age of their patients
- their gender
- levels of **morbidity** and **mortality** in the area

**Key terms**

**Morbidity** – the levels of ill-health in a particular area, in this case the GP practice area.

**Mortality** – the death rate in a particular area.

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- the number of people who live in residential or nursing homes – this generates a higher workload
- patient turnover – newer patients generate more work than established patients.

In addition, GP practices receive further payments from the NHS for the following:

- if they are deemed to give a high quality service
- for certain additional services they may provide, such as flu immunisations
- for seniority, based on a GP's length of service
- to support the cost of suitable premises and other necessary equipment, such as computers
- to cover additional costs if the GP practice also dispenses medicines.

**Research**

Find out whether your GP practice is a dispensing service. Do they dispense medicines to their patients?

**Discussion**

In groups, discuss reasons why people who live in residential and nursing homes, and new patients should generate higher levels of work in a GP practice than people living in their own homes or more established patients.

## Voluntary sector

Voluntary sector organisations are often known as charities. Voluntary organisations vary enormously in their size, history and the services they provide. They include some well-known groups, such as Shelter, the NSPCC and the Samaritans, and some very small organisations that are run solely by volunteers for specific needs or for a particular local community. Voluntary groups often rely heavily on charitable donations for their survival but may also receive support from central or local government.

The social services provided by the voluntary sector (sometimes known as 'third sector' services) are managed independently from government, but government departments may sometimes pay charities to provide services on their behalf. Charities often provide services for the NHS, adult social services and children's services. For example, MENCAP provides residential care, day care and educational services for people with learning difficulties, and service users can use their personal funding to access these services. Nacro (the National Association for the Care and Resettlement of Offenders) receives government funding for their work with offenders.

The key features of a voluntary organisation are that they:

- are not run for personal profit, any surplus income is used to develop their services
- usually use volunteers for at least some of their services
- are managed independently of central government or local authorities.

NCVO (the National Council for Voluntary Organisations) is the body that supports and promotes the work of the voluntary sector. They have over 12,000 members that range from the smallest community group to the largest of the very well-known charities.

## Private sector

Private sector health and care provision is managed by commercial companies. These are organisations that need to make a profit in order to stay in business. Private care providers work in all sectors, including the provision of:

- private schools
- nursery and pre-school services
- hospitals
- domiciliary day care services
- residential and nursing homes for older people
- mental health services.

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Private sector companies often provide services for central government and local authorities, including services for the NHS, adult social care and children's services.

Private sector companies are funded by:

- fees paid directly by service users
- payments from health insurance companies, such as Bupa, Saga or AXA – many people who choose private healthcare will subscribe to a health insurance scheme
- grants and other payments from central and local government for services provided on their behalf.

**PAUSE POINT** Close the book and briefly describe the role of the public, private and voluntary sectors in providing health and care services.

**Hint** Think about who they care for, their funding and the services they provide. Could these services be provided by the NHS?

**Extend** Why is it important that these agencies work closely together?

## The range of settings that provide health and care services

The settings in which health and care services are provided vary enormously. Settings range from domiciliary care services provided in the service user's own home to day care centres, residential care homes to hospital departments providing highly technical and sophisticated specialist treatments.

### Hospitals

Hospitals provide both inpatient and outpatient services. Outpatient services include regular clinics, day surgery and other specialist daytime care. Inpatient services include treatment for individuals whose condition requires 24-hour specialist support. If you need to visit a hospital for specialist care, you will normally be referred by your GP. When a service user is referred to a hospital for specialist care, they have the right to choose which hospital they wish to attend as well as the consultant they would like to see. In hospitals, clinical departments are organised according to medical speciality. Some hospitals have accident and emergency services, which individuals can access directly for emergency treatment.

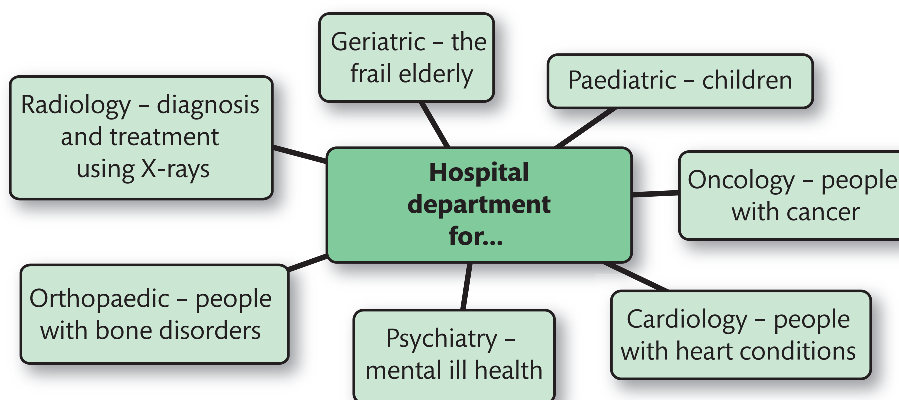


**Figure 2.8** Examples of specialist hospital departments

### Day care centres/units

Day care centres, or day care units, are normally provided for specific client groups. In most places there will be day centres for older people, for people with disabilities, people with learning difficulties, people with mental health problems and for people with specific conditions such as dementia or visual impairment. The day service

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provision is designed to provide a friendly, stimulating and supportive environment for people who otherwise would be socially isolated. Day centres normally offer educational facilities and support, where appropriate, to help people progress into employment. Day care services may be provided by statutory, voluntary or private providers.

## Hospice care

Hospice care aims to improve the quality of life for people who have an incurable illness. Care may be available from when the diagnosis of a terminal illness is made until the end of the individual's life. Hospice care is holistic, providing for the physical, social, emotional, spiritual and practical needs of the individual, their family and their carers. Care may extend to support during the bereavement period.

## Residential care

Residential care refers to the long-term care of adults and children needing 24-hour care, which cannot be provided adequately or appropriately in their own home. Residential care units are usually specialist units providing care for specific client groups, such as people with mental health problems, people with learning difficulties or older people unable to look after their daily needs. There are two types of care home:

- a residential care home, which provides help with personal care such as washing, dressing and taking medication
- a nursing home, which provides personal care but also provides 24-hour nursing care by a qualified nurse, who may also contribute to the planning, supervising and monitoring of healthcare tasks.

## Domiciliary care

Domiciliary care, sometimes called home care, is care provided in a client's home, rather than in a specialist care setting. The care may be short-term, for example providing support following discharge from hospital or for a family with a new baby, or may be needed as a long-term solution for a service user with a disability or for a frail older person. The support can vary from one visit a day to 24-hour care, providing both support with domestic tasks and intimate personal care.

Appropriate domiciliary care being provided can ensure that service users are able to live as independently as possible in their own home.

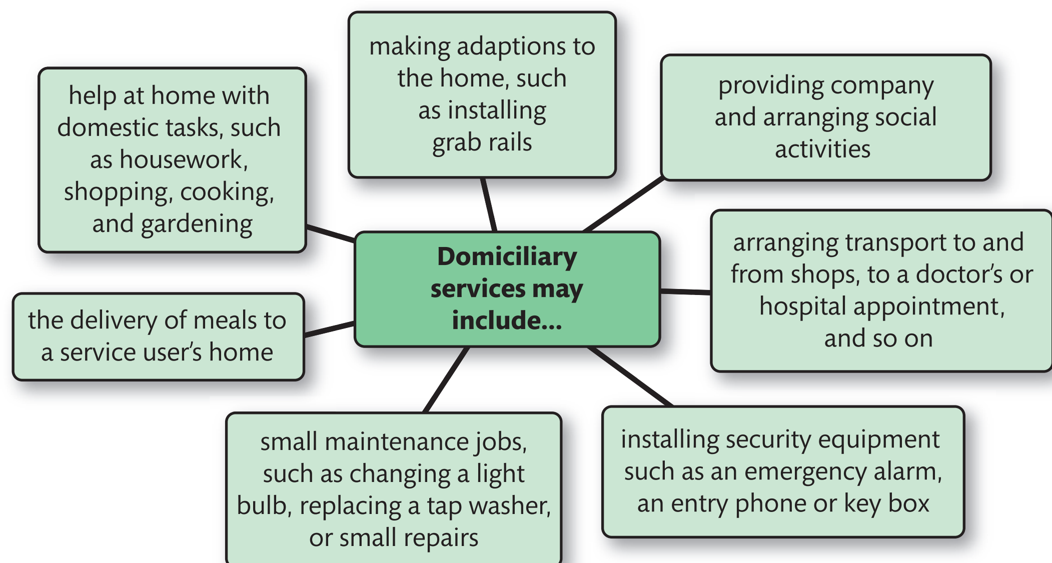


**Figure 2.9** Examples of domiciliary services

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### The workplace

Occupational health services aim to keep a workforce fit and healthy so that they are able to carry out the duties for which they are employed, or to assist employees to regain fitness following an injury or illness. These services are normally provided by an employer to support the people that they employ. This can include access to nurses based in the workplace or referral to a doctor or other health professionals. Referrals may be to a counsellor, if the employee is thought to be suffering from work-related stress, or to a physiotherapist if there is a problem with the employee's posture or a repetitive strain injury. Advice, information and treatment will vary according to the individual employee's needs.

**PAUSE POINT** Close the book. List and describe as many different health and social care settings with which you are familiar as you can.

**Hint** Think about the times that you, or someone you know, needed care. Where did you/they receive that care?

**Extend** Briefly describe the main purpose of four different care settings and the range of needs that they aim to meet.

## Issues that affect access to services

### Referral

Health and care organisations are accessed by those in need through referral systems. These are normally classified in three ways.

- **Self-referral** is when a person contacts a care provider personally, by letter, email, phone call, making an appointment or attending a care setting or surgery and requesting help. Access to the primary healthcare services, such as doctors, dentists and opticians, is normally through self-referral. Many social care services for children and adults are accessed by self-referral.
- **Third-party referral** is when a friend, neighbour or relative contacts a health or care service on another person's behalf. For example, a neighbour may ring the social services department on behalf of a frail elderly person to request care support, or a relative concerned about the general health of a person with Down's syndrome may contact the GP. These referrals are usually to services that are accessible through self-referral.
- **Professional referral** is when a health or care professional contacts another service provider to request support for a service user. For example, a GP referring a service user to a hospital consultant, or a head teacher referring a child with learning difficulties to an educational psychologist, or a social worker contacting the domiciliary care services for a client with disabilities.

### Assessment

Local authorities have a duty to carry out a **community care assessment** for anyone who appears to be finding it difficult to look after themselves without additional help. The adult social services department is usually responsible for this, and it would normally be a social worker who completes such an assessment. It may be that the service user needs:

- reassurance and information about local or national organisations that could help
- simple devices that can help the client to live independently, such as aids to open tins or jars, or equipment to help them use their bath
- a higher level of care, such as domiciliary care, or they may need residential care.

**Key term**

**Community care assessment** – professional assessment of care needs provided by a local authority adult social services department, which also provides help and advice in accessing services to best meet the service user's need.

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**Key term**

**Carer's assessment** – assessment of the needs of informal carers providing support for a vulnerable person, such as a person with a physical disability, a person with a mental health need or a frail older person.

If a client is supported in their home by family, friends or neighbours, these carers also have a right to a **carer's assessment** to see whether they need support to carry out their caring activities. These unpaid carers are often called informal carers to distinguish them from professional care staff, or representatives of charitable groups. The Care Act (2014) sets out carers' legal rights for assessment and support.

When the assessment for a service user or their carer is complete the service users must be provided with a written copy of the report outlining the needs identified and the action agreed.

## Eligibility criteria

In order to decide whether a person is entitled to care and support from the local authority, a social services department assessor, usually a social worker, has to consider whether these needs arise from:

1. a physical and/or mental impairment or illness, plus
2. an inability to achieve at least two of the following daily activities (called outcomes):
    - prepare and eat food
    - wash themselves or their clothes
    - manage their toilet needs
    - dress appropriately, especially in cold weather
    - move around their home easily
    - keep their house safe and clean
    - maintain family or other close relationships, in order to avoid social isolation
    - access work, training, education or volunteering
    - use local facilities, including shops, recreational facilities and other services
    - carry out caring responsibilities, including caring for their children
    - meet the outcomes likely to affect their health and wellbeing.

**Key terms**

**National eligibility criteria** – criteria applied to decide whether a service user is entitled to support from the local authority social services department.

**Personal budget/direct payment** – a cash payment made directly to the service user so that they may pay for identified and necessary care services to be provided.

An adult is eligible for support only if they meet both criteria. If a person meets these criteria for support, called **national eligibility criteria**, the local authority has a duty to make sure the identified needs are met.

However, social care is not usually free of charge and people may have to contribute to the cost of their care. The local authority carries out a financial assessment which will take into account the service user's regular income and their savings. The financial assessment will decide whether the service user must contribute to the cost of care and if so how much they will contribute. Service users, if they are eligible, will normally receive a **personal budget**, sometimes called a **direct payment**, which are cash payments. These payments are available to all client groups across the UK, including older people, people with physical and learning disabilities and carers. People with disabilities normally receive a personal budget to allow them to purchase care services from people or companies of their own choice. The local authority, however, still has a duty to ensure that service users' care needs are met.

**Discussion**

Discuss the advantages and disadvantages of providing service users with personal budgets rather than the local authority directly providing the care services for people who are eligible.

## Barriers to accessing health and care services

As you have seen, the health and care services available in the UK are many and various and accessing these services can be very confusing for service users, particularly when

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people are unwell or have complex personal difficulties. These difficulties may lead to service users and their families not receiving the care they need and have a right to.

Some of the barriers to accessing services may be:

- language, for example if English is not a service user's first language and there is no interpreter available, or the service user is hearing-impaired and there is no signer available to support communication
- inconvenient location of the service, particularly if the service user has to rely on public transport, additionally, the cost of travelling may be a barrier as financial help for travel is not always available
- financial, such as the cost and difficulty in providing care for children or other dependants while a service user attends a care setting, or the potential loss of wages
- scarce resources, for example long waiting times for hospital appointments or treatment, lack of beds available in hospitals or appropriate residential care settings, restricted opening times or specialist resources not easily available
- communication, such as service users feeling unable to communicate easily with care providers and other service users, because they feel discriminated against or that there is prejudice against them, or that there are negative stereotypes associated with their community. For example, some groups in society, such as travellers, may not feel comfortable at care settings where they may feel that they are discriminated against.

**Link**

Go to *Unit 10: Sociological Perspectives*, section C, Inequalities within society, to find more information about prejudice, stereotyping and labelling, and its impact on health and wellbeing.

Additionally, barriers to accessing care are made worse if an individual is poor or on a low income.

## Ways organisations represent the interests of service users

### Charities and patient groups

Many voluntary organisations or charities represent their service users when they need to contact and liaise with other official agencies. For example, MENCAP will represent their service users and support them if they are liaising with other organisations such as their local council housing department, social services or other health and care professionals. Shelter provides advice, guidance and support for people with housing problems and will represent them when they liaise with council officials, are applying for housing benefit or negotiating with landlords. These organisations also provide support if service users need to make a complaint. Patient groups in hospitals represent the needs of patients and also support individuals making complaints.

Many charitable groups act as **pressure groups** and campaign on behalf of the individual members that they represent. For example, they may write to the papers, use social media, organise demonstrations and contact Members of Parliament or local councils to raise awareness of their service users' needs and to request improvements to the services offered. For example, the NSPCC campaigns to encourage the government to introduce policies and laws that support the protection of children.

**Key term**

**Pressure groups** – people who come together to campaign to improve the services offered to their members. They aim to influence public opinion and government decisions.

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## Advocacy

If a client has a serious communication problem, an advocate may speak on their behalf. For example, clients may have a learning difficulty, a speech impediment, poor literary skills, a limited grasp of English or lack confidence when talking with professional health and care workers.

In health and care settings, advocates are usually volunteers. They work with individual service users, getting to know them well and building a trusting relationship so that they can accurately represent the needs, wishes and preferences of their client to the professional workers and to official organisations when needed. This may be through attending care meetings with the service user or completing forms, writing letters or emails on the client's behalf.

## Complaints policies

All care settings must have formal complaints procedures. The settings have a responsibility to ensure that their service users and, where appropriate, their families and other informal carers, understand how to access and use complaints procedures if they are unhappy with the quality of care provided. The procedures and the outcome of any complaints will be checked whenever the setting is inspected.

If a service user complains, they have a right to:

- have their complaint dealt with efficiently and in a timely way
- have their complaint formally investigated
- be told the outcome of their complaint.

**Research**

Investigate the complaints procedure at your work placement setting or at your school or college, and make brief notes to summarise it.

Keep your notes in the correct section of your file to help you with your revision.

## Whistleblowing policies

Care organisations are required to have whistleblowing policies, as discussed earlier in this chapter. Whistleblowing policies provide protection for staff who tell the press or another organisation outside the setting in which they work that the quality of care at their workplace is dangerously poor. For example, if they report the situation to the media, the police or to a professional body in order to heighten awareness of the problem and to bring about change.

**Link**

See section A, Accountability to professional organisations, for the earlier discussion on whistleblowing.

**PAUSE POINT** Close this book and briefly describe the different methods of referral to health and care services.

**Hint** There are three main types of referral, can you remember what they are?

**Extend** Explain the barriers that service users may have to accessing services.

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# Roles of organisations that regulate and inspect health and social care services

There are independent organisations with responsibility for the inspection and regulation of health and care services in England, Wales and Northern Ireland. This section will deal with each country in turn, but you should concentrate on the country in which you live or in which you expect to work.

## England

### The Care Quality Commission (CQC)

The CQC is responsible for monitoring and inspecting health services and adult social care services in England. Its aims to ensure that health and social care services are of a high quality and that they are delivered safely, effectively and compassionately.

The CQC monitors and inspects:

- NHS Trust hospitals and independent hospitals
- GP provision, including GP practices, walk-in services and out-of-hours provision
- clinics, including family planning clinics, slimming clinics and clinics run by GPs and hospitals
- dentists
- residential care homes and nursing homes
- domiciliary or home care services
- community care provision, including day centres and other community support for people with physical, social or mental health problems, or people who have a learning disability
- mental health provision, including provision for people who are detained, for people whose rights are restricted under the Mental Health Act (2007) and for those who voluntarily receive care, either in hospital or in the community
- accommodation for people requiring treatment for substance misuse.

All providers of these services must register with the CQC. A service provider can be an individual, a partnership or an organisation – for example a company, a charity, an NHS Trust, or a local authority.

**Reflect**

If your work placement setting is a registered care provider, identify **three** ways in which they meet the standards of the CQC.

Make notes and add any relevant information that other members of your group collect. These notes will be useful in preparing for the final assessment.

### The National Institute for Health and Care Excellence (NICE)

Following the Health and Social Care Act (2012) the National Institute for Health and Clinical Excellence (NICE), was renamed as the National Institute for Health and Care Excellence (which is still abbreviated to NICE). This name change reflects its new responsibilities for social care. NICE is responsible for providing guidance on current best practice in health and social care. It publishes guidance and advice that aims to control and improve health and social care provision. For example, NICE provides:

- guidance on the most appropriate treatments for people with specific conditions and diseases, such as cancer or diabetes

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- evaluation of whether procedures are sufficiently safe and effective to be used within the health and care services
- guidance about the use of specific health technologies and procedures, including the use of new and existing medicines, treatments and procedures
- assessment of the cost and the effectiveness of treatments
- recommendations about best practice, based on the most recent research
- support for health promotion campaigns and healthy living advice.

NICE recommendations are for the use of NHS practitioners, local authorities, charities and any organisations financed by the government who provide health and social care services.

As part of NICE's new responsibilities for social care it aims to provide a smoother transition for service users moving from health services to social care services, and from children's services to adult social services. NICE has jurisdiction in England and Wales and its recommendations are national, providing consistent approaches for service users wherever they live.

### Public Health England (PHE)

PHE is an executive agency sponsored by the Department of Health that was set up on 1 April 2013, following the implementation of the Health and Social Care Act (2012). It aims to protect and improve the **public health** and wellbeing of people in England, and to reduce health inequalities. The focus of all public health organisations is on the protection and improvement of the health of a community or population, in contrast to the individual support of a service user discussed earlier.

**Key term**

**Public health** – organised strategies to prevent disease, promote health and prolong life in a population.

Some measures that PHE uses to carry out its responsibilities are through:

- setting up health promotion programmes to improve the nation's health, for example PHE ran a high-profile campaign 'Be Clear on Cancer', with a particular focus on the prevention of lung, bowel, kidney and liver cancer
- research projects to improve our knowledge of public health issues and generate strategies to address problems, for example in 2015 PHE published a report on the prevalence of breastfeeding at 6–8 weeks after birth
- taking measures to protect the nation's health when there is a public health concern, such as when an epidemic is threatened or a new virus is circulating.

Examples of campaigns supported by PHE include, in 2013, helpful advice for people who may be affected by flooding, and in the autumn of 2015 PHE launched their largest flu vaccination programme, 'Stay well this winter'.

**Research**

Write brief notes about **one** public health campaign, including the:

1. aims and objectives
2. activities or strategies
3. outcomes.

Share your information with other members of your group. Always keep clear notes as this will make revision much easier.

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### Ofsted

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects services that educate children, young people and adults or care for children through the inspection of:

- state funded schools and colleges, and some independent providers
- adult education providers
- initial teacher education
- many private agencies who provide training in the workplace, particularly those that educate and train apprentices
- education provision in prisons and the armed forces.

Ofsted also regulates and inspects care provision for children and young people, for example by inspecting:

- nurseries, pre-schools and child minders
- fostering and adoption agencies
- settings providing residential care for children.

Inspectors make a judgement about the overall effectiveness of the provider based on their judgements relating to the:

- effectiveness of leadership and management
- quality of teaching, learning and assessment
- personal development, behaviour and welfare
- outcomes for children and learners.

Following inspection, Ofsted publishes a report and the provision is graded: Grade 1 – Outstanding, Grade 2 – Good, Grade 3 – Requires Improvement or Grade 4 – Inadequate.

(Source: adapted from Ofsted: Common inspection framework: education, skills and early years from September 2015)

Ofsted inspects schools on a regular basis

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## Wales

In Wales, health services and social care services are inspected separately. The Care and Social Services Inspectorate Wales (CSSIW) is responsible for monitoring the quality of care and social service provision and the Healthcare Inspectorate Wales (HIW) is responsible for monitoring the quality of provision of healthcare services.

### The Care and Social Services Inspectorate Wales (CSSIW)

The CSSIW is responsible for the regulation and inspection of care provision, which includes:

- residential care homes and nursing homes for adults
- domiciliary or home care provision
- nurses' agencies
- children's homes
- child minders and day care services for children under the age of eight
- fostering and adoption agencies
- boarding schools, including residential schools for children with specific needs
- further education colleges that accommodate learners under 18.

CSSIW publishes reports on the outcomes of each of its inspections.

The CSSIW aims to:

- provide independent assurance about the quality and availability of social care
- safeguard adults and children, making sure that their rights are protected
- improve care, by encouraging and promoting improvements in the safety, quality and availability of social care services
- provide independent professional advice to those who plan health and care provision in Wales.

(Source: www.cssiw.org.uk)

### Healthcare Inspectorate Wales (HIW)

The HIW inspects all healthcare provision provided by the NHS and by other independent organisations, including private or charitable organisations. Its responsibilities are wide ranging, and include:

- hospitals and clinics
- mental health and substance misuse services
- nursing agencies and midwifery provision
- Youth Offending teams
- deaths in prisons, and homicide investigations.

HIW aims to:

- contribute to improving the safety and quality of healthcare services in Wales
- improve citizens' experience of healthcare in Wales, whether as a patient, service user, carer, relative or employee
- strengthen the voice of patients and the public in the way health services are reviewed
- ensure that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

(Source: www.hiw.org.uk/about-us)



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### The National Institute for Health and Care Excellence (NICE)

NICE was discussed in relation to its responsibilities in England. However, it has jurisdiction in both England and Wales and its areas of responsibility, and the recommendations it makes, apply in both countries.

### Her Majesty's Inspector of Education and Training in Wales (Estyn)

Estyn is the organisation responsible for the inspection of education and training in Wales. Unlike Ofsted, their work is specifically linked to education and training. The inspection of children's social services is largely the responsibility of CSSIW.

Estyn's responsibilities include the inspection of:

- schools
- further education colleges
- work-based learning providers, eg apprenticeship programmes
- adult and community learning provision
- initial teacher education and training
- education in the justice sector, including prisons and young offenders' institutions.

Estyn makes judgements about the quality of provision by addressing three questions.

1. How good are outcomes? (This includes exam results and other evidence of achievement.)
2. How good is provision? (This is concerned with the quality of learning and teaching.)
3. How good is leadership and management? (This is concerned with the management and governance of the setting.)

A four-point scale is used to describe the quality of provision as judged by the inspectors: Grade 1 – Excellent, Grade 2 – Good, Grade 3 – Average, Grade 4 – Unsatisfactory.

## Northern Ireland

### The Regulation and Quality Improvement Authority (RQIA)

In Northern Ireland, the RQIA has similar responsibilities to the Care Quality Commission in England. That is, it is responsible for the regulation of both care and health services. It inspects services provided by both statutory and independent organisations, including:

- children's homes
- day care settings for older people, people with disabilities, people who have learning difficulties and people with mental health problems
- boarding schools
- domiciliary care services
- residential family centres
- nursing agencies.

### Public Health Agency for Northern Ireland (PHA Northern Ireland)

The PHA Northern Ireland was established in 2009 and brought together a number of different public health organisations. Its overall responsibility is to improve the health and social wellbeing of all people living in Northern Ireland. The PHA manages this by:

- developing effective health protection strategies, such as an immunisation programme
- developing policy to improve the health and wellbeing of the population
- conducting research and development activities to identify the causes of poor health
- recommending strategies to improve the health of the nation.

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In 2015, PHA Northern Ireland ran a campaign to urge people to take steps to reduce their likelihood of having a stroke, as part of World Stroke Day in October, and another related to Global Handwashing Day.

### The National Institute for Health and Care Excellence (NICE)

NICE does not have direct responsibility for the control and improvement of health and social care services in Northern Ireland, as it does in England and Wales. However, NICE has a direct link with the Northern Ireland Department of Health, Social Services and Public Safety (DHSSPSNI). This department regularly and systematically reviews NICE recommendations and applies them in Northern Ireland where it is thought appropriate.

### Education and Training Inspectorate (ETI)

The ETI are responsible for the inspection and improvement of educational services in Northern Ireland, which includes educational services provided in:

- early years, largely pre-school education
- primary and secondary schools
- further education colleges
- youth work
- initial teacher education
- prisons and young offenders' institutions in Northern Ireland, and other areas of the criminal justice system.

When reporting on the quality of provision in schools and colleges, the ETI uses the following descriptors to report on the quality of provision:

- achievements and standards
- provision for learning
- leadership and management.

Following inspection, a grade is awarded for the overall performance of the provider, based on the judgement of these three areas. A six-point scale is used to describe the quality of provision, as judged by the inspectors: 1 is outstanding, 2 is very good, 3 is good, 4 is satisfactory, 5 is inadequate, 6 is unsatisfactory.

## The roles of the organisations which regulate or inspect health and care services

### How regulations and inspections are carried out

The CQC in England, the CSSIW and the HIW and the RQIA in Northern Ireland all require service providers to register with them before offering care services. When a service provider applies for registration, there are checks to ensure that it meets the necessary standards of safety, and has the resources to ensure high standards of care (including an appropriate number of sufficiently experienced and qualified staff). Once registered, the services are continually monitored. This includes regular inspection.

Inspectors are drawn from a range of backgrounds, including experienced health and care professionals, members of other related professions and also care users and their informal carers. The inspection teams make judgements supported by robust evidence, on the quality of provision, such as whether the care provision is safe, caring, effective in carrying out its services, well-managed and well led.

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Each of the national regulators publishes National Minimum Standards (NMS) of provision in these areas for the types of settings that they inspect. The main sources of evidence used to support their judgements are:

- feedback from service users, their families and friends, and from staff at the setting
- written reports of care practice and procedures
- information from other linked local organisations
- records of complaints
- on-site inspection of practical care provision.

#### How organisations and individuals respond to regulation and inspection

Inspection can be a stressful experience. Weaknesses in provision may be identified that managers were unaware of being areas of concern. Managers and staff may feel vulnerable and, on occasion, angry. They may feel that they cannot make the improvements needed. To support care providers, the regulators publish clear guidance that outlines what they expect to see. Following an inspection, the regulator publishes a report. The CQC publishes the outcomes of each inspection and the health and care provision is graded according to the quality of care provided. In Northern Ireland, the RQIA assesses whether the National Minimum Standards are fully met, partially met, or not met.

#### Changes in working practice required by inspection

Following an inspection where the practice does not meet the required standards, the regulator can enforce change, which may include:

- requiring or recommending improvements to the provider's policy and practice in specific respects, for example to share good practice in the provision of care
- issuing a requirement notice or warning notice, to set out what improvements the care provider must make, and by when
- making changes to a care provider's registration to limit the range of care that they are able to provide
- pursuing a criminal prosecution in extreme cases, such as when there is inadequate safeguarding of service users from abuse and improper treatment.

**PAUSE POINT** Can you explain why inspection of health and care provision is important?

**Hint** Do you remember earlier discussions about health and safety, safeguarding and confidentiality?

**Extend** Find an online inspection report and summarise strengths and areas for improvement identified. Compare with a report for a different type of provision.

## Organisations that regulate professions in the health and social care services

Here are organisations that regulate professions in the health and social care services.

### England, Wales and Northern Ireland

#### The Nursing and Midwifery Council (NMC)

The NMC is a statutory authority set up by parliament in 2002. It is responsible for regulating the standard of professional practice of all nurses and midwives in the United Kingdom (England, Scotland, Wales and Northern Ireland) wherever they are working. This applies whether they are in paid employment or working as a volunteer.

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The NMC exists to protect the public and it sets high standards for:

- initial education and training of nurses and midwives
- continuing professional development
- standards of professional practice
- standards of personal conduct, both at work and in leisure time.

The NMC sets the standards and formal code of practice required of all nurses and midwives. Nurses and midwives have to provide evidence of continuing learning and training in order to remain on the register. All practising nurses and midwives are required to register with the NMC, who investigate any allegations that their members are not meeting the standards set. The NMC has the power to restrict a nurse's practice, for example to require that they work under supervision, take specific training or are restricted to working in a limited number of areas, or to remove them from the register. If a nurse or midwife is removed from the register they are no longer permitted to practice.

Andrea Spyropoulos, RCN President

### The Royal College of Nursing (RCN)

The RCN, although not an inspectorate or regulator of nursing practice, is the world's largest union and professional body representing the nursing profession. It represents nurses in the public, private and voluntary sectors. The RCN aims to maintain high standards in nursing practice through their education and research activities.

### The Health and Care Professions Council (HCPC)

The HCPC (formerly the Health Professions Council) was set up in 2012 under the Health and Social Care Act (2012). The HCPC promotes good practice and also exists to protect the public, throughout the United Kingdom, from poor standards of care. The HCPC regulates a wide range of health and care related professionals, sixteen different professions in all, including physiotherapists, occupational therapists, speech therapists, social workers and paramedics. Members of these professions must register with the HCPC. To register as an HCPC approved practitioner, individuals must:

- have achieved the relevant qualifications
- meet the standards of professional practice and personal behaviour required by the council.

If a member of the public feels that a professional registered with the HCPC is not meeting the standards set, they have a right to complain. The HCPC will investigate complaints and take the appropriate action. In cases of serious misconduct, this can include suspension or permanent removal from the register.

### The General Medical Council (GMC)

The GMC is an independent organisation for the registration and regulation of doctors. The GMC:

- oversees UK medical education and training
- decides which doctors are qualified to work in this country
- sets the standards that doctors must meet in their professional practice
- takes action to address shortfalls in the standards of treatment that may put patients' safety at risk, or brings the medical professions into disrepute.

When a serious concern is raised about a doctor's behaviour or professional practice, the GMC investigates. If the concern is upheld, the GMC may restrict the doctor's right to practice. The doctor may be required to work under supervision or to undertake further training or in extreme circumstances they may be removed temporarily or permanently from the register.

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## Wales

All the organisations that operate In England also operate in Wales.

### Care Council for Wales (CCW)

The CCW was set up under the Care Standards Act (2000) with the aim of registering and regulating the social care workforce in Wales. The CCW confirms and registers staff working in children's or adult social care and early years in Wales. This includes social workers, social care workers, pre-school staff, nursery staff and play workers. The CCW checks that practitioners:

- have the necessary qualifications
- are physically and mentally fit to practice and work in this area
- are of good character, which will involve a Disclosure Barring Service check
- comply with the CCW Code of Practice for Social Care Workers.

As with the other regulatory bodies, the CCW investigates complaints and takes appropriate action to protect the public if their members are not reaching the professional standards required of them.

## Northern Ireland

All the organisations that operate In England also operate in Northern Ireland.

### The Northern Ireland Social Care Council (NISCC)

The Northern Ireland Social Care Council was set up under the Health and Personal Social Services Act (Northern Ireland) (2001). This was during the time that the CCW in Wales and the General Social Care Council in England (the organisation that preceded the HCSC) were established. The overall aim of the NISCC is to protect the public and all service users by regulating the registration and practice of social work and the social care workforce.

The NISCC has responsibility for:

- monitoring and regulating the social care workforce in Northern Ireland, which includes social workers, social care workers and social care managers, and probation officers – these professionals work in a wide range of settings, including residential and day care, other community settings and in service users' own homes
- setting standards for the training and professional practice of members of the care workforce
- promoting the professional development of the workforce.

### How services are improved by regulation

The overall purpose of regulation is to protect the public by setting standards of education, training, professional conduct and professional practice, to ensure high standards are maintained throughout a health and care professional's career. Health and care work is a fast changing area, with constant new developments that require new approaches to work. This can be stressful for care workers and requires significant continuing professional development.

If an allegation is made that a practitioner is not meeting the standards of education, skill or professional conduct expected, their regulator will investigate that complaint. The regulators have the power to suspend their members, require them to take additional training, restrict the types of work that they can do or, in extreme circumstances, remove them from the professional register.

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**Case study**

### Respecting preferences

Paul is a paediatric nurse and has worked on children's wards in general hospitals for more than ten years. He enjoys his work and has always been regarded as an excellent professional nurse. Ali is a Muslim woman. She has requested that Paul does not care for her daughter, Shameena. Ali would like a female nurse to provide Shameena's care.

Furthermore, Ali has accused Paul of unprofessional conduct. She claims that Paul provided intimate personal care for her daughter without drawing the curtains, and that he has helped other children with bathing without closing the bathroom doors. Ali has informed Paul's line manager.

**Check your knowledge**

1. Do you think that Ali should be able to request nursing care from a woman for her daughter? Please give reasons for your answers.
2. If the accusation of providing intimate care without a concern for privacy is found to be true, will Paul have contravened the Nursing and Midwifery Council's Code of practice?
3. Paul is a member of the Royal College of Nursing (RCN). How might the RCN support Paul?
4. If the allegations are found to be true, what is the likely outcome for Paul?
5. How do you think codes of practice can lead to improvement in healthcare?

## Responsibilities of organisations towards people who work in health and social care settings

Organisations providing health and social care services are required to ensure that all employees understand how to meet national standards in their professional practice.

### Implementing the organisation's code of practice

The Health and Social Care Act (2008), and the linked regulations of 2014, require that registered providers of care services must ensure that they have sufficient numbers of appropriately qualified staff to meet the needs of their service users at all times. They must also provide or support training and professional development to ensure that their staff can carry out their caring role.

In social care settings, new staff are required to complete an induction programme and to meet the requirements of the Common Induction Standards (2010) within 12 weeks of commencing their new job. This requires the manager to ensure that all new employees understand how to implement the codes of practice in their workplace and how to meet the current National Occupational Standards (NOS) for their role.

### Meeting National Occupational Standards

National Occupational Standards (NOS) describe best practice. They are the standards of professional practice that should be met in the workplace. The NOS for people working in the health and social care sector are applicable throughout the UK and were updated in 2012. The NOS underpin the codes of practice in care settings and the curriculum for the training of practitioners and cover the standards that are also included in the codes of practice for professional bodies, for example the Nursing & Midwifery Council (NMC).



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## Undertaking continuing professional development

In order for health and care practitioners to maintain the high standards required in the sector, they need to continually update their skills. This will ensure that they are following the best practice and most up-to-date procedures, based on recent research. As discussed earlier in this unit all members of the GMC, the NMC and the HCPC are required to complete regular professional training to remain on their registers. It is the responsibility of care managers to ensure that support staff who are not members of professional organisations also regularly update and extend their skills.

## Supporting and safeguarding employees in health and social care

### Internal and external complaints

All care organisations are required by their regulators, which include the professional organisations and the inspection agencies, to have formal procedures to address complaints. Where allegations of poor practice are made against staff, this will normally initially be addressed through the organisation's internal disciplinary systems. However, in more serious instances the regulatory body, for example the GMC, the NMC or the HCPC may be involved. In extreme circumstances, for example in cases of assault or death thought to be caused by negligence or active abuse, the police may also deal with the complaints.

### Membership of trade unions/professional associations

Many practitioners will be members of trade unions or professional associations, which support them if they are accused of professional misconduct or are in conflict in other ways with their employer. For example, many doctors belong to the British Medical Association (BMA), nurses may belong to the Royal College of Nursing (RCN), midwives to the Royal College of Midwives (RCM) and social workers are often member of the trade union UNISON.

### Following protocols of regulatory bodies

Protocols are accepted codes of practice and behaviour required of professionals by their regulatory bodies. The regulatory bodies, such as the GMC, the NMC and the HCPC, also provide protection for employees by ensuring that the standards expected of them are clear and transparent. As part of their induction and ongoing training, health and care practitioners must fully understand their professional responsibilities and the protocols by which they must practice.

### Whistleblowing

Whistleblowing procedures can be a form of protection for all staff. If the quality of care in an organisation is poor and this is going unchecked, whistleblowing will protect not only the service user but also other members of staff and sometimes the provision itself. Poor practice damages the reputation of the sector. It may lead to investigations by professional organisations, the inspectorate and, in extreme cases, by the police. Poor practice is a matter for the organisation to check and remedy.

**PAUSE POINT** Explain how care organisations ensure that health and care workers are protected and supported in their jobs.

**Hint** Check that you understand the importance of codes of practice, NOS, CPD and safeguarding policies and practice.

**Extend** Which of these areas do you think are important for you to know about at your work placement setting?

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## Assessment practice 2.2

Muriel is 40 years old and  visually impaired. Her sight is deteriorating, and her doctors have predicted that she will be totally blind within two years. Muriel lives alone and feels lonely.

Muriel had an emergency admission to hospital to have her appendix removed but will soon be going home.

1. Identify one voluntary organisation and one statutory service that could support Muriel in maintaining an independent life at home.
2. Describe two barriers that Muriel, and other people who are visually-impaired, might face when going into hospital.
3. Explain which care provision may be most helpful in supporting Muriel to remain independent.
4. Discuss how the nurses who provided care during Muriel's stay in hospital are monitored to ensure they provide professional services.

# C Working with people with specific needs in the health and social care sector

## People with specific needs

### Physical and mental ill health

When supporting people with physical and mental illnesses, a multi-disciplinary approach is usual and normally essential. When people are supported by health and care professionals, it is not at all unusual that the service user has a range of concerns in addition to the one first presented. As discussed earlier in this unit, care professionals, whatever their speciality, aim to take a holistic approach to meet the needs of the whole person. People with mental health problems often have associated physical ill health. Poor physical health can lead to serious anxiety and depression. It is the care professional's role to judge when it is necessary to work professionally with other specialists to ensure that the service user's needs are fully met.

Mental illness is difficult to define and, therefore, difficult to monitor. What is regarded as normal and acceptable behaviour varies from one society to another, and at different times in history. In addition, the evidence available is derived largely from medical statistics, recording the number of people who present themselves for treatment. Mind, the charity that works with and supports people with mental health problems, estimates that one in four people experience a mental health problem each year.

Table 2.4 identifies a wide range of symptoms that are linked with stress and mental ill health. However, people experiencing these symptoms may not necessarily regard themselves as ill and therefore may not seek professional help.

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**Table 2.4** Some common signs of stress

| Physical | Psychological | Behavioural |
|---|---|---|
| tiredness | anxiety | increased smoking or drinking |
| a feeling of tightness in the chest | tearfulness | withdrawal or aggression |
| indigestion | feeling low | lateness |
| headaches | mood changes | recklessness |
| appetite and weight changes | indecision | difficulty concentrating |
| joint and back pain | loss of motivation | |
| | increased sensitivity | |
| | low self-esteem | |

There may be many reasons why people with mental health problems do not seek professional help, for example:

- they may not regard themselves as mentally ill, perhaps they think they are just having a hard time at the moment
- they might not want to admit that they have a mental health problem, some people feel that there is a particular stigma linked to mental illness that is not associated with physical illness
- they may be frightened to seek medical help, worried that being diagnosed as depressed or phobic would affect their employment prospects. There is some basis for this concern as people with mental health problems have the highest rate of unemployment among people with disabilities.

It is the health and care practitioner's role to be aware of changes in both a service user's mental and physical wellbeing.

## Learning disability

MENCAP, the organisation that supports people with learning disabilities, defines a learning disability as 'a reduced intellectual ability and difficulty with everyday activities... which affects someone for their whole life'. This may include difficulties with regular household tasks, shopping, using public transport or managing their money. Many people with learning difficulties also have other health needs, for example people with Down's syndrome, a common condition that leads to learning difficulties, often have heart problems and sight and hearing impairments.

Research by The Foundation for People with Learning Difficulties has found that between 25 per cent and 40 per cent of people with learning difficulties also suffer from mental health problems. The prevalence of dementia is much higher amongst older adults with learning difficulties compared to the general population.

Until relatively recently, many people with learning disabilities were cared for in large institutions or hospitals and were almost invisible to the rest of society. However, the Community Care Act (1990) increased the number of people with learning disabilities who were cared for and supported in the community rather than in large institutions. Importantly, the Disability Discrimination Act (1995) provided legal protection from discrimination in employment, access to public buildings and in renting of accommodation. However, MENCAP (2015) reports that despite recent progress, just 7% of adults with a learning disability are in paid employment, yet 65% want to work and, more importantly, have the capability to work. (This compares with one in two people with a physical disability being in work.) Of those people with a learning disability that do work, most only work part-time and are in low paid employment. Additionally, only a third of people with a learning disability take part in some form of education or training.

(Source: MENCAP 2015)

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> **Key terms**
>
> **Impairment** – physical or mental loss of function, whether permanent or temporary, that restricts an individual's ability to perform daily activities independently.
>
> **Disabling environment** – a social context in which adaptions and other necessary facilities are not in place to ensure that people with impairments can take a full part in social life.
>
> **Braille** – system of writing and printing for blind or visually impaired people in which raised dots are used to represent the letters of the alphabet, numbers and punctuation marks.

> **Link**
>
> See *Unit 10: Sociological Perspectives*, section B for a fuller discussion of the difference between disability and impairment.

## Physical and sensory disabilities

Prior to the Community Care Act (1990), many people with physical and sensory disabilities and **impairments** also lived in hospitals and other large institutions in which the focus was predominantly concerned with their physical care. There was less awareness of the need for a holistic approach. People with disabilities tended to be segregated from the community rather than included in the wider life of our society.

A sensory impairment refers to a condition where a person's sensory organs, for example their eyesight or hearing, function abnormally poorly, which limits their ability to perform day-to-day activities. However, a person with an impairment may only be disabled if adaptions and services are not in place to ensure they are able to perform their daily routines and other activities of daily life independently. A **disabling environment** describes a situation where appropriate adaptions and services are not in place to support people with impairments. For example, a person with a hearing impairment is only disabled if they do not have access to a hearing aid. Or a person with a visual impairment does not have access to information in **Braille,** if this is the system of communication they prefer.

### Poverty and disabilities

The poverty rate for adults with disabilities is twice that for adults without a disability. The main reason for this, despite the Disability Discrimination Act (1995), is the high rate of unemployment among people with disabilities. According to the Poverty Site (a website containing statistics on poverty and social exclusion), approximately one in five adults with any type of disability who wants to work is unable to find employment. This compares with one in 15 adults without a disability. Furthermore, people with disabilities face extra costs related to managing their impairment, such as the extra expense of paying for  to their homes, social care support and other mobility and communication aids.

## Specific age groups

### Early years

Human growth and development is usually described in terms of life stages, which begin with conception and range through infancy, childhood and adolescence to the final stages of adult life. The development of infants and young children can be regarded as a journey, influenced both by their physiological changes and social environment. The care and education services supporting children in early childhood are required to follow a curriculum, the Early Years Foundation Stage (EYFS) curriculum. The EYFS, which was updated in 2014, sets standards and measures progress from birth to 5 years of age. All schools and Ofsted-registered early-years providers must follow the EYFS. This includes childminders, pre-schools, nurseries and school reception classes. The EYFS covers seven key areas of learning and development, which together form a holistic model that addresses the development of the 'whole child'.

The EYFS areas of learning and development are:

1. communication and language
2. physical development
3. personal, social and emotional development
4. literacy
5. mathematics
6. understanding the world
7. expressive arts and design.



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**Link**

See *Unit 1: Human Lifespan Development* for further discussion of human growth and development.

### Later adulthood

Adulthood is the stage in human development associated with reaching physical and emotional maturity. Early adulthood, the period between the age of 18 and about 40 years of age, is associated with the cessation of physical maturation and is when the ageing process gradually begins. In the middle adult period, approximately between the ages of 40 and 65 years, people begin to notice a decline in their physical stamina. People begin to move and run more slowly than in previous years and their eyesight often deteriorates. There is a loss of skin elasticity, with an increase in wrinkles. Women will also experience the onset of the **menopause**.

**Key term**

**Menopause** – stage in life, usually between the ages of 45 and 55, when a woman's menstrual cycle gradually stops and she is no longer able to become pregnant naturally.

However, the effects of the ageing process for most people are most acute in later adulthood. At this stage, there are changes in the brain structure that result in noticeably slower intellectual and physical reactions, poorer memory and less effective problem-solving skills. Physical changes include poorer hearing and eyesight, a loss of muscle tissue leading to less strength and generally less stamina. Older people often experience changes in sleep patterns and their immune system is less efficient, making them prone to infections that take longer to clear.

Many older people, however, live active and busy lives. They may contribute to community activities, extend their education, online or through attending courses, for example, and provide essential family support for their children and grandchildren.

Many people stay active in retirement

**PAUSE POINT** Can you explain how provision of services will need to vary according to individual need?

**Hint** Briefly describe the range of people with specific needs that may need health and care support.

**Extend** In more detail, describe the range of provision for one type of service user. Compare your notes with other group members.

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## Working practices

### Relevant skills to work in these areas

As we have discussed throughout this unit, the specific knowledge and skills required for working in the health and care sector varies according to the wide range of specialist job roles within this sector. Health and care is a rapidly changing sector in which changes in the size and structure of the population present new challenges, legal requirements change and new treatments and procedures are introduced at a fast pace.

**Link**

Go to section A to remind yourself of the range of roles, responsibilities and skills required of people working in the health and care sector.

In December 2012, the Chief Nursing Officer for England launched a three-year strategy for all nurses and midwives entitled 'Compassion in Practice'. Central to her campaign was the focus on six key values, which came to be known as the Chief Nursing Officer's 6Cs (see Figure 2.10).

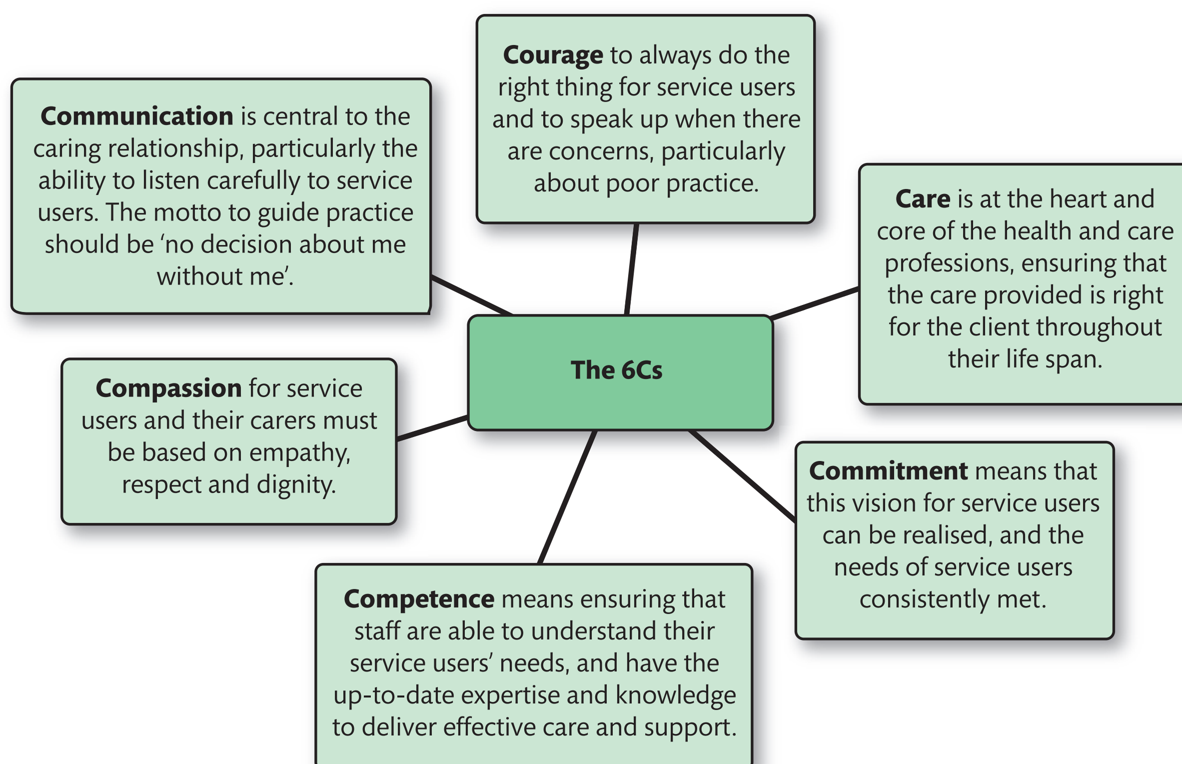


**Figure 2.10** The Chief Nursing Officer's 6Cs

The 6Cs are now incorporated into the introductory Care Certificate for healthcare support workers and adult social care workers that was introduced in April 2015.

**Research**

Using the internet, investigate the requirements of the Care Certificate for healthcare support workers and adult social care workers, introduced following the Cavendish Report in April 2015.

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## How policies and procedures affect people in these areas

The policies, procedures, codes of practice and codes of conduct for the caring professions have become more specific in recent years. They are presented so that professionals, service users and their carers can understand them clearly, and they are more rigorously enforced. The inspection agencies have a specific responsibility to monitor standards of provision, and to require immediate action where significant failings are identified. Since the publication of Robert Francis's report in 2013 into the failings of the Mid Staffordshire NHS Trust, issues of patient safety and the quality of care have been even more in the public eye.

**Research**

Using the internet, investigate the failings at the Mid Staffordshire NHS Trust reported in 2013.

## How regulation affects people working in these areas

As has been discussed, all staff working in care settings are affected by regulation and inspection, both of their provision and their professional practice.

Where provision is failing to meet the standards required, immediate action can be required and its implementation carefully monitored. Where care professionals fail to meet the standards set by their regulators, they can be disciplined and in the most serious cases removed from their professional register. This means they can no longer practice either voluntarily or in paid employment.

**Link**

Go to section B to see the codes of practice members of the health and care professions must abide by, such as that of the GMC, NMC and HCPC, and the Code of Conduct required of healthcare support workers and adult social care workers in England.

## How working practices affect people who use services in these areas

Of course, the overall aim of all health and care provision is to meet the individual needs of service users. The policies, procedures, legislative requirements and regulation of health and care providers is in place to ensure that standards are high, and also to ensure that service users can take action where there are failings in provision.

## Recent examples of how poor working practices have been identified and addressed

Changes in policy and the regulation of care services have often been introduced following the investigations of failings in the health and care settings. The following are examples of where this has been the case.

### Victoria Climbié

Victoria Climbié was abused, and finally died, while living with her guardians in the Borough of Haringey, London, in February 2000. Victoria was born in the Ivory Coast, West Africa, and came to live in London with her great aunt and her great aunt's boyfriend. They claimed to be able to offer her a better life. In January 2001, the great aunt and her boyfriend were convicted of Victoria's murder. While Victoria was living in London, and during the period she suffered horrific abuse, several organisations

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had contact with the 'family' and had noted signs of abuse. These included the police, social workers from four different local authorities, two housing authorities, the National Health Service, the National Society for the Prevention of Cruelty to Children (NSPCC) and local churches.

Following Victoria's death, an enquiry was set up under the direction of Lord Laming to investigate how and why, despite being known to the authorities, this tragedy was allowed to happen. Lord Laming identified countless examples of poor practice **within** these services and organisations; and very poor levels of communication **between** them. The report by Lord Laming led to the government taking the following steps.

- Every Child Matters (ECM), this initiative was launched in 2003. ECM was to ensure that all children, regardless of their background, should have the chance to reach their full potential by reducing levels of ill health, eradicating abuse and neglect and improving educational success for all children. The five outcomes to achieve for all children are for them to:
  - stay safe
  - be healthy
  - enjoy and achieve
  - make a positive contribution
  - achieve economic wellbeing.
- The Children Act (2004), which led to the:
  - appointment of a Director of Children's Services in every local authority, who has responsibility for the care and education of children in their area
  - 'duty to cooperate' for all services concerned with the care and safeguarding of children
  - setting up of local Safeguarding Boards, which are responsible for monitoring the professional practice of agencies in the safeguarding of children in their area
  - creation of a Children's Commissioner, with responsibility for representing and promoting the interests of children and young people, particularly the disadvantaged and children whose voices are rarely heard.

### Jessica Chapman and Holly Wells

In August 2002 two primary school children, Jessica Chapman and Holly Wells, were reported missing from their home. Less than two weeks later, their bodies were found. The girls had been sexually abused and murdered by their school caretaker. It emerged during the investigations that the caretaker had been investigated in the past for sexual offences and burglary, but he had still been appointed to work in a school. An enquiry, led by Sir Michael Bichard, was set up to investigate this tragedy. One of the key recommendations of the Bichard Report was that there should be a statutory agency with responsibility for vetting all individuals wanting to work with children or vulnerable adults, whether as a paid member of staff or as a volunteer. This was initially the responsibility of the Criminal Records Bureau (CRB) set up in 2002. In 2012, the responsibility for vetting staff and volunteers was given to the newly created Disclosure and Barring Service (DBS).

### Peter Connelly (Baby P)

In 2008, seventeen-month old Peter Connelly, still often referred to as Baby P, died after suffering serious physical and psychological abuse over a nine-month period. Just as in the case of Victoria Climbié, he had been seen by numerous health and care professionals during this period, but they failed to intervene and avert the tragedy. Further, just like Victoria Climbié, Baby P was also living in the Borough of Haringey. Lord Laming conducted a review to establish why, despite the changes in legislation, the tragedy had occurred. He found that yet again communication had been poor,

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practice unprofessional and the standards of care inadequate. As part of his review, Lord Laming recommended that there should be:

- a review of the recruitment, training and supervision of social workers to ensure that they received better child protection training
- improved safeguarding training for staff with a responsibility for the care of children.

### The Mid Staffordshire NHS Trust

In 2013, the Francis Inquiry reported on the failings in the standard of care at the Mid Staffordshire NHS Trust. Concerns were raised in 2007 by the then Healthcare Commission about the apparently high death rate at the Mid Staffordshire Hospital Trust. Its final report did not conclude that the higher number of deaths was caused by inadequate provision, but serious failings were identified in the quality of care provided. As a result of these concerns, a number of investigations, including the influential Francis Inquiry, led to reports of widespread failures in the quality of care within the Trust. These included:

- chronic staff shortages
- patients having inadequate access to food and water
- patients left in soiled bedding
- a culture where raising concerns about the quality of care was discouraged
- a failure in the management and leadership of the trust.

As a result of the Francis Inquiry, a further report by Camilla Cavendish was set up to investigate the quality of recruitment, training and support for non-registered staff in hospitals and other care settings. This included all staff who were not professionally trained doctors, nurses or other regulated and professionally trained health and care staff; that is, most care assistants and healthcare assistants. The Cavendish Review recommended that improved induction training should be in place for all healthcare assistants and support workers, and this was introduced in March 2015. Employers are required to ensure that all newly appointed support staff complete the Care Certificate, which covers fifteen units of study, including:

- understanding the role as a support worker
- a carer's duty of care
- equality and diversity
- communication
- privacy and dignity
- safeguarding
- health and safety
- infection prevention and control.

(Source: adapted from: http://www.nhsemployers.org/your-workforce/plan/education-and-training/care-certificate)

The Care Quality Commission (CQC) are responsible for ensuring that the Care Certificate is effectively delivered. Their guidance is that it should be completed within 12 weeks of a new entrant beginning their job.

**PAUSE POINT** Can you identify and describe how good health and care practice is promoted, and the quality of provision monitored?

**Hint** You should refer to the impact of policies and procedures, and of inspection.

**Extend** How have investigations into failures in provision led to improved policies and practice?

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## Assessment practice 2.3

Peter is nineteen. He has a range of health and care needs. He is grossly overweight, has high blood pressure and suffers from bronchitis. He was bullied at school and left with few qualifications. He has never worked. His self-esteem is low and he has recently been diagnosed with clinical depression.

1. Identify two of the health and care professional who may be involved in Peter's care.
2. Describe the key skills that the two professionals need to effectively support him in living an independent life.
3. Explain why a multi-disciplinary team is likely to be involved in Peter's care.
4. Discuss the importance of good communication between members of a multi-disciplinary team and the possible consequences of poor communication between professionals.

**Plan**

- First collect all your notes and handouts that relate to these questions.
- Divide them into sections according to the theme of the question.

**Do**

- Highlight the key points for quick reference.
- Make separate notes that directly answer the questions set. Extending bullet points may help.
- Learn your work. Write your answers without looking at your notes.
- Remember that for the final question you need to discuss different aspects of Peter's care and how they are linked together. Also to take into account different ideas and opinions.

**Review**

- Try to identify the strengths and weaknesses in your answers.
- Fill in any gaps that you identify.
- If you have time re-do the 'test' without looking at any of your notes.

### Further reading and resources


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## Websites

**www.gmc-uk.org**
The General Medical Council regulates doctors in the UK.

**www.nmc.org.uk**
The Nursing and Midwifery Council regulates nurses and midwives in the UK.

**www.hcpc-uk.co.uk**
The Health and Care Professions Council regulates health care workers.

**www.nice.org.uk**
National Institute for Health and Care Excellence (NICE) provides guidance and advice to improve health and social care.

**https://www.cqc.org.uk/**
The Care Quality Commission regulates health and social care in England.

**www.ccwales.org.uk**
The Care Council for Wales regulates social care in Wales.

**www.niscc.info**
The Northern Ireland Social Care Council (NISCC) registers social care workers in Northern Ireland.

**cssiw.org.uk**
Care and Social Services Inspectorate Wales (CSSIW) inspects social care and social services in Wales.

**www.estyn.gov.wales**
Estyn (The education Inspectorate Wales) inspects education and training standards in Wales.

**www.hiw.org.uk**
The Healthcare Inspectorate Wales inspects healthcare organisations in Wales.

**www.gov.uk/government/organisations/ofsted**
Ofsted regulates and inspects services for children and those providing education and training.

**www.gov.uk/government/organisations/public-health-england**
Public Health England works to protect and improve the health and wellbeing of the national population.

**www.publichealth.hscni.net**
The Public Health Agency for Northern Ireland works to protect and improve the health and wellbeing of the population in Northern Ireland.

**www.etini.gov.uk**
The Education and Training Inspectorate (Northern Ireland) inspects educational standards in Northern Ireland.

**www.rqia.org.uk**
The Regulation and Quality Improvement Authority regulates health and social care in Northern Ireland.

**www.mind.org.uk**
Mind is a charity that supports people suffering from mental health problems.

**www.mencap.org.uk**
MENCAP is a charity that supports people with learning disabilities.

**www.nspcc.org.uk**
The National Society for the Prevention of Cruelty to Children (NSPCC) is a charity that helps children who are at risk of abuse and neglect.

**www.ageuk.org.uk**
Age UK is a charity that helps and supports older people.

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# THINK FUTURE

**Leo Watkins**

Domiciliary Care Worker

I've been working as a domiciliary care worker for over two years. Most of my service users are older people, including Alf, whose wife has just died. I also support Mohammed, who has mild learning difficulties, and Julia, a single parent who has three children under the age of four and needs practical care support. So many of my friends are surprised that I do this work and even more surprised that I don't just do the cleaning. They don't realise the level of responsibility, particularly as I'm normally working on my own in the client's home.

I have to check that my service users are safe, that they are eating properly, that they are keeping well, both physically and emotionally, and that they are managing to carry out the normal routines of their daily life. My aim, and the aim of our service, is that they should be able to live independently in their own home for as long as possible.

Of course, our service users are individuals with their own needs, preferences and choices. Some are able to live more independently than others. We aim to work with the individual service user to ensure that they are safe and that their rights, including the right to choice, dignity and independence, are respected.

# Focusing your skills

## Respecting the rights of service users

It is important to ensure that the rights of service users are respected. Here are some tips to help you do this.

- It is essential that you know that your service users are safe. Consider the hazards and risks that Alf, Mohammed and Julia may encounter.
- How might you expect the specific care needs of Alf, Mohammed and Julia to differ?
- How can you be sure that you provide care consistent with your service users' culture, beliefs and preferences? What particular religious needs may Mohammed have?
- It is important that service users are empowered, that they take a full part in the discussions about their care. How can you be sure that your service users exercise their right to choice and their independence is promoted?

## Your safety and protection as a domiciliary care worker

- How can you be sure that you are safe as a lone worker in other people's homes?
- What is a code of practice? How will this help to ensure that you are safe?
- Are there professional organisations or trade unions that would protect your rights if necessary?
- If you are concerned about your safety at work, or travelling to work, what should you do?

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# Getting ready for assessment

This section has been written to help you to do your best when you take the assessment test. Read through it carefully and ask your tutor if there is anything that you are still not sure about.

## About the test

The assessment test will last 1 hour and 30 minutes and there are a maximum of 80 marks available. The test is in four sections. Each section will be based on a different short scenario briefly explaining the situation of a person with health and social care needs. Each scenario is relevant to a different service user group.

Each section of the paper will be structured with questions awarding 2, 4, 6 or 8 marks. These will require:

- short answers, worth either 2 or 4 marks, responding to the command words identify and describe respectively
- longer answers, worth 6 or 8 marks, responding to the command words explain and discuss.

Remember that all the questions are compulsory and you should attempt to answer each one.

## Sitting the test

Listen to, and read carefully, any instructions you are given. Lots of marks can be lost through not reading questions properly and misunderstanding what the question is asking.

The questions will contain command words. Understanding what these words mean will help you to understand what the question is asking you to do.

Arrive in good time so you are not in a panic.

| Command word | Definition – what it is asking you to do |
|---|---|
| **Analyse** | Identify several relevant facts of a topic, demonstrate how they are linked and then explain the importance of each, often in relation to the other facts. |
| **Assess** | Evaluate or estimate the nature, ability, or quality of something. |
| **Consider** | Think carefully about (something). The question will often require you to make a decision on the issue as part of your answer. |
| **Define** | State the meaning of something, using clear and relevant facts. |
| **Describe** | Give a full account of all the information, including all the relevant details of any features, of a topic. |
| **Discuss** | Write about the topic in detail, taking into account different ideas and opinions and how they relate to each other. You will examine how the opinions are similar or contrast with each other. |
| **Evaluate** | Bring all the relevant information you have on a topic together and make a judgement on it (for example on its success or importance). Your judgement should be clearly supported by the information you have gathered. |
| **Explain** | Write about the origins and functions or objectives of the subject, with examples and reasons to support an opinion, view or argument, where possible. |
| **Identify** | Name and briefly give the main features of something and its qualities. |
| **Justify** | Give reasons for the point your answer is making, so that your reader can tell what you are thinking. These reasons should clearly support the argument you are making. |

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Work out what question you need to answer and then organise your time, based on the marks available for each question. Set yourself a timetable for working through the test and then stick to it – don't spend ages on a short 1–2 mark question and then find you only have a few minutes for a longer 7–8 mark question.

If you are writing a longer answer, try and plan before you start writing. Have a clear idea of the point your answer is making, and make sure this comes across in everything you write, so it is all focused on answering the question.

Remember you can't lose marks for a wrong answer, but you can't gain any marks for a blank space!

Try answering all the simpler questions first then come back to the harder questions. This should give you more time for the harder questions.

## Sample answers

For some of the questions, you will be given some background information on which the questions are based. Look at the sample questions that follow, and our tips on how to answer these well.

### Answering short-answer questions

- ☐ Read the question carefully.
- ☐ Highlight or underline key words.
- ☐ Note the number of marks available.

Make sure you make the same number of statements as there are marks available. For example, a two-mark question needs two statements.

**Scenario:** Peter is 70 years of age. He has mild learning disabilities and now has mobility problems. He is using a wheelchair most of the time. It is thought that he needs twenty-four-hour care. Three weeks ago he moved into a residential care home for older people.

#### Worked example

**Question:** Identify **one** social care practitioner and **one** healthcare practitioner who may support Peter with his mobility problems. He is using a wheelchair. [2]

**Answer:** The healthcare practitioners could include (any one of) nurses, doctors, healthcare assistants, physiotherapists and occupational therapists.

The social care practitioners could include (any one of) social workers, care assistants in the residential home, social work assistants or support workers.

Look carefully at how the question is set out to see how many points need to be included in your answer.

This answer names the occupational roles of a range of health and care practitioners and that is what you are asked for. You do not need to explain how they would contribute to care for this 2-mark question.

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## Worked example

**Question:** Describe **two** responsibilities of care assistants who work in residential homes for older people. [4]

**Answer:** The responsibilities could include any of the activities that are part of the care assistant's routine duties, for example:

- Helping residents to eat and drink – care assistants provide support at all meal times and when residents are having a snack or a cup of tea to ensure that residents can enjoy a nutritious diet and the social aspect of meal times. Most residents will be able to feed themselves but others will need some help. The care assistant may suggest special cutlery or adapted plates and cups to support the resident's independence.
- Helping residents to maintain and improve their mobility – care assistants encourage and support residents in taking exercise to keep supple and to maintain mobility. They may suggest mobility equipment, walking sticks or walking frames to support mobility and independence.
- Enabling residents to maintain their personal hygiene – care assistants support residents with washing, showering, bathing, hair washing, shaving and general personal cleanliness and hygiene. Most residents will be able to do some of these tasks. The care assistant provides support, as necessary, but always tries to maintain the resident's independence. They may suggest specially designed clothes, dresses without buttons or zips, for example.
- Enabling residents to use the toilet facilities – care assistants monitor the continence of residents and provide support when people are not able to use toilet facilities in the way they used to. Care assistants should provide support and minimise the resident's embarrassment. For example, they may suggest the use of continence pads.
- Promoting communication with residents and supporting their communication with each other – care assistants support clients in maintaining their social skills, which includes good communication. They may arrange social activities for the residents, support them in making meal times a social occasion, and encourage them to communicate with visitors.

These answers are by way of illustration. You should be able to suggest other responsibilities of care assistants in residential settings. They give brief descriptions of the responsibilities of care assistants. You do not need to give any more detail for a 4-mark question of this sort. There will be 2 marks for each of the responsibilities that you describe.

## Worked example

### Answering extended-answer questions

*Question: Explain how the physiotherapists who support Peter are monitored by the Health and Care Professions Council (HCPC) to ensure that they maintain high professional standards in their care practice. (6)*

**Answer:**

The Heath and Care Professions Council (HCPC) was set up in 2003, with the aim of promoting high standards of practice in a range of health and care professions throughout the United Kingdom. It monitors practice for some 16 professions including physiotherapists, social workers, speech therapists and occupational therapists. The HCPC also exists to protect the public, throughout

For a question using the word 'explain', you must do more than just describe. You must show that you understand the functions and purposes of the organisation. You must show that you understand the origins of the subject or organisation and why it is important. You need to show that you understand its suitability for purpose and give reasons to support your opinion, view or argument.

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the United Kingdom, from poor standards of care. Members of these professions must register with the HCPC. They cannot practice in the UK unless they are members of the HCPC.

In order to register with the HCPC, all physiotherapists must have achieved the approved qualifications, must complete ongoing training after they have qualified, and they must meet the standards of professional practice required by the HCPC. If Peter or any member of the public feels that a professional physiotherapist is not meeting the standards set, they have a right to complain. The council will investigate and take the appropriate action. In cases of serious misconduct, this can include suspension or permanent removal from the register.

The HCPC is not very well-known by the public and a service user with learning disabilities, like Peter, may find it very difficult to make a formal complaint. Peter would need support if he really was going to follow the complaints procedure.

This answer describes the origins of the HCPC and its main purpose. It describes why the HCPC is important and its role in maintaining high standards within physiotherapy. Some of the ways of maintaining these standards are shown. Reasons why it may be difficult for members of the public to lodge complaints is considered. The answer clearly explains how the HCPC can be important in protecting service users such as Peter. You may write more than one paragraph.

## Worked example

*Question: Discuss the effectiveness of using an advocate to ensure that Peter has the care he needs from the care practitioners who support him.* *(8)*

**Answer:**

An advocate is a person who represents a service user and speaks for them. They will try to ensure that the professionals and other people who support Peter understand his wishes and his needs. People with learning disabilities often have difficulties in communicating with officials, writing letters and filling in forms. The best and most effective advocates will get to know their client very well and build a trusting relationship with their client so that they can accurately convey their needs, wishes and preferences to the professional workers, and to official organisations. If this works well, it is an excellent provision and ensures that, despite his mild learning difficulty, Peter's needs and wishes can be clearly explained. However, most advocates are volunteers and not everyone who needs advocacy can get that support. It just depends on the number of volunteers. Advocates do not need to have formal qualifications. The training of advocates varies and so the quality of the support is not very reliable. There is no professional organisation to monitor the quality of their work.

The advocate, therefore, is a very important and helpful service. However, advocates are not usually paid and so it is difficult to ensure that there are enough advocates and that the quality of service is consistent.

For a question using the word 'discuss', you must do more than just explain. You might need to talk about the issues or the advantages and disadvantages of an approach, and take in different opinions.

This answer explains what an advocate is and describes their role in representing the wishes and needs of service users.

The learner discusses both the value of good advocacy in helping people communicate effectively with professionals and formal organisations and also explores the limitation, such as the scarcity of provision that may leave some service users vulnerable. For a higher mark, the learner could explain how important this can be in empowering service users.

The learner will usually write a longer section here, perhaps even multiple paragraphs. However, the important thing is that they look at different aspects of the topic, take in different opinions and look at the advantages and disadvantages.

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