Framework Training

Framework Training

Welcome to Care In Hands Framework Training Section for

* Senior Field Supervisors
* Field Supervisors
* Call Monitors

This programme is designed to provide you with all the tools and information you will need to be successful in your roles.

The programme has been divided into sections to enable you to easily navigate around the information required

* Section 1 - Understanding Care in Hand and you Role within it
* Section 2 - Effective Communication and Partnership working
* Section 3 - Care Planning
* Section 4 - Safeguarding
* Section 5 - Challenging Behaviour
* Section 6 - Health & Safety
* Section 7 - Supervision and Staff development
* Section  8 - Personal development and Lifelong Learning
* Section 9 - Quality Assurance

[**Enter Framework Training**](https://www.careinhand.co.uk/en/framework-training1/understanding-care-hand-and-your-role-within-it/)**>>**

## (Page appending approval) **Understanding Care in Hand and your Role within it**

Some of the sections within this training are the same for all job roles. Some sections we have broken down into specific information. As you go through this training you will be required to click on your role type to see the information relevant to you.

### **Expectations:**

Our expectation is that all employees work to the same standards following the provided and outlined guidance within your training and within the scope of your role.

Firstly we would like you all to understand Care in Hands ethos, objectives and our purpose as an organisation. This can be found in our Statement of Purpose.

As an organisation we are required to be registered to operate with [Care Inspectorate Wales](https://careinspectorate.wales/). This organisation regulate what we do, and we are inspected by them on a regular bases. CIW publish a report about Care in Hand each year, which can be found on their website.

In addition to this CIW review our policies and procedures against [The Regulated Services (Service Providers and Responsible Individuals (Wales) Regulations 2017](http://www.legislation.gov.uk/wsi/2017/1264/pdfs/wsi_20171264_mi.pdf) and [Statutory Guidance for Service Providers](https://gov.wales/sites/default/files/publications/2019-04/guidance/4/providers/and/responsible/individuals.pdf) and responsible individuals of care home and domiciliary support services.

We are also required to employ a registered workforce. The regulator for registration of the workforce is Social Care Wales.

Care workers are responsible for the upkeep of their own registration and will have a log in portal in the Social Care Wales website.

As part of this registration all staff are required to work in accordance to:

[Code of Professional Practice for Social Care Workers](https://www.careinhand.co.uk/index.php/download_file/view/914/582/)

[Domiciliary Care Worker Practice Guidance](https://www.careinhand.co.uk/index.php/download_file/view/823/582/)

[Professional Duty of Candour](https://www.careinhand.co.uk/index.php/download_file/view/913/582/)

## **Our Organisational Structure**

The Teams at Care in Hand are divided into 4 distinct groups.

**Strategic Management Team & Responsible Individuals for Care in Hand**

This team provides vision, direction and leadership within Care in Hand. They set strategic objectives, operational policy, financial viability, organisation stability, legal compliance, staffing structure and management.

They work in partnership with external governing bodies, monitor and respond to internal development and external policy agendas, reports, research and facilitate change.

**Operational Management Team**

Our operational management team implement operational policy and business planning. The team implements legal compliance, contract requirements, costings, tendering, financial management, workforce training strategies, IT development and respond to internal and external changes, development and decision making.

**Care Management Team**

This team implements the day to day operational procedures, working directly with people who need care and ensure service delivery. They ensure legal compliance is implemented and best practice is achieved daily. They support a workforce, identify training needs and work in partnership with district nurses, physiotherapists, and OT and hospital discharge coordinators. This team works closely with family carers. The team is result focused contributing to informing the direction of the organisation and manage change within their teams. The team is responsible for scheduling care provision and covering out of hours requirements.   

**This team is made up of:**

**C**are Managers/ Senior Field Supervisors

Field Supervisors

Business Support Officers

Induction Coordinators

Field Practice Coordinators

M&H Competency Assessors

**Call Monitoring Team**

Our Call monitoring team monitor our provision of service delivery each day using our Call monitoring system.  Their role consists of ensuring that all visits are attended within acceptable timescales. They support front line care staff during their working hours. This team provide guidance where necessary and escalate any concerns to senior filed supervisors and support staff during each shift. They are responsible for completing a handover at the end of each shift to the Operational Care Management Team in regards to the performance of that shift. They are the front line communicators with our service users in regards to their care provision and carers.

**Please Visit Our Teams Page**

Our Organisational Structure is an important Part of how we operate and oversee the day to day service provision

Our webpage has information on who's who. Please review this as part of your induction.

Your Role will be outlined within your Job Description. A job description tells you what your main duties and responsibilities are and who you have to report to.

**Call Monitor Job Description**

**Field Supervisor Job Description**

**Senior Field Supervisor/ Care Manager Job Description**

We are very committed to working as one Team. Team building training is available as part of your Induction but not mandatory at this point. Please ask the training department for log in details if you wish to undertake this training at this point.

**Duty of Care**

You have a duty of care to all those receiving care and support in your workplace. This means promoting wellbeing and making sure that people are kept safe from harm, abuse and injury.

Duty of care is a legal requirement; you cannot choose whether to accept it. It applies as soon as someone has care or treatment. Breaking this duty, for example through negligence, could result in legal action.

Wellbeing could be defined as the positive way in which a person feels and thinks of themselves.

The **Code of Professional Practice** tells you how you are expected to behave as a care worker

Your duty of care is also to other workers, for example, hospital employees, to General Practitioners, District nurses, Occupational Therapists and fellow support workers.

As Home care workers and supervisors you will probably work alone in a variety of people’s homes, but there may well be other people in the premises, as well as whoever you are there to support. Your duty of care is to each individual and to the other workers you come into contact with in the community.

As part of your duty of care you should pass on any concerns you have about wellbeing. In this first instance to the Senior Member of staff on duty.

Care in Hand operates an **Escalating Concerns Procedure** and any concerns can be reported to operations@careinhand.co.uk or alternatively through our Whistleblowing Procedures.

Concerns could be about anything from poor working conditions or equipment to untrained workers, as well as suspected abuse. In any situation, if you do not know what you should do, ask your senior on shift.

**Advocate**

An advocate is a trusted, independent person who can speak and act for the individual. They can advise on matters such as welfare benefits and can ensure that the individual’s point of view is heard in care & support planning meetings, to make sure that decisions are made in the interests of the individual. The importance of advocates and advocacy services is emphasised by the Care Act 2014.

[Pembrokeshire Advocacy Services](https://www.pembrokeshire.gov.uk/help-in-making-decisions/advocacy)

**Supporting Independence & Wellbeing**

The code of conduct requires that you work in ways that respect and protect the individuals rights, including their right to live as independently as possible, to make their own choices and take risks.

There may be times when they make choices that you think are unwise, unsafe or that you disagree with. In this event you should make sure that the service user has as much information as possible about their choice and what could happen. If they still choose to make a risky choice by completing a risk assessment it may identify further ways that risk reduction can be achieved and the service user can be supported to make those decisions.

However the right to make decisions that a service user is legally capable of making must not be taken away from them by social care staff.

**Complaints & Compliments**

You are also required to ensure that the people you care for have the legal right to make a complaint about their care and support. It is important that you accommodate this is a quick, open and positive way.

Complaints should be taken seriously and explored so that any learning can be used to keep doing the right things to make improvements.

Positive comments are equally as important, as positive ways of working can show good ways of working making a positive difference.

Further Guidance on [Our Complaints Policy and Procedure](https://www.careinhand.co.uk/en/framework-training1/effective-communication-partnership-working/complaints-compliments/)

**Professional Boundaries & Positive Relationships**

You will need to work in partnership with the individuals you support and their families and carers in your role. Part of a successful working relationship is maintaining professional boundaries whilst developing a caring relationship.

[Care in Hand's Professional Boundaries Policy](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset)

[Social Care Wales - Professional Boundaries - A Guide for Managers](https://socialcare.wales/cms_assets/file-uploads/Professional-boundaries-A-resource-for-managers.pdf)

**Information Technology**

Update coming soon

# Effective Communication and Partnership Working

Good communication develops your knowledge and understanding about individuals and the part played by other workers so that the best care and support possible can be provided.

It helps build working relationships where each person’s views are valued and taken into account.

**Communication** is an essential part of a caring relationship and helps to encourage trusting relationships with other workers, families, as well as the individuals you care for.

## **Types of communication**

Talking is often seen as the most common method or type of communication but most communication is silent.

**Gestures, tone of voice, grins, grimaces, shrugs, nods, moving away or closer, crossing arms and legs** all tell us far more than words.

Learning to take account of these reactions is all part of developing your communication skills to achieve the best outcomes for individuals.

Communication can be harder when we can’t see these signs such as when we use the phone, texts or email.

Different people have different ways of communicating that work best for them. Some of the different types of communication are:

**Verbal communication** - Differences in how you speak, including the tone, pitch, speed and volume of your voice could change how your messages are taken in. Try to avoid using jargon or abbreviations and complicated words and terminology. Make sure you always speak in a respectful way, adjusting your speech to suit the individual.

**Sign language** - This is a recognised language throughout the world. British Sign Language (BSL) is used by individuals in this country and there are variations of sign language in different regions.

**Makaton** - This is a form of language that uses a large collection of signs and symbols. It is often used with those who have learning and physical disabilities, or hearing impairment.

**Braille** - Is a code of raised dots that are ‘read’ using touch. For people who are visually impaired or who are blind, the system supports reading and writing.

**Body language** – This is a type of nonverbal communication. There are many different aspects of body language, including gestures, facial expressions, eye contact, body positioning and body movements. Each of these will communicate information about an individual or a worker often without them realising it.

**Gestures** – These are hand or arm movements that emphasise what is being said or used as an alternative to speaking.

* Facial expressions – These support what is being said by showing reactions or feelings. They can give you valuable clues that you can use to check out a person’s feelings.
* Eye contact - Maintaining good eye contact is an important way for a worker to show that they are engaged and listening.
* Position - The way that we stand, sit or hold our arms when we are talking will provide others with clues about our feelings, attitude and emotions.

**Written communication** - This method is used to send messages, keep records, or provide evidence.

## **Communication with other Individuals**

Workers will develop many different relationships. Some will be formal and others more informal.

Successful two-way communication is crucial in both cases.

A relationship based on trust and understanding from the beginning will provide the basis for good care and support whether short or long-term.

Poor communication can quickly lead to confusion and distress. The process of exchanging information through communication is not always straightforward. If the information shared is inaccurate or misleading, mistakes can be made which can result in poor care.

**Formal communication** is likely to be used in the working environment, particularly between you and other workers.

**Informal communication** is likely to be used with friends and family, using familiar words or slang. You should always use the communication method that is appropriate for the person and situation

You should watch for clues from any individual that come from unspoken messages.

These non-verbal ways of communicating come from **body language, position, facial expressions** or **gestures**.

For example, when asking someone if they are in pain, they may say ‘no’ but a wrinkled brow, uncomfortable facial expression or body movement may say otherwise.

As an observant worker you will be able to notice when an individual is becoming confused, angry, upset, stressed or anxious without them telling you.

You can then take action to help stop this from happening or help them express their feelings in the best way for them.

By noticing an individual’s reactions you can ask yourself the following questions:

* Do I need to change the type of communication I am using to help the individual understand?
* Do I need to be aware of how the conversation is affecting them?
* Is there something that the individual is not communicating to me that may help?

Recognising the unspoken messages can help you to ask good questions and develop supportive relationships. It improves trust as the individual can see that you are interested in them and trying to understand and meet their needs.

## **Communication and language needs, wishes and preferences**

To find out what an individual needs or wants, so your work can be centred on them as a person, you have to connect with them.

So that means that you must understand their communication needs right from the outset.

People’s unique communication needs vary depending on their ability, disability, illness or condition, as well as on their personal preferences.

If you can’t find out from talking and listening how a person needs to communicate, you will need to use other methods of communication to help them get information across to you in a way that works best for them.

The individual’s family, friends or carer might be able to share experience of which communication methods work best—but sometimes part of the problem is that they don’t communicate well with the person being supported, so don’t rely on this method alone.

## **Communicating by Touch or Physical Contact**

The individual’s preferences are particularly important in relation to using touch as part of non-verbal communication.

Touching a person might be done as a form of communication, for example shaking hands or kissing. But other types of touch will almost certainly also communicate something to them, for example what they experience from the ways that they are physically helped to stand or sit or turn over in bed, and particularly their experience of being touched in the course of intimate personal care such as washing.

In all cases, how you touch anyone must be decided **thoughtfully** and in a **person-centred way.**

So your use of touch may well be different from one person to the next, and will be something that you will need to talk about with each person whom you are helping so that you know their particular**preferences.**

This is also a key area to talk about with your manager and work colleagues, especially if you are supporting anyone who cannot clearly communicate their own preferences to you.

On the whole, any form of touch must be**consented** to by both people. But sometimes it may be necessary to touch someone when they do not want to be touched, for example if they need to be physically restrained for their own or someone else’s safety.

You must talk with your manager about what are the agreed ways of working in your workplace so you know what to do if this happens.

Remember too that the use of touch must be within the rules for infection control in your workplace.

## **Some specialist methods of communication**

**Touch** is used in particular ways to communicate with people who are deaf and visually impaired. Workers sign information onto the individual’s hands as a way of passing on information.

For those whose communication skills may be limited, technological aids can be used.

**Hearing aids, hearing loops, text phones, text messaging on mobile phones and magnifiers** are all forms of technological communication devices.

Some individuals may use **word or symbol boards** to support their speech and/or their understanding. This helps the listener by to associating a picture or printed word with the verbal communication in order to be able to understand what is being said.

Others may use**speech synthesisers**, which replace speech either by producing a visual display of written text or by producing synthesised speech that expresses the information verbally.

**Voice recognition software** can be purchased for computers (including many tablet ‘pad’ computers with touch screens) to translate speech to written text or the other way around. Some word-processing programs and apps have this already built in.

When using communication aids always check that they function properly, that they are clean and in good working order. Should you have any worries about communication aids or technology not working properly, or being unclean, report this to a senior member of staff or the individual’s carer or family member.

## **Barriers to effective communication**

A barrier is anything that will get in the way of communication.

There are a wide range of barriers including:

**Attitude** – When a worker is abrupt due to time limits, not having enough resources or their mood, the person they are speaking to may feel intimidated or frustrated and not want to communicate.

**Limited use of technology** – When the technological aids known to be the best way for someone to communicate are not available.

**Body positioning** – Sitting too close could be intimidating and would make an individual feel uncomfortable. Sitting too far away could show lack of interest or concern.

**Emotions** – When someone is depressed, angry, embarrassed or upset their emotions may affect their ability to think and communicate in a sensible way.

**Physical** – When someone has physical conditions that create communication difficulties, for example, being breathless, not having any teeth or being in pain.

**Not enough time** – Not giving individuals time to say what they want may make them feel rushed and reluctant to express their true wishes.

**Poor or negative body language** – Crossed arms or legs, poor facial expressions, poor body positioning, constant fidgeting or looking at a watch or mobile phone can all make someone less likely to communicate.

**Lack of privacy** – Think carefully about where and when private and confidential conversations should take place.

**Stereotyping** – Generalisations about a group of people that are wrong and misleading. An example would be that ‘all older people are hard of hearing’.

Other barriers include **sensory impairments, culture, language, noise, lighting or substance misuse.**

## **Reducing barriers to communication**

As a worker you should do what you can to reduce any barriers to communication.

The most effective way to make sure that you are meeting someone’s communication needs and providing person-centred care is to know as much as possible as you can about them.

A person's assessment documentation provides vital information about their needs, wishes and preferences. This pulls together the information into a format that is easy to read.

Putting something like this together with an individual can be another good way of getting to know them well and understanding their needs.

If a person as very specialised communication techniques you can refer to the Complex Care Board (complexcare@careinhand.co.uk) for further advice.

It is important to get regular feedback about your communication style and methods from the people you provide care and support to so that you can continue to improve how you communicate.

You could also increase your awareness of different communication needs and methods through taking up learning opportunities.

Experience will help you to develop a variety of new methods of communication and selecting the best one in each situation.

Be creative.

Open body language and a positive, non-judgemental attitude will further help reduce barriers.

Your communication skills should be seen as a toolbox, using the right tool for the right job and choosing a different tool if one doesn’t work well.

## **Checking understanding**

Checking that communication has been understood is an essential part of the process.

A vital skill that checks understanding is **summarising.**

**Summarise**This means to think about the main points of the conversation or communication and shorten or simplify them in order to repeat them back to the individual. This will help to check your and their understanding.

Questions are another way of checking whether a message has been received.

Make sure you ask questions in a way that the individual has to provide a detailed response (open questions), rather than asking questions which require only a ‘yes’ or ‘no’ reply (closed questions).

For example: ‘What do you like to do in your spare time?’ However, closed questions can be useful in some situations.

## **Additional information and support**

Information and support on particular communications needs can be found from specialist charities and associations, especially those specialising in particular disabilities or medical conditions.

Websites can provide material on forums, services or groups in the local area that you could attend or use to find out more.

In addition, some local charities offer specific human aids such as befrienders, advocates or mentors. In Pembrokeshire we have the community connector’s team and a referral can be made to them by completing the referral form and emailing it to communityconnectors@pavs.org.uk

A befriender could support an individual in overcoming emotional difficulties that are a barrier to their communication.

An advocate could communicate on an individual’s behalf if their skills are very limited. A number of additional key experts available to support individuals with their communication needs include**speech and language therapists, interpreters, translators, and clinical psychologists or counsellors**.

Further learning can come from other workers, your manager and a wide range of courses and qualifications.

## **Confidentiality**

Confidentiality is an essential principle in health and social care and forms the basis of all ways of working and codes of practice.

The basis of a good working relationship is **trust**.

This is dependent on the individual being confident that personal information about them is treated confidentially.

Information about someone must only be shared with others involved in their care and support on a **‘need-to-know’ basis**.

Any information should not usually be disclosed without the person’s informed **consent.**

The circumstances when information must be shared even if the individual does not give consent are listed later in this section.

An individual’s right to confidentiality also means that a person’s notes or details must always be stored securely, for example in a locked cupboard, and not be left where they can be seen by unauthorised people.

Computers or mobile devices such as electronic tablets need to be protected by a password and firewall.

When talking about an individual you must ensure no others can overhear you.

It is essential that you obey the laws about confidentiality, particularly:

**General Data Protection Regulation 2016** – which place obligations on organisations to process personal data securely. This includes protecting people’s privacy, giving individuals the right to consent to data collection and the right to have data removed.

**Human Rights Act 1998** – This Act determines a number of basic rights for any citizen of the UK. The important one in this context is the right to respect for private and family life, home and correspondence. www.legislation.gov.uk/ukpga/1998/42/contents

Please read Care in Hand's policy on GDPR and information sharing:

## **Limits to confidentiality**

Whenever possible, individuals should provide their consent for the transfer of information.

However, this may not always be possible and there will be occasions when information normally considered confidential needs to be shared.

Examples of occasions when confidentiality may have to be broken are:

* **a person is likely to harm themselves**
* **a person has been, or is likely to be, involved in a serious crime**
* **a person is likely to harm others**
* **your safety is placed at risk**
* **A child or vulnerable adult has suffered, or is at risk of suffering, significant harm.**

There will be times when you face dilemmas about confidentiality, not knowing what to do or if you should speak to anyone about the information you have.

At these times it is important to speak with your manager and follow the agreed ways of working. If your manager is not available, a senior member of staff be able to help.

## **Communication in summary**

Communication may take place**face-to-face**, by**telephone** or **text**, by **email, internet** or**social networks**, by **written reports** or **letters**.

It requires you to**listen** or**read** (and understand) as well as to **speak** or **write**.

Whether you are communicating face-to-face, on the telephone or in written form, always be **respectful,** try to match your method of communication to the individual’s needs and be aware of **confidentiality**.

**Reporting Procedures**

Every role in Care in Hand has a duty to report their daily observations and work completed. There is many aspects to reporting.

Firstly in order to be able to report you need to understand how to report effectively.

**Escalating concerns (default page)**

**Senior field supervisor (page pending approval)**

**Service Withdrawal**

**Field supervisor (default page)**

**Call monitors (Default page)**

**Complaints and compliments (default page)**

**Default page (see below)**

## **Heading**

*Care in Hand’s Live-in service affords people of every age, living anywhere across Wales the chance to access 24/7, quality care from highly qualified care professionals - all within the comfort and privacy of their own home.*

*For some, the service offers a critical life-line to those suffering from long-term conditions or acute disabilities. For others, it is an appealing alternative to traditional residential or nursing home care, allowing couples or companions the chance to live together. In other cases, it provides much needed relief and short-term support in the form of respite care.*

*Whilst Live-in Care allows for familiarity and comfort as a form of care provided within the home, we believe the continuity of Carers, many of whom work with a single or small group of clients, brings further comfort through a sense of routine and companionship.*

*Whatever the requirement - from simple day-to-day****tasks****to specific means of support such as****complex care****(including high-dependency) or****respite care****(including hospital discharge) - you can rely on Care in Hand.*

Complex care board (default page)

Meeting & information sharing within care in hand (page pending approval)

GDPR

Welsh Language

Field Supervisor Forum

Ops Meeting

Staff Meetings - CM Team, Care Teams, FS Forum

SFS/ / Area Manager Meetings

Complex Care Meetings

Record keeping (Default page)

# ****Care Planning****

Care planning forms a large part of the role of the field supervisor and senior field supervisor.

A care plan is required document that sets out in detail the way daily care and support must be provided for an individual. Care plans may also be known as ‘plans of support’, ‘individual plans’, etc by other agencies, such as different local authorities or by CIW.

The role of the call monitor within care planning is to escalate any concerns from the care staff to the field supervisor and senior field supervisor or MDT to ensure that adequate reviews are taken in a timely manner if the care plan is not working to the best interests of the service user.

## **Regulations**

We are regulated by Care inspectorate Wales in terms of how we complete our care assessments and care plans.

There are a number of regulations that feed into care planning and assessments as this is the essence of what the care staff do on a daily basis.

Further guidance on these regulations will be discussed throughout this section but can also be found on the [statutory guidance](https://gov.wales/sites/default/files/publications/2019-04/guidance-for-providers-and-responsible-individuals.pdf)

Section 1.3 Requirements on service providers as to the steps to be taken on commencement of the provision of care and support (Part 5)

* Regulation 15 - Personal Plans
* Regulation 16 Review of the Personal Plans
* Regulation 17 Records of Personal Plans
* Regulations 18 Provider Assessment

Section 1.4 Requirements on service providers as to the information to be provided to individuals on commencement of the provision of care and support (Part 6)

* Regulation 19 - Information about the Service
* Regulation 20 - Service Agreement
* Regulation 21 Standards of Care and Support (Overarching Requirements)

Our Care and Support Plans policy along with additional policies sets out how we at Care in Hand put these regulations into practice for our service users and staff.

## **Values in Care**

Whether or not we are aware of it, we all live our everyday lives by a set of values that shape how we think and react.

Values are beliefs and ideas about how people should behave which have been formed by our childhoods, families, backgrounds, cultures, religions, educations and relationships.

Whilst we each have our own values there are values which are important for working in health and social care.

Six values are now recognised as applying to health and social care workers.

* **Care**: having someone’s best interests at heart and doing what you can to maintain or improve their wellbeing.
* **Compassion:** being able to feel for someone, to understand them and their situation.
* **Competence:** to understand what someone needs and have the knowledge and skills to provide it.
* **Communication:** to listen carefully but also be able to speak and act in a way that the person can understand.
* **Courage:** not to have fear to try out new things or to say if you are concerned about anything.
* **Commitment:** dedication to providing care and support but also understanding the responsibility you have as a worker.

Another way of looking at this, is that each individual must be placed at the centre of their care and support.

It must fit the individual, rather than the individual being made to fit existing routines or ways of doing things.

This is known as **person-centred working**. Person-centred values tell you how to work in a person-centred way.

In health and social care person-centred values include:

* **Individuality:** Each person has their own identity, needs, wishes, choices, beliefs and values. ‘One size fits all’ does not work when it comes to providing care and support.
* **Rights:**   The Human Rights Act 1998 is the main legislation that sets out the rights of people in the UK. You have the right to speak your mind and be kept safe from harm, as well as the right to respect, dignity and equality. You should make sure an individual’s rights are respected, not only by yourself but by other people involved in their care.
* **Choice:**   Each individual should be supported to make choices about their care and support. They should be given information in a way that they can understand so they can make informed choices. When working with individuals who cannot express their wants, needs and wishes in words, you must find other ways of communicating.
* **Independence:**  Promoting an individual’s independence means to look at what they can do for themselves and empowering them to do as much as possible for themselves. It does not mean leaving someone to cope alone but agreeing the support they need and want.
* **Privacy**: Everyone has a right to private space and time when they need it. Privacy affects how and where care and support is given, especially when it involves personal hygiene or intimate procedures. Privacy includes not talking to anyone about the individual’s private information unless they give permission and it is on a need-to-know basis to improve their care and support
* **Dignity:** Treating somebody in a dignified way means to treat someone with respect, valuing their individuality and their ethical and moral beliefs. In order to provide dignified care you need to have an open and positive attitude. Take time to do things their way, don’t make assumptions about how they want to be treated and be aware of how personal care may affect their dignity.
* **Respect:** Respecting someone means believing and showing that they have importance as an individual. It means that they have their own opinions and feelings and that even though you may not agree with them, you do respect them.
* **Partnership:**  You work in partnership when you involve the individual and their family and work alongside other workers. The key to a successful partnership is good communication and trust; valuing and respecting what others have to say.

## **Working in a way that promotes person-centred values**

Working in a person centred way means working in partnership with the individual to plan for their care and support.

The individual is at the centre of the care planning process and is in control of all choices and decisions made about their lives.

The values of compassion, dignity and respect are essential when involving people in their own care. Decisions should be shared decisions, with the individual seen as an equal partner in their care.

People should be involved in the design and delivery of the services they are accessing.

Person centred planning is about discovering and acting upon what is important to the individual and what matters most to them in their lives.

The key features of person centred planning are:

* The belief that the individual is best placed to decide what care and support they need and can plan for themselves. By working with the individual to identify their strengths and abilities they can make their own decisions. For example, an individual may want to make their own decision about which mobility aids to use to walk short distances based on their ability, rather than use a wheelchair.
* The care plan, or care and support plan, is owned by the individual and is written in the first person, where possible. For example ‘I would like to try a walking frame when I am moving around the house moving short distances outside rather than using my wheelchair’.
* The individual has as much control as possible over the choices they make.   For example, the individual is supported to try to use the walking frame.
* The care plan, or care and support plan, is ‘needs’ led not ‘service’ led. This means that support is designed to meet the unique needs of the individual to make their life better, and not to fit them into the needs of the service or staff.

## **Promoting dignity**

Focusing on the value of every individual, respecting their views, choices and decisions, not making assumptions about how they want to be treated and working with compassion and person-centred values means you are promoting their dignity.

Our Privacy and Dignity Policy sets out the guidance for staff on privacy and dignity within Care in Hand.

## **The importance of finding out the history, preferences, wishes and needs of the individual**

To provide care and support that respects the individual’s wishes, needs and preferences, you will need to find out what you can about them.

This will vary depending on the person and how much they are willing to participate, if the service user is funded by social services then you may already receive an integrated assessment from the social worker which will provide you with this information.

Taking time to find out about their personal history by talking with them or reading any information you have will give you a deeper insight into their likes and dislikes.

This will help the care plan to be put together with them.

## **The changing needs of the individual**

Care plans or service delivery plans are an important source of information as they are dynamic records that are constantly reviewed and updated in response to changing needs and preferences.

A review will look with the individual at what is working, what doesn’t work and what might need to change. For example, if an individual is unable to eat certain foods due to a new type of medication they are taking, their diet will need to change but still reflect the things they would like to eat.

Care plans are also legal documents which might be needed as evidence if an individual makes a complaint.

Properly maintained care plans mean that workers changing runs or returning from holidays, will always have up-to-date information about the individual, enabling them to provide the best possible person-centred care.

It will also enable them to know how to provide care and support for individuals new to them.

All care plans are stored in the client files in the care drive, along with a hard copy in the blue office files that are kept in the locked filing cabinet in the offices, this is due to GDPR, and a copy in the home file for the care staff and the service user.

As a call monitor if you feel that an individual’s care plan needs to be changed, talk to the field supervisor or senior field supervisor.

## **Supporting individuals to plan for their future wellbeing and fulfilment, including end-of-life care**

The person-centred approach uses the idea that everyone has an inner wish to fulfil their personal potential.

In a safe, non-judgemental and compassionate place the individual can think about what is important to them and make the best decisions.

It is important that individuals are supported to plan for their future wellbeing and fulfilment so that their quality of life is improved, even if they are only in short-term care.

Under the social services and wellbeing act there is a bigger emphasis on outcomes and wellbeing for service users. The means that service users are all entitled to be working towards or maintaining their wellbeing goals that are personal to them. These fall under 8 categories.

* Having Control over Daily Living
* Maintaining Physical, Mental and Emotional Wellbeing
* Protection from Neglect
* Participating in Education, Training and Recreation
* Maintaining Personal, Professional, and domestic relationships
* Having Contribution to society
* Maintaining Social and Economic wellbeing
* Having a good Suitability of living accommodation.

Individuals should be encouraged to express themselves and to change their mind about aspects of their when they want to.

It is important to take time to talk about their needs, what they want and also what they don’t want.

This is especially true for end-of-life-care where a person might not be able to voice their wishes as they could before. You will then need to use different ways of communicating. This may also involve working with an advocate who is able to express the individual’s wishes on their behalf if they are unable to communicate the information themselves. Ideally the individual will have planned ahead and expressed what they would like to happen within their care if they cannot decide for themselves anymore. This is called advance care planning (ACP) and is backed by the Mental Capacity Act 2005.

 Outcome focused approach

# ****What are personal outcomes?****

Personal outcomes describe what a person wants to achieve. These are realistic goals that the person receiving care and support, and their care worker or carer can work towards. They are usually based around supporting the individual’s wellbeing.

Outcomes will vary from person to person and child to child because they’re about what matters to that individual.

### **Some examples of personal outcomes are:**

* “I want to get to school on time like the other kids and have a clean uniform”
* “To be able to go back home, build my confidence and live on my own like I did before”
* “I want to see my brother, speak to him and spend time with him and not lose touch now we don’t live together”
* “I want to go to swimming classes, but I need to know my husband will be okay and that someone will be there for him when I’m not.”

### **Personal outcomes should be:**

* driven by the person’s aspirations – they are unique to the person and their life
* Realistic – it can’t be the same as it was, so how can I adapt, manage, remain hopeful and feel in control?
* Achievable – what strengths have I got to deal with the future? What resources do I have within myself, my family, friends and community?
* meaningful – addressing the person’s real concerns and dilemmas
* Evolving and changing – accepting that nothing stays the same.

### **Personal outcomes are not services or resources.**

Some example of services and resources are:

* A person might attend a parenting group
* have a walk-in shower fitted
* receive a home care service

These are the things the person does or is provided with (the inputs) to help the person to achieve their outcomes, but they are not an outcome in themselves.

Try this exercise to see if you can identify the personal outcome statements.

[Personal Outcomes statements](https://socialcare.wales/cms_assets/file-uploads/Personal-outcomes-statements3.pdf)

This booklet gives a summary of how to use personal outcomes:

[Personal Outcomes Booklet](https://socialcare.wales/cms_assets/file-uploads/Personal-outcomes-booklet-ENG-PRINT.pdf)

Social Care Wales have also provided some videos that may help you understand an outcome focused approach more:

[Introduction to an outcomes focused approach with Rhoda Emlyn-Jones](https://socialcare.wales/resources/introduction-to-an-outcomes-focused-approach)

[What do we mean by personal outcomes?](https://socialcare.wales/resources/what-do-we-mean-by-personal-outcomes)

The Following presentation from SCW will also assist you to understand more about the outcomes focused approach

[Understanding Outcomes](https://www.careinhand.co.uk/index.php/download_file/view/953/667/)

## **Why is an outcomes approach important?**

By focusing on what matters most to people, we can improve their health and well-being. Working with people in this way is called an outcomes approach because this is how we support people to understand and achieve their personal outcomes.

The aim of an outcomes approach is to make sure that people who receive care and support and their family or unpaid carers are supported to live the best lives possible, building on their own strengths and capabilities. It also requires organisations to focus their resources on the impact they have, as well as the activities they carry out.

The [Social Services and Well-being (Wales) Act 2014](https://socialcare.wales/hub/sswbact) requires us to focus on people’s well-being and put them at the centre of their care and support planning.

An outcomes-based approach is based on these principles:

* People are experts in their own lives
* They are best placed to tell you what’s important to them and what gives them a sense of well-being, but they may need help to do this
* People want to do the things that matter most to them, in their own way
* People’s strengths are important and need to be acknowledged
* We start by identifying what the person wants to achieve, and then thinking through how to achieve that outcome and agree a plan to help them to do this
* The person’s family, carers and local community can also contribute to this plan
* Meaningful conversations are central to understanding a person’s outcomes
* A personal outcome is the picture the person paints of what it is they want to achieve.

A sense of well-being comes from things like:

* relationships
* feeling loved
* being respected
* having a sense of purpose
* making a useful contribution
* The little things...that make life feel worthwhile.

Regulations 15, 16 and 21 also discuss the importance of involving a service user in an outcome focused approach, looking that their

* Personal development
* Emotional and mental wellbeing
* Having a healthy diet and fluid intake
* maintaining good skin integrity
* Continence management
* Being cared for in their final days
* Being cared for with sensory impairment
* Being cared for with cognitive impairment
* Being supported with oral hygiene

The following videos by Social Care Wales discuss why outcome focused approaches are important.

[Why Outcomes focused practice is important](https://socialcare.wales/resources/why-outcomes-focused-practice-is-important)

[What really mattered to me?](https://socialcare.wales/resources/what-really-mattered-to-me-by-mr-david-britton)

[Knowing what really matters to people](https://socialcare.wales/resources/knowing-what-really-matters-to-people-by-lucy-warren-social-worker)

[Personal Outcomes: Banking home care hours](https://socialcare.wales/resources/personal-outcomes-banking-home-care-hours)

[Personal Outcomes: Christmas shopping trip](https://socialcare.wales/resources/personal-outcomes-christmas-shopping-trip)

[Personal Outcomes: Sharing a story](https://socialcare.wales/resources/personal-outcomes-banking-home-care-hours)

## **How to find out what matters to people and agree their personal outcomes**

An outcomes approach prioritises good conversations with people about what matters to them over gathering data for organisational purposes. The focus on personal outcomes provides opportunities for the person to reflect on their life, reduce the assumptions made by others and improve understanding between everyone involved.

The most valuable conversations are the ones where people feel really listened to. In being listened to, people often start to make sense of their own situation as they can put time and thought into it.

A good way to remember the core skills for having a good conversation with people is the word **OARS**:

* **O**pen ended questions
* **A**ffirm – notice strengths
* Listen **R**eflectively
* **S**ummarise in an empowering way.

Focus on people’s strengths is a key part of an outcomes-focused approach, but this means asking the right kind of questions and letting the conversation flow:

* engage with people and help them explore their hopes and fears before putting a plan in place
* explore the pro and cons – help people think and talk
* help people build on their strengths and those of their family and community
* Help people notice their achievements and anticipate threats.

Remember to:

* listen carefully and show empathy
* explore concerns and aspirations
* expect natural defensiveness
* support the person’s sense of their own abilities
* Avoid arguments and confrontation.

Here is a resource that gives examples of strengths-based questions you can use at different points of the conversation. These hints and tips can help you build a good conversation, avoid traps and support people to focus on what is strong, rather than what is wrong.

[Hints and tips for having good conversations and understanding what matters to people](https://socialcare.wales/cms_assets/file-uploads/Hints-and-tips-ENG-FINAL.pdf)

The following two videos show the difference between using an outcome focused approach and a task lead approach.

The first video shows the worker focusing on paperwork and risk. This isn’t using an outcomes approach.

[Not using an outcomes focused approach](https://socialcare.wales/resources/example-of-not-using-an-outcomes-approach)

The second video shows the worker using an outcomes-focused approach, building trust and helping mum talk about what has happened

[Using an outcome focused approach](https://socialcare.wales/resources/example-of-using-an-outcomes-approach)

## **Recording and Monitoring Outcomes**

People in Wales, including those with complex care and support needs, want to live in their own homes and communities with the support they need, when they need it.

Domiciliary care is one way of supporting people to stay at home.

For service users who are funded by the local authority the social worker is responsible for agreeing and setting outcomes for the service user.

Some people may not wish to discuss outcomes with the social worker and this will be highlighted on the integrated assessment and care and support plan.

**Field Supervisors and Senior Field Supervisors** are responsible completing the assessments with the service user and anybody they wish to be involved in their care.

It is during this assessment that they will discuss how to work towards achieving the outcomes that have been set out in the integrated assessment and care and support plan.

If at this point the service user informs the field supervisor or senior field supervisor that their outcomes may have changed they must inform update the social worker of this change so the care and support plan and integrated assessment can be updated to reflect this.

The Field Supervisor and Senior Field Supervisor are responsible for recording the outcomes, and the progress to achieving these outcomes for each service user on their team.

The outcomes for each service user are recorded on their service delivery plans, under the titles of the National Outcomes, control over daily life, protection from abuse and neglect etc.

* Each service user will have a baseline score. This is where they think they are at the time of commencement of care.
* Each service user will also have an aspiration score - this is where they want to be.

It is important to note that with the scores it is what a score of 10/5/7 etc means to the service user, not what the field supervisor or senior field supervisor thinks themselves.

However, there may be times where the field supervisor and service user may differ on whether they think they have made progress, it is important to document these conversations too.

In order to get a holistic approach it is important to include any social workers, district nurses, family members in any reviews that take place.

If at the point of review, the service user may not be achieving any of their outcomes then we may need to refer this back to the social worker, or other multi-disciplinary team members to see if there are additional resources that could assist.

The senior field supervisor may be required to review the care plan and staff skill who attend the calls to see if there are any internal measures in place that could support with this. If there is not then they must report this to the complex care board for review.

Further guidance on the recording and monitoring of outcomes is found in the following presentation from SCW:

Senior and Field Supervisors

[Recording and Monitoring of Outcomes](https://www.careinhand.co.uk/index.php/download_file/view/954/668/)

In care in Hand our [Guidance on Assessments](https://www.careinhand.co.uk/index.php/download_file/view/955/668/) document highlights the process that we follow for recording outcomes.

In brief:

* These are recorded on the service delivery plans for the service users.
* They are scanned using the scanner app to the service user’s individual file on the care drive and saved in the outcome review folder.
* The scores are saved in the outcome scoring spreadsheet on the care drive.
* A note is put on the observations section on CM2000 to say that the review has been completed and if any updates to the care plan is needed. It is closed off and the next review is added.
* The service user is advised of where to find a copy of the review within their home file.

In order for outcomes to be met for service user it is important the whole team adapt the same approach so therefore this is important for the FS when completing spot-checks and working with the care staff to discuss this with them and guide them in moving towards an outcome based approach.

Likewise the SFS and FS can discuss this at team meetings, supervisions and annual appraisals.

## **How do personal outcomes link to the National Outcomes Framework?**

The Welsh Government has a clear commitment to improving the well-being of people in Wales and places it as a central principle in all its policies.

The [National Outcomes Framework](https://gov.wales/social-services-national-outcomes-framework) is for:

* any individual who needs care and support
* carers, friends and family who need support
* Any services undertaking social services functions under the Act, such as local authorities, social enterprises, co-operatives, and user led services, the third sector and the independent sector.

The Framework describes well-being and gives a consistent way to measure it. People will want to achieve outcomes that are personal to them in their own circumstances. However authorities will need to report these outcomes against national indicators, which are explained in the [National Outcomes Framework](https://gov.wales/social-services-national-outcomes-framework).

This means that Sheena Umanee as Quality Assurance Director is required to report to the local authority and CIW how the service users of Care in Hand are achieving their personal outcomes and if they are not why.

In Order to do this the Field Supervisors and Senior Field Supervisors are required to complete outcome reviews every three months with the service user and record how they are progressing on a scale of 1-10, this is then audited by Sheena and if a service user is not achieving their outcomes then a referral may be needed to their social worker to make them aware.

Sheena then complies a report to submit with CIW and the Local Authority.

CIW and the Local Authority will often be required to comply their own reports of outcomes from all providers and submit to the Welsh Government.

For example they might notice that only 40% of older people in Pembrokeshire are reaching their goals for their training recreation and social inclusion as there are limited day centres in Pembrokeshire so the government may need to support

Further guidance on how personal outcomes link into the national outcomes framework can be found in this presentation:

[Linking up with the National Outcomes Framework](https://www.careinhand.co.uk/index.php/download_file/view/956/668/)

The reasons why the reviews take place every three months is as a result of the guidance set out in regulation 16 Review of Personal Plans Page 24. It states that a review must take place every three months or sooner, look at how a person is moving towards an outcome and involve the social worker (local authority/commissioning body) or representative unless this is not the request or in the best interests of the service user.

## **Positive Risk Taking.**

A lot of time in order for a service user to achieve their outcome goals they are required to take some risks.

For example a service user might be learning to walk again following a fall.

These are the service known as positive risks.

However, there may also be times where a service user may understand the risks of harm and wish to continue to try to undertake the task despite guidance or may not have the capacity to understand, these are different.

It is important for the care worker to weigh up the positive risks vs what could be unsafe.

Balancing rights and responsibilities can be difficult, as professionals often see risk as something to avoid and control, instead of being part of a shared decision-making process.

In reality, taking some risks is an important part of everyday life that supports people to do what matters to them.

At point of assessment or review the field supervisor might need to place an enhanced risk assessment in place, with guidance, or refer it back to the social worker or another MDT member such as a GP or district nurse or occupational therapist to find another solution.

Sometimes in rare cases risks might not be in a person's best interest and then the depravation of liberty may be considered by all involved.

Therefore when completing an assessment or outcome review it is always important to look not just at the risk to the individual but also to the care staff or family members if the service user tries to continue to reach their outcome goal or if they cannot reach this and what are the barrier to this, or do the benefits outweigh the risks?

If we do identify risks we should always have a risk reduction plan in place.

For example

* The outcome could be: Mrs Jones wishes to walk to the bathroom.
* The risk - Mrs Jones is at risk of falls and injury to herself and other staff. If she does not walk she may become unmotivated or upset at losing her independence
* The risk reduction is that Mrs Jones can stand with the supervision of two staff, Mrs Jones must use her wheeled walker and one care staff walks alongside her and another follows with her wheeled commode incise she becomes weak she can sit down.

[Personal stories about balancing rights, risk and responsibilities](https://socialcare.wales/cms_assets/file-uploads/Chapter-3-personal-stories.pdf)

The following document also provides guidance for you on positive risk taking and balancing the responsibility as a Senior Field Supervisor or Field Supervisor.

[Practice principles Balancing risks, rights and responsibilities for adults: a positive approach to risk](https://socialcare.wales/cms_assets/file-uploads/Practice-principles-224-June-20.pdf)

Further information on positive risk taking can be found on this document:

[Positive risk taking and decision making](https://socialcare.wales/cms_assets/file-uploads/Positive-risk-and-shared-decision-making.pdf).

## **Care Assessments and working in Partnership.**

When a new service user commences care with Care in Hand there is a collaborative approach, between the care department, finance, commissioning, service user, family members and if they are funded through the local authority or local health board then members of these teams are involved too. However, on times there may also be a required need of having feedback from the hospital or care home, district nursing team or a physio or occupational therapist.

It was discussed earlier in effective communication the importance of good communication between the team to ensure a holistic approach to the care assessment.

The field supervisor or senior field supervisor are responsible for the assessment of a new service user for Care in Hand.

For more complex assessments the Senior Field Supervisor may require guidance from the complex care Board on what risk assessments and guidance and training is needed for the care staff to be able to care for this service user safely.

# The Assessment Process

Under Section  1.2 Requirements on service providers as to the steps to be taken before agreeing to provide care and support (Part 4) of the [*Statutory Guidance*](https://gov.wales/sites/default/files/publications/2019-04/guidance-for-providers-and-responsible-individuals.pdf), Regulation 14 - Suitability of the service we need to have a process in place to ensure that we have all the necessary procedures in place before commencing the package of care.

**The Commissioning Officer** is responsible for sourcing new packages for Care in Hand.

She will be responsible for working with the brokerage team within the local authority or local health board to arrange the times, call durations and contracts for the new service users.

If the package is a private package then she will liaise with the service user or their family for this process and also discuss costings. This may require her to work closely with the Senior Finance Assistant or the Responsible Individual for this.

If the commissioning officer identifies any complex care needs she may wish to refer this to the complex care board where additional training or risk assessments might be required. If this is required from an OT or social worker then she will liaise back with the brokerage team to discuss this with them. She may request that the clinical senior field supervisor assists the senior field supervisor with the assessment

## **Private Referrals**

On a daily basis any officer member, including a call monitor, field supervisor and senior field supervisor may receive a phone call from a member of the public enquiring about private care.

If it is possible please pass this phone call through to the commissioning officer to action.

* If the commissioning officer is not available then the person receiving the call should complete a F10 referral form (page 1) on this they need to get the name, address, date of birth, and phone number for the person being referred, and the name, contact details of the person making the referral .It is very important that you ask if the personal making the referral for the service user has gained their consent, if they have not then we cannot proceed. If they have not but are legal power of attorney over health and finances then we can proceed.
* There is no need to discuss the services or the type of care required as the commissioning officer will look at then when completing her assessment.
* Once you have completed this form then it can be emailed to referrals@careinhand.co.uk the commissioning officer will action from here.

For any packages that come through the **local health board** these are reviewed by the **complex care board** and the clinical senior field supervisor will assist with the assessment for these as the needs of these service users are often more complex and guidance must be taken from the local district nursing team as they are the care coordinators. This will be discussed further in the complex conditions section.

The Commissioning officer works closely with the Senior Field Supervisors to arrange the assessments and place times within agreed time bands and arrange the assessments for the senior field supervisor and field supervisor.

She ensures that all the relevant information is received prior to giving a handover to the SFS and FS to action

**Under Regulation 15 Personal Plans and Regulation 18 Provider assessment it states that the assessment must take place in advance of the commencement of care unless it is an emergency otherwise it must be done within 24 hours.**

In order to complete a good assessment and ensure the service user feels at ease with the process and commencement of care the following guidance may help:

### **Minimising environmental factors that may cause discomfort or distress**

The following are examples of things in the area around an individual, the environment they find themselves in, that may cause discomfort or distress:

* lighting
* noise
* temperature
* Unpleasant odours.

### **Being aware of actions that may be causing discomfort or distress to individuals**

As part of an individual’s care plan you may have to do things that are uncomfortable or even painful for them, for example when moving or assisting them.

You will need to carry out these activities with the greatest care and sensitivity.

Before you begin a task or touch the individual in any way, you should ask them and tell them that what you are about to do might be uncomfortable or painful.

Don’t forget that consent is a vital part of care work and particularly important when you need to do things that are unpleasant. If, for example, you need to open curtains and let in bright light or make noise, it is respectful and polite to tell them so they are prepared.

As a call monitor, field supervisor or senior field supervisor you should explore with the staff or service user if you feel that there might be other ways of approaching something to reduce discomfort or distress. You may need to get further advice and support if necessary, for example by requesting a referral to the GP.

Other systems, for example handovers or team meetings, are good opportunities to make co-workers aware of the concerns you or other staff may have. Together you can find ways of working that minimise distress and discomfort. It may also highlight that worries are shared by others who can help identify a procedure that needs to be changed.

Reporting your concerns is good practice as it can improve the quality of care and support, this is a vital role of the call monitoring team to act as the bridge and support for the staff completing the call.

### **Supporting individuals to minimise pain or discomfort**

Usually, if someone feels uncomfortable they will move about until they find a more comfortable position.

Individuals with limited movement or mobility might not be able to do this.

In order to promote wellbeing the individual should feel comfortable where they are.

* If they find the lights are too bright, dim them where possible.
* If it is too noisy you might close doors or windows or adjust the volume on the TV.
* If possible, adjust the room temperature so that they feel comfortable and air rooms or clean away anything that might cause unpleasant smells.
* The important thing to remember is that you ask them about anything they are not happy with and then do what you can to make the environment the best it can be for them.

If you are working at night it will be impossible to work in the dark or without any noise at all, but you need to be careful to minimise any discomfort or stress.

If you are worried that the individual’s environment is causing them distress and you cannot solve it straight away, talk to their next of kin during the assessment or review on ways to resolve.

Family members might be another source of information as they will know the individual better and may have solutions that you haven’t thought of.

Apart from the individual telling you that they are in pain or discomfort, there are also non-verbal signs.

The way they look, their body language such as gestures or facial expressions could be a good sign, for example doubling over, gritted teeth, pale complexion, sweating, tears or furrowed brows.

Other messages could be becoming very quiet, tearful or aggressive.

If you know or suspect that someone is in pain or discomfort, work with them to try and find a way of making them more comfortable.

This may be by helping them to change their position.

Make sure that you do this with support from another worker if necessary and always in line with the individual’s care plan.

You may notice that the equipment that they are using is causing them discomfort or pain. Take steps to change the positioning of equipment if necessary, but ever only with the individual’s consent. If as a call monitor you are unsure about what to do, always check with the senior field supervisor or field supervisor, if they are unable to help they may refer to the clinical senior field supervisor for further advice or the GP, DN or OT.

### **There may be additional environmental factors that could be causing distress.**

These could include wet or soiled clothing or bed linen, poorly positioned lighting or noise.

Make sure that you follow care in hand's infection control guidance for disposing of and changing soiled bed linen.

Also, with any changes you are making, talk through your actions with the individual so that they understand what you are doing and why you are doing it. This will reassure them and keep them involved.

### **Supporting individuals to maintain their identity and self-esteem**

Wellbeing is the term used to describe feeling comfortable in one’s life.

It can relate to many aspects of life, such as the:

* spiritual - finding meaning and purpose in life (this could be through religious faith, but may be equally as important to a non-religious person)
* emotional - how we feel about ourselves
* Cultural - in both senses: our sense of identity and our engagement with arts, sciences, crafts, hobbies, etc.
* religious or philosophical - our faith or other beliefs
* social - our relationships (including any romantic ones)
* political - peace and stability in our homeland, justice campaigns or simply  political opinions
* sexual - our intimacies
* physical - leading an active life
* Mental - realising our potential and ability to contribute to society.

All these aspects of wellbeing make up who we are, or our identity.

Everyone has different feelings, attitudes and goals.

Each one of these aspects also influences your self-esteem and feeling of self-worth.

If you were cut off from your friends and family you would quickly feel lonely and unloved. If, on the other hand, you were leading an active life, having the choice to do what you want with lots of friends you would feel valued and self-confident.

You would have a good sense of identity and self-worth.

In order to promote the individual’s wellbeing they need to be happy with as many aspects of their life as possible.

If the individual thinks that something would help them to feel better; be positive, understanding, empathic and non-judgemental. Listen to what they consider important in their lives and help them to make the changes they want, for example, to be able to join in particular activities or groups.

It is important that you raise any concerns you might have about the emotional or spiritual needs of an individual. A field supervisor or senior field supervisor may have to look into what can be done to meet these needs.

Often this will be achieved by working together with those important to the individual and other services.

If the individual cannot communicate their emotional or spiritual needs their family or friends might be able to advise on how to help, or be able to provide help themselves. However, you must not assume that an individual has the same spiritual or ethical outlook as their family or friends or necessarily want to join in the same practices or activities

Some policies that support individuals and care staff to all them to maintain their identity include:

* Religion and Belief Policy
* Sexuality Policy

Please link onto the associated tabs for guidance on your specific role in relation to care assessments.

### **Assessment Documentation**

It is important for all roles to know where to access information for a service user so you are able to advise care staff, social workers, district nurses or Gps.

The different forms we within Care in Hand are highlighted below and what information they hold.

All assessment documentation is stored in the Care planning Master Documentation Folder in the care drive. Additional notes and Penn Portraits may also be stored on CM2000 - this includes information such as key safe numbers.

Basic Information and Risk Assessments

* **F17 - Basic Information**- this includes the service user’s name, address, date of birth contact details of them, their next of kin, district nurse, Gp, pharmacy and any other professionals involved. It also includes details on their wellbeing and medical diagnosis
* **F18 - Property Risk Assessments** - this is the assessment of the property and access to the property, guidance such as how to access, emergency exits, what appliances are assessed for use, any issues with lighting or parking etc are all detailed here and how to reduce any risks.
* **F22J - Medication risk Assessment** - This is assessment as to what level of support a service user needs with medication, who delivers or disposes of medication and where medication is stored.
* **F25A/F25 - Moving and Handling Assessments**. Service users who are relatively independent with their mobility may have a F25A, this is highlights how they mobilise. The F25 is the All Wales Moving and Handling and this is guidance for service users on what bed they use, any hazards to moving and handling and how the care staff assist with each transfer.
* **F43 - Pressure Area Care Plan** - this is the care plan with the guidance from the district nurses on what creams to use and how to prevent skin integrity concerns from getting worse.
* **F47 - Falls Risk Assessment** - this is a document that highlights what puts the service user at risk of falls and what the care staff can do to reduce the risk of falls.
* **F46 - Enhanced risk assessment** - this is an enhanced risk assessment document that is required for there are risks specific to the service user, this form can be used to write up the risk reduction plans.

Service Delivery Plan

* **F20A - Control Over Daily Life** - this is where medication is discussed what a service user likes to be known as, what they like to have choices in and what language they like to speak or communication issues and about eyesight and hearing
* **F20B -Physical, mental and emotional wellbeing** - this is where continence, personal care, behaviours, meal preparation are all discussed and the contingency arrangements for thesis
* **F20C - Protection from Abuse and Neglect** - topics such as key safes, self-neglect, lifelines etc are all discussed here.
* **F20D - Education training and recreation** - this discussed if they train or like to study anything and what they like to do to pass the time, such as reading, watching quiz shows.
* **F20E - Personal, professional and domestic relationships** - this is where it is discussed if there are any MDT members involved and how they help and how often, if there are family or friends who support and what level of support they provide and how the service user's relationship is with them.
* **F20F - Contribution to Society** - this is their life history and if they do anything now to access the community such as day centres.
* **F20G - Social and Economic wellbeing** - who sees to their bills and shopping and are there any concerns, do they have any social inclusions or friends visits, their culture, religion etc.
* **F20H - Suitability of living accommodatio**n - any issues with their home or living in it, who supports them to maintain their home and the aids within their home.

### **Contingency Planning**

Contingency planning for service users is very important as it can help reduce the anxiety for the service user.

Contingency planning is where an open conversation is discussed about different aspects of their care and what would happen if in the event of what is in the care plan cannot be achieved.

This might include:

* If a service user declines care or care staff cannot complete care?
* Care staff cannot make the call due to adverse weather conditions, are there family members that could assist?
* If the pharmacy/shop could not deliver the medication or food who could assist?
* If they could not attend day centre how would they have lunch?
* Who delivers their continence aids?
* Who could help if there was issues with the house, such as broken lights?

If they could not attend Church or see their family would they become low in mood, would they want a befriending service?

 Care in Hand could support with some of these tasks but this may need to be referred into the commissioning officer to review if it is covered within the normal package or if an additional charge is needed.

There are voluntary services such as the Community connectors or Pembrokeshire Supply Hub that might be able to help.

If they cannot then often a referral might be needed to the social worker or other members of the MDT team such as the district nurse, physio or occupational therapist.

## (Page pending approval) **Call Monitor Role in Care Planning and Assessments**

Call Monitors as the first point of contact for the care staff play a pivotal role in supporting the care staff in the community and the field supervisors and senior field supervisors in the implementation of care plans and assessments.

The Senior Field Supervisor will add the calls and the client to the CM2000 system. They will send the call monitor a handover of when the service user will commence care, what calls they need and who will complete the calls.

The call monitor holds responsibility for checking that the calls are all populated to the correct people.

Although the care staff might already have received a handover from their field supervisor it is often good practice for the call monitor to phone the carer going there, check that they remembered they have a new service user and give them a handover from the assessment documentation they have read or the pen portrait on CM2000 so they feel more confident attending the call for the first time.

They should always check with the care staff following their first visit to a new service user how the call went and if there are any concerns in completing the call or accessing the property, if the call took longer or shorter than required and the reasons why.

This is vital information that should be put in their handover and passed to the field supervisor or senior field supervisor to review.

As the package of care continues the call monitor remains a vital member of the team to identify where deteriorations or changes are occurring.

For example a service user may wish to remain in bed today. The call monitor is on two days in a row and knows that this is not normal for the service user so they may wish to call the doctor or district nurse and phone the field supervisor or senior field supervisor to ensure they are aware.

Therefore it is good practice for the call monitors to make themselves aware of the care plans and assessment documentation of new service users or if they have noticed that there has been a recent review to ensure that the guidance is up to date when the care staff contact them to raise concerns, or give feedback.

As Call Monitors are monitoring call durations and carers punctuality they can also provide feedback to a field supervisor or senior field supervisor if they feel an increase or decrease in time is needed or additional travel time or a change of the route of the run is required to ensure the care staff and the service users have the time they need without feeling under pressure. This will also support the senior field supervisor with their compliance reports.

## **Field Supervisor Role in Completing Assessments**

The Field Supervisor often plays an important role in completing assessments.

The Senior Field Supervisor may have assigned them the role of assessing the new service user in full or even just with their moving and handling or the environmental risk assessment.

The Field Supervisor may might be the first person from the company the service user or their family speak to or see, so it is important to remain professional at all times and remember they might be anxious about having care, so it would be important to help put their mind at ease.

The assessment should include the following procedures:

* Introduction of the Field Supervisor, and service user and family.
* Explanation as to what to expect from the assessment and why it’s needed.
* Discussion surrounding the assessment and care needs and care plan formulation.
* Environmental and moving and handling risk assessment.
* Explanation of the expectations of Care in Hand for PPE, terms and conditions, GDPR, Call monitor role and call logging system, service user guide and complaints procedures, important numbers to keep.
* Questions the service user or family may have.
* Referrals to external MDT members as needed.
* Handover to staff
* Completion of the paperwork

Therefore it is important for a field supervisor to familiarise themselves with the following in case the service user has any questions, if they are unsure they should escalate the query to their senior field supervisor or area manager.

* terms and conditions,
* GDPR policy,
* service user guide,
* complaints procedures

It is important that following the assessment a handover is also sent to the call monitors and the pen portrait on CM2000 is updated.

Any concerns noted at the assessment should be escalated to the senior field supervisor or area manager in the senior field supervisor's absence. Or it might be appropriate to contact the OT, social worker or district nurse directly if advice is needed.

[WI14 Guidance on Assessments provides](https://www.careinhand.co.uk/index.php/download_file/view/963/663/) in-depth guidance on the assessment process.

# Handover to staff

The handover process to staff is vitally important. It improves the communication within a team and puts the care staff and the service user's mind at ease that they have knowledge of the service user's needs and how to access the property.

A good handover message to staff includes:

* The name of the service user.
* The Address of the service user
* The directions how to get to the service user, including where to park and access the property.
* The call times and what runs the service user is on (Please remember that the carers will not know the names of the runs as they appear on Cm2000, they will know this by the name of the first client on the run such as the "Mrs Jones run")
* The medical diagnosis of the client
* What they like to be known as
* What is required for the care staff to complete in any call and if there are any risks.

It is good practice to call the carer who is attending first to give them a handover as it is the first call and to call them afterwards to see how the call went and if there were any concerns.

### **Time Bands**

The times within Pembrokeshire work in Bands. This means a call time can be offered anywhere within that time bracket as such. We offer Bands times and these are as follows:

**Morning Visits:**

* Band 1 - 06:30-08:30AM
* Band 2 - 08:30-10:30AM
* Band 3 10:30AM-12PM

**Afternoon visits**

* Band 4 - 12Pm-2PM
* Band 5 - 2:30PM-4:30PM
* Band 6 - 4:30PM-6:30PM

**Evening visits**

* Band 7 - 06:30-08:30PM
* Band 8 - 08:30-10:30
* Band 9 - 10:30-12:30PM

Within Care in Hand we aim to start the carer’s runs at 06:45/07:00 and finish the morning shift by 13:30 or 14:00 at the latest.

We aim to start our evening runs at 15:45/16:00 and finish by 22:00, however in some cases due to service users’ needs we may be required to finish after 10PM. but no calls would commence after this time.

 If at point of assessment a service requests an earlier or later call time or does not wish to continue with a call, this cannot be agreed at the time of assessment and should be referred back to the senior field supervisor and commissioning officer. However, depending on the request the senior field supervisor may wish to contact the family to discuss or update the social worker who accepted the package of care on behalf of the service user.

## **Senior Field Supervisor Role in Completing Assessments.**

***It is important for the senior field supervisor to familiarise themselves with the regulations set out on the care planning introduction page to ensure that all assessments for their team are meeting these regulations.***

It is also important that the Senior Field Supervisor is familiar with the term set out for a service user.

Senior Field Supervisors are responsible to working with the commissioning officer to place new packages of care for their area in a safe manner that supports both the service users and the staff and keeping in the best interests of the business' objectives.

A Senior Field Supervisor will work with the commissioning officer to look for capacity of a new package of care.

Once they have read the care and support plan they may feel they need to complete a F109 form which is for additional training for their staff and submit this to the training department, if there are specific needs such as stoma care. They are responsible to ensuring their team have the right skills to provide adequate care to the service user.

The Senior Field Supervisor may work with the complex care board and the guidance they provide for more complex care service users.

Once they have looked at their rotas, travel time and skill needs for the service user they may wish of offer times for the service user.

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### **Awarding of a Package of Care**

If the package is awarded then the commissioning officer forwards on the care and support plans, any associated emails from the commissioning services, and the integrated assessment to the senior field supervisor.

The SFS will then set up the folders for the assessment and prepares for the assessment.

Following this they will either complete the assessment or assign the assessment to their field supervisor to complete.

The [WI14 Guidance on Assessments](https://www.careinhand.co.uk/index.php/download_file/view/963/664/) provides further guidance on this process.

The SFS is responsible for escalating any concerns to the occupational therapist, district nurse or social worker following an assessment and ensuring the correct guidance is in place for the staff.

 If at point of assessment a service requests an earlier or later call time or does not wish to continue with a call, this cannot be agreed at the time of assessment and should be referred back to the senior field supervisor and commissioning officer.

However, depending on the request the senior field supervisor may wish to contact the family to discuss or update the social worker who accepted the package of care on behalf of the service user.

 A SFS is responsible for ensuring all procedures are in place for the staff and a clear handover has been sent by themselves or the field supervisor to the staff and call monitoring team.

## **Live in Care Assessments**

On some occasions we may be required to complete an assessment for a service user who wishes to have 24hour care.

Our live in Policy and[Live in Guidance Document](https://www.careinhand.co.uk/index.php/download_file/view/966/606/)

These assessments differ to that of a domiciliary care assessment, as the care worker is living with the service user then  we need have a greater knowledge of their needs throughout the day, what they like to spend time doing, do they like to go for a sleep in the afternoon, do they wake often in the night?

The contingency planning is essential for the service user as often the reason for live in care is that the service user has no family close by to assist, so rely on the care staff to assist with arranging appointments for the service user. Therefore, the guidance and risk assessments should be very clear in what the roles and responsibilities for care staff are.

The commissioning officer will have set up the terms of the package with the SFS or in some cases the Clinical Senior Field Supervisor and the finance department in relation to what tasks can be undertaken within the package and whether additional resources such as staff to cover breaks or night care to allow the live in care worker to have adequate rest breaks.

Human resources department will assist with the staffing for the package of care as it will often depend on the need of the service user and the availability of staff as to what way the schedule is arranged by the Senior Field Supervisor for the live in care

There are additional risks associated with live in care. These include:

* Environmental - is there adequate space for the care worker to sleep, wash and dress and prepare food for themselves.
* Financial - under the financial procedures policy the service user may not have full understanding or ability to manage their finances for daily shopping needs, therefore risk assessments should be provided to safeguard the care staff and the service user.
* Lone working - often the care staff are often quite isolated as they are working outside the hours of our Call monitoring team, if a concern happens during the night they must have the competence to contact the emergency services or next of kin, also in cases of dementia for example behaviours may change and this may put the care worker at risk, or in cases of adverse weather we would need to ensure they have adequate resources for the service user and care worker to remain safe should they not be able to leave the apartment,
* Service user safety - During the initial assessment it would be important to explain to the family member the roles of the care worker and if the service user can be left alone and for how long they can be left alone, for example if they are at risk of falls or if they have dementia and are at risk of wandering. It is very important to highlight that if the service user has been assessed that they can be left alone that the care staff are not responsible for any injury occurred during these times, however the risk assessment should be reviewed regularly as the needs continually change of service users.

In order to safeguard the care staff and service user the care staff are advised to log in or contact the call monitoring team each day to let them know that everything is ok. They are also required to provide the field supervisor and senior field with a written report at the end of every week to give them a handover of what has taken place during the week including any health and safety concerns, or falls or if they were required to make any referrals to the Gp or district nursing teams.

Often service users may wish to go with the care staff to the shop or out for a drive, this cannot be done routinely and should be documented in the risk assessment and service delivery plan or moving and handling plan if this has been agreed or assessed as part of the live in package of care.

The reviews for a live in care package of care and supervision of live in care staff remain the same as they would for a domiciliary care package and should be completed every three months.

## **Domestic Support Assessments**

Within Care in Hand we offer both domestic and support calls.

We also offer support under the mental health support living services. These assessments and packages of care are often commissioned by the local authority and these assessments will be completed by the mental health key worker and completed by the mental health support staff.

However, there are additional domestic and support calls that we can supply privately. These include:

* Shopping
* Cooking meals
* Befriending/sitting services
* Cleaning/Laundry
* Accessing the community
* Taking to dentist appointments
* Collecting shopping or medication.

We have domestic and support workers, it is important to note that some domestic or support workers are not trained to complete personal care tasks so therefore would be unable to complete this.

The following Policies are required to be considered for domestic support:

* Moving and Handling Policy
* COSHH Policy
* Health and Safety Policy
* Infection Control Policy
* Financial Transaction Policy
* Assessing and managing risk Policy
* Spillages Procedures
* Food Hygiene

Any queries that come for domestic support calls should be referred into our commissioning officer for review and to arrange the terms and conditions of service, once they have liaised with either the service user, their next of kin or the social worker they will notify the social

## **Domestic tasks and cooking**

When looking at cleaning and cooking taks it is important to look at the risks to the worker as well as the family or client

This is covered in more detail in the Health and Safety Section of the framework.

However a greater emphasis should be placed on the risk surrounding COSHH.

The person assessing the risk should look at the risk of exposure to cleaning chemicals, they need to look to see if they are stored correctly, what chemicals should be used and is there waste disposal facilities. We also need to note that there is adequate ventilation for the care staff so they are not affected by some of the fumes that are associated with certain chemicals such as bleach.

When we are completing cooking tasks within domiciliary care we often say that we will only use a microwave oven, this is a health and safety measure. However, if we have a support call that has been assessed for cooking tasks we might be able to use a cooker, however this must be assessed on an individual basis. We would not recommend to use grills and deep fat fryers should not be used under any circumstance due to the high fire risk. We may use a hob or an oven, however we advise that these should not be gas cookers, again due to the fire risk.

This information would be noted on the environmental risk assessment.

When completing shopping, cooking, cleaning tasks we need to assess inanimate moving and handling. We need to look at if the staff are exposed to:

Bending/stooping/twisting

Lifting heavy objects (Heavy pots, shopping bags, bins)

Pushing or pulling (For example a hoover)

We then complete an inanimate moving and handling risk assessment, this highlights what the risk is and how can we reduce it.

Our guidance on risk matrix and inanimate moving and handling provide further guidance on how to assess these risks.

An F25B will be where the information is stored. It is the role of a field supervisor or senior field supervisor to assess these risks.

## **Support and accessing the community**

When accessing the community

## **Night Care**

Within Care in Hand we offer a night care service.

Our Commissioning officer supports with the setting up of these packages along with the clinical care manager, area manager, senior field supervisor and human resources.

There are two types of night care services:

* Sleeping night - this is where the care worker can sleep as the service user will not wake more than twice in once night or more than 15mins. They often want the reassurance that they are not alone.
* Waking night - this is where the service user is awake throughout the night as the service user may need regular supervision throughout the night as they are at risk of falls or need assistance with medication management or continence management or wander for example.

A night shift is from 10PM-7AM.

Our night care policy and night care guidance provides guidance for all staff on our procedures for night care within Care in Hand.

Night Care can pose its own risks which are highlighted under our lone working policy.

Care staff have limited support as the call monitoring team are not available throughout the night. Therefore there needs to be clear guidance within the assessment completed by the field supervisor and senior field supervisor as to what the emergency contact details in the event there are any concerns during the night.

The call monitor should link in with the night staff when they come on shift and before they leave their evening shift to ensure that everything is ok with the service user and the staff themselves. Any concerns should be escalated to their senior on duty.

The Field Supervisor and senior field supervisor should receive a weekly report from the night care staff so that they can manage any concerns that might be occurring and monitoring that the staff are receiving the rest they require.

When the field supervisor or senior field supervisor is assessing the care for night, they might have already assessed this for another service user as domiciliary care.

However, when looking at the night care we need to take a few points into consideration:

Who is the emergency point of contact throughout the night shift?

Is there adequate space for the staff to sit/sleep with adequate access to toilets and food and drink?

Are there any heating problems over night?

If the service user likes the lights to be off, what risks does this pose to the care worker.

We also need to look at the service user’s needs. What are their routines, if they wake in the night? Are there any techniques that they find helps them get back to sleeps, such as medication management for pain, a drink of tea or continence management.

When looking at personal care needs and continence management or pressure area care it is important to note if this can be done safely with one person, if not then it might be worth making a referral to the district nursing team or occupational therapist to see if there is further equipment or techniques that might be able to assist this.

There are times where night care is provided to palliative care service users, this is often to provide respite to the family members and give the service user and family peace of mind that they are not being left alone.

Further information on palliative care can be found in our palliative care section. However full guidance on palliative care guidance for night care can be found here:

# Palliative Care

Under**Section 1.5, Regulation 21 - Standards of Care and Support  - Overarching Requirements** of the [Statutory Guidance](https://gov.wales/sites/default/files/publications/2019-04/guidance-for-providers-and-responsible-individuals.pdf) we are required to monitor and work in partnership with other agencies to look after a person and their families wellbeing in their final days.

Our policy on palliative care and care of the dying provides information for the care staff on the procedures and guidance for end of life care.

There is a difference between palliative care and end of life care.

* A person may be considered palliative where there is no improvement or change of full recovery for their condition. For example a person may have a diagnosis of cancer and be told that they are palliative but may be able to live up to 2 years under symptom control.
* However, end of life means that they are sadly reaching their end of life, their organs may slowly be shutting down and they may soon often within the next 12 months, or sooner.

Palliative and end of life care may be upsetting for family members or service users if they have not had time to prepare for this fully and achieve the things the wished, or they might seem in denial of what is happening, however for some service users and families it may be peaceful as they may have been fighting an illness for a long time which can be upsetting for family members, friends to go through with the service user.

For some service users it might be a spiritual time and they may wish to pray or have certain customs they wish to carry out.

In any case every situation is different and service users and family members should be treated with respect and compassion during this time.

For care staff who have been caring for the individual for a long time it may become upsetting for them to see the changes that occur and saying goodbye to the service user and the family.

As call monitors, Field supervisors and senior field supervisors the support and guidance that we provide the staff during this time is very important for their own wellbeing.

The Staff debriefing guidance should be followed following each time the staff attend the call, and particularly at point of death.

The field supervisor plays a pivotal role in training the guiding the staff on how to carry out the care procedures and answer questions from family members at end of life.

The Royal College of Nursing provides a resource on [End of Life Care](https://rcni.com/hosted-content/rcn/fundamentals-of-end-of-life-care/end-of-life-care-%E2%80%93-fundamentals-of-nursing-care-end-of-life)that may be helpful for understanding the process and changes that occur during this time and how we can support an individual.

## **Palliative Care Protocol**

When a service user is reaching end of life care, there is a collaborative approach from the social worker, district nursing team, Gp, and SFS and FS and Clinical Care Manager.

Our [palliative care guidance](https://www.careinhand.co.uk/index.php/download_file/view/982/609/) sets out clearly the procedures we follow.

At end of life the district nurse oversees their care needs and any care plans and guidance must be taken from them.

In order for the district nurses to take over the care for the service user from the social services then the care needs to be transferred to Continuing HealthCare (CHC) there is an assessment process known as a Fast Track that is completed. This is a multi-disciplinary assessment that says the service user has a greater health need at this time and they are singed off by the doctor.

The district nurse with the guidance of the doctor then oversees any medication management and pain management.

Often at this time there may be other agencies such as a palliative care nurse, Paul Satori, Macmillan Nurse involved as well to support the family during the transition.

When a service user is funded by CHC or is end of life the Clinical Care Manager will support the FS and SFS to put a file together for the care staff, this provides the care staff with guidance on how to carry out the care, and what to do in the event that the service user passes away during their calls.

There will also be information for the family members on who they can contact within Care in Hand if they need further advice too.

Guidance can be provided to the staff as well from [clinicalskills.net](https://www.clinicalskills.net/)

The palliative file is often a red file and can include:

* F21A - Palliative Care Welcome Letter
* Service user Guide
* F17 - Basic Information
* F22J - Medication risk assessment
* F18 - Property Risk Assessment
* F25 - Moving and Handling Form.
* F43 Pressure Area care plan
* F42 - SSKIN BUNDLE
* Any end of like service user specific care plans.

There may be times where a service user dies unexpectedly and this can be very shocking for the care staff, following our reporting on an incident and staff debriefing guidance the adequate support should be given to the care staff.

As a call monitor you should contact your senior on shift immediately who will take managing the incident following our safeguarding procedures.

Our ill, unresponsive and dead service user’s policy provides full clear guidance on what procedures need to take place.

During these incidents it is vital that all information is documented clearly on an incident report and within the service user's notes on CM2000.

Dementia care (default page)

# Pressure Area Care and Skin Integrity Concerns

The elderly are often prone to skin integrity concerns and pressure area concerns.

This is often as a result of underlying conditions, poor appetite or diet which means there is not a healthy blood supply and adequate protein, nutrients or hydration required to help with repairing damaged skin cells.

Under**Section 1.5, Regulation 21 - Standards of Care and Support  - Overarching Requirements** of the [Statutory Guidance](https://gov.wales/sites/default/files/publications/2019-04/guidance-for-providers-and-responsible-individuals.pdf) we are required to monitor and work in partnership with other agencies to look after a person's skin integrity – this includes seeing advice, having care plans and SSKIN BUNDLES

Our medication policy also provides advice on our roles and responsibilities with the applications of dressings and creams for service users. Any prescribed creams should be referred to the clinical care manager and complex care board for review.

There are two main categories of skin integrity concerns:

1. **Pressure sores** - these are often sores that develop on the bony areas of the body, such as the heels, elbows, sacrum’s, shoulders, hips, nose (from glasses or oxygen tubing) these often first appear as a red or dark mark on the area of skin. They normally occur where a service user may not be able to reposition themselves, so therefore the pressure on the skin is not relieved and the cells underneath begin to become damaged.
2. **Moisture Lesions:** Moisture lesions often occur as a result of the skin being exposed to moisture for long periods of time, such as urine, sweat, faeces. These are more commonly seen in the skin folds of individuals and on their bottom and groins.

The treatment of moisture lesions and pressure sores can often differ, and sometimes you may see a moisture lesion alongside a pressure sore.

Often in pressure area care we talk about blanching and non-blanching skin.

* **Blanching Skin** - this is where you touch the skin and it changes colour, it may go white or red in colour but it will return within 2 seconds or so to the original colour, this shows that there is a good blood supply to the area.
* **Non blanching skin** - this is where you touch the area and there is no change to the colour of the skin, this is a sign of poor blood flow or more serious damage to the blood supply to the area.

The local district nursing teams take the lead on all skin integrity concerns and we as an organisation must follow their guidance.

Our local safeguarding team advise that where new areas of red skins appears or any deterioration of skin that this is reported immediately to the district nursing team.

When the district nursing team complete their assessments they often grade pressure sores using grades 1-4 this highlights to what extent the skin has been damaged, sometimes a sore could be deemed unstageable, this means due to the way in which they would is presenting it is hard for the nurse or the tissue viability nurse to assess what damage has been completed.

Sometimes the nurses use a pressure area risk assessment to see how likely a service user is at risk of skin damage, in Hwyel Dda they use the Pressure Sore Prevention Score (PSPS) system this assesses, their age, skin condition, aids in place, continence, underlying conditions, nutrition and mobility and how they impact on their risk to develop pressure sores. If a service user has a score of 10 or above then they are at high risk and require regular interventions from the district nursing teams.

The following documents may assist you to understand the difference between pressure sores and moisture damage and how to prevent or treat these:

[Pressure Ulcers](https://www.careinhand.co.uk/index.php/download_file/view/977/611/)

[Moisture Lesions](https://www.careinhand.co.uk/index.php/download_file/view/976/611/)

[Great Skin - Moisture Lesion](https://www.careinhand.co.uk/index.php/download_file/view/974/611/)

[Diet and Pressure Ulcers](https://www.careinhand.co.uk/index.php/download_file/view/981/611/)

React to Red

## **Reporting on Pressure Sores and Skin Integrity Concerns**

 Under **Regulation 60 and Schedule 3 Part 1 of the**[**Statutory Guidance**](https://gov.wales/sites/default/files/publications/2019-04/guidance-for-providers-and-responsible-individuals.pdf) we are required to report any skin integrity concerns grade 3 or higher or unstageable to safeguarding and Care Inspectorate Wales under our reporting responsibilities.

Therefore, it is important as call monitors, field supervisors and senior field supervisors we action any feedback from care staff about skin integrity concerns and encourage staff to continue to report concerns under their duty of candour and code of conducts.

Our[Guidance on Pressure area Prevention](https://www.careinhand.co.uk/index.php/download_file/view/979/611/) provides more information on this topic

### **Call Monitor Responsibility**

As a Call monitor you may be the person who receives the information about a skin integrity concern, it is your responsibility to notify the district nursing team about this under our[district nurse referral process](https://www.careinhand.co.uk/index.php/download_file/view/980/611/). It is important that the information is written into private notes on CM2000 and the observations on CM2000 include as much information as possible.

If you manage to speak to a nurse make sure to document the first and surname of the nurse you spoke to and the guidance they have given within the observation.

You may also be required to update the care staff on the guidance given.

When care staff phone with concerns or queries as to what creams to apply, never give out advice unless you have the guidance in front of you, always refer to the pressure area care plan or any updates on this for the latest guidance from the DN team.

### **The Field Supervisor and Senior Field Supervisor Responsibility**

The Field Supervisor and Senior Field Supervisor hold the responsibility for liaising with the district nursing teams,[under the district nurse referral process](https://www.careinhand.co.uk/index.php/download_file/view/980/611/)

They must ensure that all care staff within their teams have been trained and have a good understanding of pressure sore prevention and our role within it, this can be done through formal training, supervision and guidance within the community.

Where an observations are added to CM2000 for skin integrity concerns these should be followed up at the start of the shift and feedback from the district nurse sought on what treatment plan the care staff should follow.

Any feedback received must be documented on a pressure area care plan (F43) and the information cascaded to the staff and call monitoring team, a new plan is not needed for each review, as these can be updated in the review sections.

However, although they need to be reviewed following each concern reported, if concerns are not reported they should be reviewed at least once a month by the field supervisor who will have a better knowledge from completing the calls in the community

If a district nursing team is not responding to a request for feedback it is important to follow this up with an email so that there is a clear audit trail.

Likewise it is good practice to follow the advice received over the phone with an email to ensure that there is no confusion and a clear audit trail

All service users who suffer with skin integrity concerns are placed on a SSKIN BUNDLE document as per regulation 21. The care staff must fill out at every call.

These are accessible to the district nursing team and may contain vital information for the district nurses, GP or safeguarding team to whether a treatment plan is working or concerns have been escalated.

They are broken down into 4 sections:

* **S - Surface** - this looks at the surfaces the service user comes into contact with, are these working or might they be adding to the pressure damage for the service user.
* **S - Skin** - this is the condition, colour of the skin, if any creams or dressings are applied or if there is any excaudate from the wound.
* **K - Keep Moving** - This section looks at if the service user moved, or repositioned, if they needed aids, if they declined, maybe they requested to be put back on the same side so the pressure was still on the wound.
* **I - Incontinence** - being constipated can often put more pressure on the sacral area and increase the risk of sores, stoma sites often get sores from the stoma bags, if their continence aids are not absorbent enough the risk of moisture damage may increase, likewise if they wear aids too absorbent this may dry the skin out and it may crack and break more easily.
* **N - Nutrition** - Are they eating and drinking enough to maintain a healthy diet and help with keeping their skin healthy.

It is vital that the senior field supervisor and field supervisor review the SSKIN Bundles on regular occasions to ensure that care staff are completing these correctly and identify any concerns that may be occurring so they can be escalated to the district nursing team to action.

On occasions we may have service users who may decline care, they are at risk of skin infections and moisture damage, it is vital that these are reported to the district nursing team immediately and an email is sent to the complex care board to monitor.

The following documents may support the SFS and FS understand the documentation and safeguarding concerns linked with skin integrity concerns:

[All Wales Pressure Ulcer Prevention](https://www.careinhand.co.uk/index.php/download_file/view/978/611/)

[Nice Guidance on Pressure Ulcers Prevention and Management](https://www.nice.org.uk/guidance/cg179/resources/pressure-ulcers-prevention-and-management-pdf-35109760631749)

The SFS or FS should escalate any concerns to the clinical care manager who will review at complex care or advice on safeguarding concerns including:

* poor feedback from the district nursing team
* Family not agreeing with prescribed techniques
* Service user not responding to treatment
* Service user declining assistance despite district nurse and care advise
* Grade 3/4/unstageable sores or lesions

This will be reviewed under our safeguarding procedures and escalating concerns procedures.

Continence management (default page)

Nutrition, hydration and oral care (default page)

Complex care & service user specialist need (default page)

Sensory Impairments (default page)

Huntingtons Disease (default page)

Multiple Sclerosis (default page)

Stroke (default page)

Parkinsons (default page)

Diabetes (default page)

Discharge Planning (default page)

Safeguarding

# ****The principles of safeguarding adults****

Safeguarding is about people and organisations working together to prevent and stop both the risks and the actual experience of **abuse**or**neglect**.

Safeguarding balances the **right to be safe** with the **right to make informed choices**, while at the same time making sure that the a**dult’s wellbeing is promoted**.

This includes taking the person’s **views, wishes, feelings** and**beliefs** into consideration in deciding on any action.

Health and social care organisations have particular responsibilities, but every worker has a part to play.

The Social Services and Wellbeing Act defines Wellbeing as relating to a person's ability to

* Having Control over Everyday Life
* Maintain their Physical, Mental and Emotional Wellbeing
* Maintaining their domestic, personal (family) and professional relationships
* Being Protected from Abuse and Neglect
* Being able to participate in education, training and recreation
* Being able to have a Valued Contribution to Society
* Maintaining good Social and Economic Wellbeing
* Living in accommodation suitable to their needs

All these aspects of wellbeing are relevant to people with care and support needs, and to carers.

There is no hierarchy, and all these aspects of wellbeing should be given equal importance when considering any person’s wellbeing.

Each of these aspects is a positive ‘outcome’ of good wellbeing.

Informed choices are decisions made by people when they have been provided with all the information.

## **Your responsibilities**

As a worker, it may be thought of as abuse or neglect if you cause harm to someone or do not do the things you should to prevent harm.

**Harm** includes:

* **ill treatment (including sexual abuse**, **exploitation and forms of ill treatment which are not physical**)
* the **impairment of health (physical or menta**l)
* the **impairment of development (physical, intellectual, emotional, social or behavioural**)
* **self-harm and neglect**
* **unlawful conduct which adversely affects a person’s property, rights or interests (for example, financial abuse)**

It is important that you know the ways of working to safeguard adults in your workplace please See Care in Hand's Policy on Safeguarding.

The Code of Conduct states that workers must: “Always make sure that your actions or omissions do not harm an individual’s health or wellbeing. You must never abuse, neglect, harm or exploit those who use health and care services, their carers or your colleagues.”

**Within your Safeguarding Training you will have learned; spotting signs of abuse or neglect**

Everybody needs to be vigilant about adult safeguarding concerns in all walks of life.

Findings from serious case reviews have sometimes stated that if professionals or other staff had acted upon their concerns or sought more information, then death or serious harm might have been prevented.

Regardless of what any particular safeguarding concern might be, everyone should understand what to do, and where to go locally to get help and advice.

It is vital that professionals, other staff and members of the public are vigilant on behalf of those unable to protect themselves.

This will include:

* knowing about different types of abuse and neglect and their signs
* supporting adults to keep safe
* knowing who to tell about suspected abuse or neglect
* supporting adults to think and weigh up the risks and benefits of different options

**It is therefore important in your role that you can recognise the types of abuse and neglect, their signs and indicators**

You should be able to identify the different types of abuse and neglect and the signs or ‘indicators’ that they are happening.

The more you are able to get to know someone the more you are likely to notice any changes.

In community settings where care and support can be short term and involve ad hoc daily visits, this can be more difficult, but you should still look out for any signs or indicators.

Incidents may be one-off or multiple, and affect one person or more. You should look beyond single incidents or individuals to identify patterns of harm.

### **Physical abuse**

**Physical abuse** is an individual’s body being injured or hurt due, for example, to assault, hitting, slapping or pushing.

It can also be the wrong use of restrictive practices (see below).

Examples could be the misuse of medication or using inappropriate restraint such as locking someone in a room, tying them to a chair or using inappropriate physical sanctions

**Physical abuse Signs and Indictors include:**

Injuries that are unexplained or haven’t been treated.

There could be a number of injuries of different ages and in different places.  
Examples include:

* Broken bones
* Bruises
* Unexplained loss of clumps of hair
* Bite

### **Burn or scald marks.**

### **Domestic violence**

**Domestic violence** – is any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

It includes psychological, physical, sexual, financial and emotional abuse, and so-called ‘honour-based’ violence.

**Signs and indictors of domestic violence** can be any of those relating to the different types of abuse or neglect that can occur in any incident.

### **Modern slavery**

**Modern slavery** – this encompasses slavery, human trafficking, and forced labour and domestic servitude.

Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

**Signs and indictors include**

Signs of physical or psychological abuse, being malnourished or unkempt, appearing withdrawn.

Rarely being allowed to travel on their own, seemingly under the control and influence of others, rarely interacting or appearing unfamiliar with their neighbourhood or where they work.

Having few or no personal belongings or documents.

Avoiding eye contact, appearing frightened or hesitant to talk to strangers and law enforcers.

### **Financial or material abuse**

**Financial or material abuse** is the use of a person’s funds and belongings without their permission.

This could be

* theft,
* fraud,
* internet
* scamming,
* coercion in relation to an adult’s financial affairs
* or arrangements, including in connection to wills
* property,
* inheritance or financial transactions,
* Misuse or misappropriation of property, possessions or benefits.

**Signs and indictors** include:

Bills not being paid.

Loss of assets such as a house being sold and the money from the sale disappearing.

Expenditure higher than the living conditions suggest.

Not having enough food or clothing.

### **Sexual abuse**

**Sexual abuse** is when a person becomes involved in sexual relationships or activities that they do not want to be involved in.

They may have said that they do not want to be involved or they may be unable to give consent

Sexual abuse includes:

* rape
* indecent exposure
* sexual harassment
* inappropriate looking or touching
* sexual teasing or innuendo
* sexual photography
* subjection to pornography
* witnessing sexual acts
* Indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting to.

**Signs and indictors** are

Pain, sores and bruising around the inner thighs and genital, anal or breast areas.

Bloodstained underwear.

Pain and discomfort when walking or sitting.

Sexually transmitted infections and pregnancy are indicators for sexual activity and can indicate abuse if the person does not have the capacity to provide consent.

### **Neglect**

**Neglect** is also known as the ‘omission to act’ or ‘failure to act’.

It is a failure to meet the basic needs of the individual.

It includes

* ignoring medical, emotional or physical care needs,
* failure to provide access to appropriate health, care and support or educational services
* the withholding of the necessities of life, such as medication, adequate nutrition and heating

**Self-neglect** is a person’s failure or refusal to take care of their own basic needs.

Neglecting to care for one’s

* personal hygiene,
* health
* surroundings
* Can include a wide range of behaviours such as hoarding.

**Signs and indictors** of neglect by others and of self-neglect are similar.

They include:

* malnutrition
* dehydration
* bedsores
* dirty clothing and bedding
* Taking the wrong dosage of medication.

### **Psychological abuse**

**Psychological abuse** results in a person feeling worthless, unloved or uncared for.

It includes

* emotional abuse
* threats of harm
* abandonment
* deprivation of contact
* humiliation
* blaming
* controlling
* intimidation
* coercion
* harassment
* verbal abuse
* cyber bullying
* Isolation or unreasonable and unjustified withdrawal of services or supportive networks.

**Signs and indictors** include

* Anxiety
* Lack of confidence
* Low self-esteem
* Disturbed sleep.

### **Organisational abuse**

**Organisational abuse** happens where services provided are focused on the needs of the organisation.

For example, not providing choice over meal times or bed times because this is easier for the organisation.

It includes neglect and poor care practice within an institution or specific care setting such as a hospital or care home or in relation to care provided in one’s own home.

This may range from one-off incidents to ongoing ill-treatment.

It can be through neglect or poor professional practice as a result of the structure, processes, policies and practices of the organisation

**Signs and indictors** include

* Poor care standards
* Rigid routines
* Lack of staff learning, development and support.

### **Discriminatory abuse**

**Discriminatory abuse** refers to an individual or group being treated unequally because of characteristics identified in the Equality Act 2010.

It involves

Ignoring a person’s

* values,
* beliefs
* culture

It includes forms of harassment, slurs or similar treatment because of

* race,
* sex,
* gender reassignment,
* age,
* disability,
* sexual orientation,
* religion or similar belief,
* marital or civil partnership status,
* pregnancy or maternity

**Signs and indictors** include

* Poor service that does not meet the person’s needs
* Verbal abuse and disrespect
* Exclusion of people from activities and/or services.
* Discrimination can be either direct or indirect

## **Restrictive practices**

This term refers to actions that may need to be used such as physical restraint or use of devices, medication or seclusion. Restrictive practice must always be legally and ethically justified and must ever only be used when absolutely necessary to prevent serious harm. Any restrictive practice that is used inappropriately will almost certainly be a breach of human rights

Adult safeguarding policy & procedural Guidance

Care in Hand has in place several Policies & Procedures to safeguard the wellbeing of our service users.

Within each policy there are procedural guidelines that you will need to familiarise yourself with.

Please take the time to read through each policy.

[Adult Safeguarding Policy](https://www.careinhand.co.uk/index.php/download_file/view/972/621/)

**Contains Information on:**

The Role and Accountability of Staff in relation to Abuse

Care Management & Operational Management Responsibilities

Recruitment Practices

Prevention

Identifying Actual or Possible Abuse

Procedures for when abuse has occurred

Procedures for investigating Alleged Abuse

Follow Up to an Investigation Planning Further Action/ Lessons Learned & Improvement

Record Keeping

Referrals to DBS & Social Care Wales

Training

Related policies

**Related Policies to our Safeguarding Procedures are**

[Missing Person Procedures](https://www.careinhand.co.uk/index.php/download_file/view/969/670/)

[Medication Error Procedures](https://www.careinhand.co.uk/index.php/download_file/view/882/670/)

Whistleblowing Procedures

Overseas Workers Procedures Professional Boundaries Policy

Staff Incident Debriefing

UN Responsive Service Users

Safeguarding Service Users from Financial Abuse, and Gifts & Legacies Procedures

Lone Working Procedures & Risk Assessment

Management reporting & escalating concerns

# ****Sources of advice and information****

In order to respond appropriately where abuse or neglect may be taking place, anyone in contact with an adult, whether in a voluntary or paid role, must understand their own role and responsibility and have access to practical and legal guidance, advice and support.

This will include understanding local inter-agency policies and procedures. In November 2019 New Wales Safeguarding procedures were launched. The Wales safeguarding procedures are aimed at guiding all safeguarding practice for all staff employed in public & private sectors across Wales. The Mid & West Wales Safeguarding Board is [CWMPAS](https://www.cysur.wales/home/)

The procedures were not designed to be printed they are in digital format only. They are updated on the App or on line [www.safeguarding.wales](https://www.safeguarding.wales/)

In working Partnership with these local published guidelines Care in Hand have revised and updated their Adult Safeguarding Principles & Procedures.

Our policies and procedures or agreed ways of working will give you guidance on prevention and procedures to follow if and when abuse or neglect has happened or is suspected.

**You’re Area Manager or SFS or Complex Care Board should always be your point of contact for any questions or concerns you might have.**

Please Read and familiarise yourself with the following policies for further guidance on Care in Hand's procedures for Safeguarding:

* Adult Safeguarding Policy
* Escalating Concerns Procedures
* Safeguarding Vulnerable Service Users from Financial Abuse, and gifts and Legacies Procedures
* Identity Card Policy
* Ill, Injured, Dead and Irresponsive Service Users Policy
* Missing Persons Policy
* CCTV in Service Users Home Policy

## **How do we promote the dignity, rights & wellbeing of our Service Users**

Putting individuals who receive care and support in control of their care can reduce the chance of abuse or neglect happening.

It means making sure that in any care environment dignity and rights are promoted.

Lines of communication between individuals and workers are always open.

Relationships are based on trust.

Individuals play an active part in decisions about their care and support.

Individuals are aware that they can share their concerns or complain and that they will be taken seriously.

Individuals are supported to be as independent as possible to reduce their reliance on others who may take advantage of them.

Individuals know their rights and understand how they can expect to be treated.

## **How will individualised person-centred care help?**

Person-centred care means working together with the individual to plan their care and support to meet their unique needs.

This cuts down the risk of negative, unfair or harmful treatment and neglect.

The individual is put at the centre, able to choose and control how they want their care and support to be.

Active participation describes a way of working that makes sure an individual can take part in the activities and relationships of everyday life as independently as possible. They are an active partner in their own care and support.

Ensuring someone has the right equipment that they need to get around or to eat and drink without help are good examples of resources that support active participation.

Person-centred care should help the individual to make their own choices, assess and take risks. It is important they understand the consequences of the decisions they could make.

For example, if a friend brings an individual food that has been out of the fridge for a while on a hot day it is their right to weigh up whether it is likely to make them ill and to decide whether to eat it. In this way those who receive care and support can contribute to their own safeguarding.

## **Managing risk**

Risk enablement plays a natural part in self-directed care and support.

It empowers the individual to take control over their care, doing what they can to prevent themselves from being harmed or injured and agreeing the care and support that they need. For example, if an individual wants to go to the bathroom on their own but has mobility problems and is also feeling weak due to being unwell, risk enablement would be used to ensure they have the mobility equipment they need, and that they have a way of calling for help if they get into difficulty.

Being in control increases their self-confidence.

As confidence grows they are more likely to be open about reporting anything they are unhappy about.

As a result the risk of abuse and neglect happening is reduced.

Risk enablement Involves supporting individuals to identify and assess their own risks, enabling them to take the risks they choose.

It is a key part of person-centred care and emphasises that the individual is the expert on their care.

Care in Hand is active and positive about safeguarding adults and will:

* be open and clear about how they look out for each individual’s wellbeing
* be open and clear about how they put into practice the Professional Code of Practice for Health and Social Care, and the regulations set out
* show how workers should look out for abuse and neglect by publicising signs and indicators on posters or leaflets
* be responsible for providing learning and development for workers on safeguarding adults
* treat all allegations of abuse or neglect seriously
* Promote the values of person-centred care.

Where service users wish to take risks or any risks have been identified, that may pose a risk to themselves or others such as behavioural, self-neglect or moving and handling this must be documented by the field supervisor or senior field supervisor on the service delivery plan and associated risk assessments.

Senior Field Supervisors refer into the Complex Care Board anything they feel may reach the ‘threshold’—that is, the point at which something becomes a safeguarding issue.

For example, a one-off situation where a team is short of a worker on shift, despite efforts to find a replacement, may not be seen as a safeguarding issue as the service user lives with his daughter and she is able to see to the meal preparation needs. In another situation where individuals have complex and multiple needs, and lives alone or with an elderly family member, the same staffing issue might be a seen as a risk to people’s health and wellbeing and thus be a safeguarding concern.

## **Complaints**

It is important that individuals feel able to challenge poor standards of care. They should know how to complain and feel confident to make a complaint without the fear of reprisal.

Individuals should be informed that their concern or complaint will be taken seriously, be dealt with independently and that they will be kept involved in the process to the degree that they wish to be.

They should be reassured that they will receive help and support in taking action.

They should also be advised that they can nominate an advocate or representative to speak and act on their behalf if they wish.

If an adult has no appropriate person to support them, and has substantial difficulty in being involved, they must be informed of their right to an independent advocate, you can contact the contact centre to make the social worker aware of the service user's request for this.

An open and honest culture can encourage individuals to raise concerns before they come to harm.

You should do what is appropriate in your role to try to resolve any concerns.

If someone is still unhappy you must tell them how to complain in line with Care in Hand's complaint's procedure, this is also outlined in their service user guide in their hone file.

There should be a recorded process with agreed timescales, this is done in line with our action planning process.

You may need to support the individual to make a complaint by explaining the process and supporting them to communicate.

It is really important to make sure their voice is heard as this is part of developing a way of working that puts the individual at the centre of their care.

## **Reporting and responding to abuse and neglect**

You should know what to do if you suspect abuse or if abuse is disclosed or made known to you.

All suspicions have to be followed up in a formal way.

It is your responsibility to respond to allegations or suspicions in line with Care in Hand's safeguarding policies and procedures.

You must understand:

* what you should do if you suspect abuse or neglect is taking place, including who you should report to in the first instance
* what you should do if it is not appropriate to raise your concerns with that person
* What you should do if you feel that your concerns have not been addressed or if you experience a barrier in any part of the process.

Please refer to your Care in Hand's policies and procedures or speak to your Senior or Complex Care Board to make sure you know what you should do in each of these circumstances.

In an emergency situation you must take action to protect the safety and wellbeing of the individual.

If they need medical assistance you should call for a suitably qualified worker -where you would call 999/111 for an ambulance or medical advice.

If you suspect that injuries are not accidental, make the appropriate other workers aware of this so they can preserve evidence that could be used in a criminal case.

You should speak to your Senior or Complex Care Board about the next steps to take.

All safeguarding concerns are overseen by the Senior Field Supervisor and the Complex Care Board and a referral to the safeguarding team should be made via email on a form know as a MARF (Multi agency referral form)

If an offence has been committed it may be necessary to contact the police and a safeguarding investigation may need to be started immediately, but please contact the Complex Care Board for advice.

When abuse or neglect has taken place, it needs to be dealt with quickly and efficiently.

Information about the safety and welfare of an individual must be shared with your senior. It is important that you take the matter further if your senior has failed to deal with it and notify the complex care board.

This is a barrier that you might experience when trying to help and support an individual.

You may also find that working with multiple agencies acts as a barrier if the concerns are not taken seriously. If this happens, one option is to report it to the complex care board or operations team. They will be able take appropriate action. They will advise if you need to could inform the individual’s advocate or social worker, Adult Safeguarding Team, or Care Inspectorate Wales or the police.

It is important that the Complex Care Board are kept updated with all the details of the safeguarding procedures as we are regulated by CIW and certain safeguarding concerns must be reported under a notification to CIW as set out by Regulation 60 and Appendix 3 in the Statutory Guidance for Domiciliary Providers.

## **Whistleblowing**

Whistleblowing is the reporting of unsafe or illegal practices in the workplace.

At Care in hand we have set out our guidance on Whistleblowing in our Whistleblowing Policy.

As a registered social care worker under the Duty of Candour you have a responsibility to report things that you feel are not right, are illegal, or if anyone at work is neglecting their duties.

Speaking to your senior will normally be your first step.

However, if it is this person’s work that you are concerned about you can seek support from the Area Manager.

If you raise a concern with the CIW the information you give them will be dealt with in confidence, and you can raise concerns anonymously. The CIW have a quick guide to whistleblowing or guidance for workers that gives helpful advice on speaking out about poor care and what protection you will have from the law.

## **Confidentiality**

In terms of safeguarding and information sharing, this should be done be in line with the General Data Protection Regulation (GDPR) 2016 principles, ensuring that:

Information will only be shared on a ‘need-to-know’ basis when it is in the interests of the adult

Confidentiality must not be confused with secrecy

Informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement;

It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk.

Where an adult has refused to consent to information being disclosed for these purposes, then the relevant workers must consider whether there is an overriding public interest that would justify information sharing (for example because there is a risk that others are at risk of serious harm) and wherever possible, the complex care board should be involved as they are responsible for protecting the confidentiality of an individual’s information and enabling appropriate information sharing.

Decisions about who needs to know and what needs to be known should be taken on a case-by-case basis, and take into account by the Complex Care Board and a Care in Hand’s policies and the constraints of the legal framework.

## **Record Keeping**

Good record keeping is a vital part of good practice.

You should be given clear direction as to what information should be recorded and in what format.

All records should be factual and up to date. All care plans should be reviewed by the field supervisor and/or the Senior Field Supervisor at least three monthly and risk assessments annually, or sooner if there is any changes to ensure that they are still meeting the individual's needs and they are being protected from harm and neglect.

A call monitor is responsible for ensuring that any concerns that are reported to them through their shift are referred to the senior on duty and recorded on CM2000 private notes and their daily handover reports.

For the purpose of safeguarding the Senior Field Supervisor will ensure that an action log is opened in the safeguarding folder under the Action planning procedures.

The Senior Field Supervisor under the guidance of the Complex Care Board are responsible for ensuring that all correspondence that relates to the safeguarding concern are logged here, this might be emails, incident reports from care staff, the safeguarding referral,, communication notes, risk assessments, complaints forms, correspondence from the district nurses, Gps, social workers or other members for the multi-disciplinary teams.

If there is evidence of poor practice from a staff member this falls under the Hr procedures and can be known as professional concerns. In these incidences the HR Manager, Area Manager or Senior Field Supervisor may be required to supply records of DBS, training, supervisions, spot checks, and any capability procedures to the safeguarding team.

The Safeguarding team will always provide the lead person on the safeguarding case for Care in Hand (normally the SFS or a member of the CCB a copy of the closure letter with any recommendations for Care in Hand to implement in order to safeguard the service user or staff members in the future.

It is important that these are stored in the safeguarding folder and all actions are implemented by the SFS before the referral can be closed under CIH's procedures, any concerns implementing these guidelines should be referred to the complex care board or HR team if the guidelines are relating to staff.

[The Six Principles that underpin all Safeguarding Procedures](https://www.careinhand.co.uk/en/framework-training1/safeguarding/six-principles-underpin-all-safeguarding-procedures/)

**Six key principles underpin all adult safeguarding work**

* **Empowerment** – People being supported and encouraged to make their own decisions and informed consent.*“I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.”*
* **Prevention** – It is better to take action before harm occurs.*“I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.*”
* **Proportionality** – The least intrusive response appropriate to the risk presented. *“I am sure that the professionals will work in my interest, as I know them and they will only get involved as much as needed.”*
* **Protection** – Support and representation for those in greatest need. *“I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.”*
* **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. *“I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.”*
* **Accountability** – Accountability and transparency in delivering safeguarding. *“I understand the role of everyone involved in my life, and so do they.”*

Abuse and neglect can take place anytime and anywhere. However, some situations increase an individual’s vulnerability to the risk of abuse or neglect happening.

Examples are:

* In an individual’s own home it is easier for an abuser to hide their actions from others.
* Organisational abuse is more likely to happen when standards are poor and routines are planned to fit around a rota, or when workers feel unsupported by their management. This can lead to incorrect ways of working that everyone begins to see as acceptable. They do not try to challenge the situation because they are afraid of speaking out about what is being accepted by the majority.
* Any workplace where individuals display difficult or challenging behaviour that workers are not trained or supported to deal with.
* Particular care and support needs of the individual such as a sensory impairment, a mental health issue, dementia or a learning disability. If the person has communication difficulties their reaction to abuse or neglect could be mistaken as a symptom of their condition rather than an attempt to tell someone what is happening to them.

Challenging behaviour

Managing conflict and difficult situations

There are many things that can cause conflict with and between people. Conflict or ‘behaviour that is challenging’ often happens as a result of distress or because needs are not being met. It could be caused by a number of factors including:

* biological, for example because an individual is in pain or suffering the side effects of medication or substance misuse
* social, for example because of being bored, wanting social contact, having a need to be in control, not being able to communicate or understand what is being said
* environmental, for example because of loud noise or bad lighting or barriers to mobility
* Psychological, for example because of feeling left out or lonely.

Care in Hand operate A Behaviour Management Policy with a further policy on Leadership and management of Behaviours that challenge.

There is also a form to report what happened, who has been involved and where and when the incident took place.

You should include whether anyone has been injured and needed medical assistance or whether the police have been called, and sign and date the form.

This will then be used to determine any action that is needed to support the individual better.

An open discussion with any individual, where they are treated with respect and dignity, can often find a solution.

If possible and safe, when working with a person whose behaviour is challenging: ­ take them to a quiet place ­ ask questions and listen carefully to what they say ­ take their feelings of being upset or angry seriously ­ try to find a way forward that they understand and can agree to. It is important that you get to know the individuals you are working with as far as possible, so you can recognise what triggers their distress. It is also important that you don’t get emotionally involved but keep a clear head and look out for body language and reactions. If you feel that a one-to-one situation between yourself and an individual has the potential to become confrontational you should try to leave the scene to give them time to calm down. When you recognise frustration and aggression in a person’s behaviour you will learn, as you develop in your role, how to use your communication skills and other ways of working to manage a situation before it becomes violent or aggressive. Your manager will provide guidance, explain ways of working and support you to develop your knowledge and skills as you progress in your work.

Debriefing

Managing conflict and difficult situations there are many things that can cause conflict with and between people. Conflict or ‘behaviour that is challenging’ often happens as a result of distress or because needs are not being met. It could be caused by a number of factors including: ­ biological, for example because an individual is in pain or suffering the side effects of medication or substance misuse ­ social, for example because of being bored, wanting social contact, having a need to be in control, not being able to communicate or understand what is being said ­ environmental, for example because of loud noise or bad lighting or barriers to mobility ­ psychological, for example because of feeling left out or lonely. Your workplace might have a policy on responding to behaviour that challenges. There will usually be a form to report what happened, who has been involved and where and when the incident took place. You should include whether anyone has been injured and needed medical assistance or whether the police have been called, and sign and date the form. This will then be used to determine any action that is needed to support the individual better. An open discussion with any individual, where they are treated with respect and dignity, can often find a solution. If possible and safe, when working with a person whose behaviour is challenging: ­ take them to a quiet place ­ ask questions and listen carefully to what they say ­ take their feelings of being upset or angry seriously ­ try to find a way forward that they understand and can agree to. It is important that you get to know the individuals you are working with as far as possible, so you can recognise what triggers their distress. It is also important that you don’t get emotionally involved but keep a clear head and look out for body language and reactions. If you feel that a one-to-one situation between yourself and an individual has the potential to become confrontational you should try to leave the scene to give them time to calm down. When you recognise frustration and aggression in a person’s behaviour you will learn, as you develop in your role, how to use your communication skills and other ways of working to manage a situation before it becomes violent or aggressive. Your manager will provide guidance, explain ways of working and support you to develop your knowledge and skills as you progress in your work.

Positive behaviour and risk taking (default page)

# ****Health and Safety at Work****

The main reason for health and safety legislation is to protect people at work and those who are affected by work activities.

Legislation (that is, laws) is made so that everyone in society knows which behaviours are acceptable and which are not.

Laws cover all aspects of our lives including protecting the health and safety of people at work and those affected by work activities including those who receive care and support.

**Health and Safety at Work etc. Act 1974** – sets out how employers, employees and the self-employed must work in a safe way, giving every person on the work premises legal duties and responsibilities. As this act is very general, subject-specific ‘regulations’ have also been put in place to help every workplace to be safe. [www.hse.gov.uk/legislation/hswa.htm](http://www.hse.gov.uk/legislation/hswa.htm)

**Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013** – are often referred to as ‘RIDDOR’. Reporting accidents and incidents is an important part of your work in any health or social care workplace. The most serious accidents and incidents are reportable to health and safety authorities. [www.hse.gov.uk/riddor/](http://www.hse.gov.uk/riddor/)

**The Management of Health and Safety at Work Regulations 1999** – are about how health and safety is managed within a care workplace, including risk assessment, training and ensuring employees receive the information they need. [www.legislation.gov.uk/uksi/1999/3242/contents/made](http://www.legislation.gov.uk/uksi/1999/3242/contents/made)

**The Regulatory Reform (Fire Safety) Order 2005** – sets out how every workplace must prevent/protect against fire. [www.legislation.gov.uk/uksi/2005/1541/contents/made](http://www.legislation.gov.uk/uksi/2005/1541/contents/made)

**Control of Substances Hazardous to Health Regulations (COSHH) 2002** – are designed to protect people from hazardous substances - that is, any substance that can cause harm or ill health.<http://www.hse.gov.uk/coshh/>

**The Manual Handling Operations Regulations 1992** – cover the transporting or supporting of any load (including people) and how to carry this out safely and prevent injury. [www.hse.gov.uk/msd/pushpull/regulations.htm](http://www.hse.gov.uk/msd/pushpull/regulations.htm)

**The Provision and Use of Work Equipment Regulations (PUWER) 2002** – set out how any type of equipment is to be used safely. Work equipment needs to be checked and maintained regularly and employees trained in its safe use. In a care or health setting, ‘equipment’ includes not only specialist devices like lifting aids, but also everyday things such as televisions. [www.hse.gov.uk/work-equipment-machinery/puwer.htm](http://www.hse.gov.uk/work-equipment-machinery/puwer.htm)

T**he Lifting Operations and Lifting Equipment Regulations 1998 (LOLER)** have specific requirements relating to work equipment which is used for lifting and lowering people or loads. [www.hse.gov.uk/work-equipment-machinery/loler.htm](http://www.hse.gov.uk/work-equipment-machinery/loler.htm)

## **Health and safety policies and procedures**

Care in Hand have a health and safety policy along with a number of additional policies which sets out how they will protect everyone who is affected by our business, including employees, family members and individuals who access services.

Even if your role involves working in the private homes of individuals you need to know what health and safety legislation applies there and everyone has a responsibility to report any concerns relating to health and safety to their senior to action accordingly.

As a registered social care worker, you are responsible for taking reasonable care of yourself and others in the workplace. You need to follow the policies and procedures of Care in Hand and not act in a way which will cause an accident or ill health to yourself or others.

You will probably work with a number of individuals who all have different needs and who require different types of care and support. Any task you do whilst at work, must not put them at risk.

An example of how you can take reasonable care of those within Care in Hand would be to report anything that could cause someone to trip or fall, like a frayed carpet or a wet floor, and take any action that you are asked to do.

At Care in Hand the appointed person to oversee Health and Safety is the Responsible Individual Delan Umanee. He has many legal responsibilities; these are likely to be carried out by Senior Field Supervisors and Field Supervisors. His overall responsibility is to ensure the health, safety and welfare (or wellbeing) of all employees. The RI must make sure that this happens by putting in place policies and procedures and ensuring there is enough time and money to put safety at the centre of all tasks.

The RI must provide:

* a safe place to work
* necessary training
* Appropriate and safe work equipment. (However for equipment for service users this is provided by the occupational therapist and SHAPES).

## **Health and safety tasks that require special training**

There are a number of activities that you must not carry out until you have received special training.

Usually such training would include some practical elements and assessment by a competent person

These activities include:

* **Use of equipment such as hoists and lifts** to move people and objects safely: each piece of equipment that you will use will have instructions for safe use.
* **Medication:** there is legislation and guidance that controls the prescribing, dispensing, administration, storage and disposal of medicines.
* **Assisting and moving**: it is essential that you know about safe moving and handling so you don’t hurt yourself or the individual.
* **First aid**: this is the immediate assistance given to someone who has been injured or taken ill before the arrival of qualified medical assistance. If you have not been trained you should get help from a qualified first aider or call an ambulance. You should not attempt first aid without training as you could make their condition or injury worse. However, you should also know your ‘basic life support’ duties
* **Emergency procedures**: for emergency situations such as fire, explosion, flood, building damage, etc.
* **Food handling and preparation**: this will help you to prepare food that is safe for individuals to eat and stop you from causing food poisoning.

To make sure that you are keeping the individuals you support as safe as possible, you should only undertake certain activities once you are competent to do so.

## **Additional support and information about health and safety**

There may be times when you feel you need to know more about how to prevent accidents or ill health.

Please contact your senior for the updated policies and guidance or please contact the complex care Board or the responsible individual who can help you to find information or answer a question.

Health and safety law posters (displayed in the office) are other ways of gaining more knowledge.

## **Risk assessment**

A risk assessment helps the individual to have their choices met in the safest possible ways.

Risk assessments are not only a legal requirement, they also provide clear guidance and information on how to keep people safe and prevent danger, harm and accidents.

They identify hazards in a home or office, evaluate the level of risk and put in place measures or procedures to reduce the risk.

There are five steps to a risk assessment which you will need to understand:

1. **Identify the hazards** of an area, a specific task or situation.

2. **Identify those who may be harmed**, such as individuals being supported, visitors, other workers and contractors.

3. **Evaluate** the risk by looking at what methods are in place to control risks or reduce them.

4.**Record** the findings of the risk assessment to help to remind everyone of what the risks are and how to reduce them.

5. **Review and modify** the risk assessment if and when changes happen to the tasks or workplace. Changes may increase risks or reduce them.

**Hazard** - This is something with the potential to cause harm. For example soiled bed linen or clothing, spillages of bodily fluids and assisting people to move.

**Risk** - The likelihood of the hazard causing harm. For example picking up an infection from soiled bed linen, slipping on fluids from spillages or trapping injuries from using a hoist.

The most important part of hazard reporting is that you act quickly and tell a senior who can take action to prevent an accident or harm.

**It is a legal requirement that you do this**

Once a hazard is identified, a risk assessment needs to be carried out.

Our policy on[Assessing and Managing Risks for Service Users Policy](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset) also provides more information for on risk assessments

# ****Moving and Handling****

Your role may include moving and assisting people and will certainly involve moving and handling objects.

There are laws specifically about tasks that involve lifting, putting down, pushing, pulling, carrying or moving by hand or bodily force.

These tasks are governed, in particular, by the last three regulations in the list of legislation on the Health and Safety Page

All staff in Care in hand are often required to be familiar with the use of assisted beds and hoists to help with moving and assisting individuals. In order to have a full understanding of their roles and responsibilities they need to read and understand our [Moving and Handling Policy](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset)

You must have proper training before using this equipment, to ensure that you use it properly and do not injure yourself or the individual.

Other tasks that require training and an assessment of competence include:

* supporting an individual to transfer from a bed to a chair
* helping with daily assisting routines like bathing
* Moving on and off the toilet.

You should always carry out moving and assisting tasks in the agreed ways found in our policies and procedures and the individual’s moving and handling plan.

Over a third of injuries in the workplace, which lead to time off work, are due to moving and handling. It is extremely important that any moving and handling concerns are reported and actioned immediately this will prevent accidents and minimise the likelihood of injury to the individuals you support, yourself and others.

Often we come across service users who are at risk of falls or who have suffered falls. As part of the management team you should be able to advise the care staff on the procedures that will support them during the situation.

The policies

[Falls Prevention and Risk Assessment](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset)

[Care of somebody who has suffered a fall](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset)

Provides further guidance on this and should be read by all management staff.

## **Training**

In Care in Hand we provide in house All Wales Moving and Handling Passport training during induction this is a 3 day training course for all staff.

The training department are then responsible for allocating moving and handling refreshers annually.

Field Supervisors and Senior Field Supervisors along with moving and handling competency assessors are responsible for overseeing competency assessments of staff in the community

Field Supervisors and Senior Field Supervisors along with moving and handling competency assessors are responsible assessing service users’ needs and ensuring that their techniques are safe for care staff to complete. If specialised training is identified then the complex care board must be contacted. The training department must also be notified. Any specialised training should be provided by the occupational therapist or physio department.

## **Assessment**

Field Supervisors, Senior Field Supervisors and moving and handling competency assessors are responsible for completing the assessments for service users and ensuring the moving and handling plans and guidance is relevant, up to date and safe for the care staff to follow.

The moving and handling forms are:

* **F25A - Initial Moving and Handling Assessment** - this is an assessment form and a form for service users who are independent or require very minimal assistance.
* **F25** -**All Wales Moving and Handling Form** This is the fill All Wales Moving and Handling Assessment and sets out any contributing factors such as health, the environment and the step by step guidance on how to complete the moving and handling tasks, whether it is assisting with getting in or out of bed using a steady or turning in bed using slide sheets.
* **F25B Inanimate Moving and Handling Risk Assessment** - this in an inanimate moving and handling form, this is often used for domestic support or where staff are required to move inanimate objects such as hoovers or bins.

Any service users with complex needs or complex moving and handling including bariatric care should be referred into the complex care board for review.

A SFS, FS or MHCA are responsible for working with the occupational therapy department and physio department for all new assessments and reassessments of service users where hoists and additional equipment such as molests or Return tables are used. They will provide the written guidance and Moving and handling guidance for us.

However, should an individual have minimal moving and handling requirements then we should have the capabilities to complete the moving and handling assessment documentation ourselves (F25A or F25).

**The Physiotherapy Department** support us with all mobility and walking concerns and often provide techniques or exercises that may support the service user with this. Please see the attached guidance for further information on the [physiotherapy role in the community](https://www.careinhand.co.uk/index.php/download_file/view/948/624/). They are based at the local hospital, this might be Withybush for the North Pembrokeshire and South Pembrokeshire Hospital for South Pembrokeshire or Glangwili for Carmarthenshire.

The **Occupational Health department** provide support with adaptions and equipment that support the individual to maintain their independence for as long as possible and keep the staff safe.

There are two teams of occupational therapy in the community, these are the **Community OTs and the Health OTs**.

* The **Community OTs** see to long term concerns and general deterioration of a service user. They are based at the council and are contactable through the contact centre.
* The **Health OTs** see to acute changes to a service users’ needs such being bed bound due to a UTI where normally they are fully mobile. They also support individuals to adjust back home and overcome any moving and handling concerns following a period in hospital.

Please see the attached [presentation](https://www.careinhand.co.uk/index.php/download_file/view/949/624/) for further guidance on what the community OTs can support with and the referral criteria for their department.

All moving and handling forms should be reviewed at least annually, or sooner if there are any concerns. If a service user has a progressive condition such as Parkinson's or Motor Neuron's Disease the field supervisor or senior field supervisor may wish to review this monthly, or every three months. However routine moving and handling checks can be done by the field supervisor working with the service user by completing one of their calls, or a spot check of another care worker.

[Clinicalskills.net](https://www.clinicalskills.net/) also provides pictorial guidance for moving and handling techniques and hazardous moving and handling that is very beneficial for, call monitors, field supervisors or senior field supervisors may provide staff with, especially if they may be new to care or a new procedure or where they may be some communication barriers.

## **Falls Prevention**

Many Service users are at risk of falls, and due to their condition, such as Parkinson's or Dementia or Macular Degeneration these falls may increase as their condition progresses.

Care staff may report concerns over moving and handling to the Call Monitor, it is important that the Call Monitor documents this in their handover and the individual's private notes on CM2000 and escalates this to the Field Supervisor and Senior Field Supervisor immediately for further advice.

Often individuals may find it hard to speak about falls as they may not wish to admit they are increasing, it is important that the Field Supervisor or Senior Field Supervisor approaches this with sensitivity.

The following document supports the FS and SFS with techniques to support open conversations about this topic.[Have a Word About Falls.](https://www.careinhand.co.uk/index.php/download_file/view/950/624/)

The following links will also provide further information on falls prevention in the elderly:

[Falls Older People](https://www.rcn.org.uk/clinical-topics/older-people/falls)

NICE (2019) [Surveillance of falls in older people: assessing risk and prevention (NICE guideline CG161)](https://www.nice.org.uk/guidance/cg161/resources/2019-surveillance-of-falls-in-older-people-assessing-risk-and-prevention-nice-guideline-cg161-pdf-8792148103909).

[Aging Well in Wales - Falls Prevention](http://www.ageingwellinwales.com/en/themes/falls-prevention)

[Steady on...Stay Safe](http://www.wales.nhs.uk/sitesplus/888/page/83453)

Senior Field Supervisors are responsible for ensuring all incidents of falls are reviewed in a timely manner in line with Care in Hand's Risk Matrix.

They may wish to open an action log in line with the action planning procedures, they are responsible for ensuring that all actions are completed in a timely manner before the action plan is closed.

The SFS may request that the Field Supervisor support them to complete a falls risk assessment.

A fall risk assessment takes a number of factors into consideration. These include

* **History of previous falls** - is there a developing pattern?
* **Medical Factors** - any conditions that may increase their risk of falls.
* **Medication** - some medication may cause blood pressure to lower or increase or cause dizziness
* **Eyesight and Hearing** - ability to see where they are going, hear commands
* **Balance and orientation** - certain conditions such as acquired Brain Injury or Stroke or dementia may affect their ability to manage their own balance unaided or their ability to be orientated in the space they are in.
* **Posture and gait**- Certain Conditions such as osteoporosis may affect an individual's posture when standing.
* **Diet and nutrition** - if an individual is not eating very well or eating unhealthy foods it may increase their risks of falls if they become weaker or dehydrated.
* **Attitude and emotional state** - an individual who is depressed may not be motivated to move and spend long periods in bed and therefore by not moving frequently may be more at risk of falls.
* **Transfer abilities** - If an individual struggles to get in or out of bed or stand from a chair if they try this without support this may result in a fall.
* **Environment**- if there is poor lighting, steep steps, cluttered home, frayed carpets, trailing wires, this may increase the risk of trips.
* **Aids**- maybe they have aids that they forget or refuse to use?

It is important to review the key factors and summarise how these could put the service user at risk of falls and what effect that may have on them, their family and the care staff.

If there is a risk identified then the **guidance** and **risk reduction plans** must be put in place for the care staff, sometimes additional support from the district nurses, Gp, physio or OT might be needed to overcome this risk.

If a senior field supervisor has tried to reduce the risk and there are still barrier remaining that may put the staff and service user at risk then this can be referred into our **Complex Care Board** and looked at under our service withdrawal policy.

However, at this time the senior field supervisor would be required to provide the complex care board with a copy of the:

* Incident reports
* Action plan and any communications with the MDT or service users/family.
* Risk assessments.
* Care and Support plan if they are funded by the local authority.

The complex care board will provide guidance for the senior field supervisor on what steps to take next to resolve the issue.

**The risk assessment should be reviewed after each fall and at least annually.**

## **Inanimate Moving and Handling**

 There may be times where staff are required to lift of move inanimate objects, this is more common in domestic support calls.

This can cause issues as these items can often be awkward in shape and difficult to hold, therefore the staff could be greater risk of injury.

This could include:

* Pushing/pulling a hoover
* Lifting a hoover up/downstairs
* Lifting Laundry up/downstairs
* taking out the bins
* pushing/pulling a table or box
* Lifting a box/shopping bags

Space constraints could increase the risk of twisting/stooping/leaning.

Although the risk may seem low at point to assessment, if care staff are continually exposed to this then they run the risk of suffering injury from the repetitive motion.

It is important for field supervisors and senior field supervisors to work with the service user, family or social worker to reduce the risks as far as reasonably possible and ensure that guidance is clear and easy to follow for the staff.

This might be a solution such as:

* Having two hoovers one for upstairs and one for downstairs to reduce having to carry the hoover
* Only taking half a load of laundry to the washing machine at the time so it is easier to carry and using a basket to prevent trailing sheets.
* Emptying the bins when they are 3/4 full or using a wheelie bin that can be wheeled rather than lifting the bag.
* Taking some items out of the box/shopping bags so they are lighter and easier to carry.

Care staff may report to the **call monitor** that there are issues with space or that service users need assisting with domestic duties. A call monitor should always check in the moving and handling plans and service delivery plans if this has been risk assessed for the staff to do this, and report any concerns to the field supervisor or senior field supervisor.

The**Field Supervisor** is responsible for completing routine checks when out on community runs or spot checks of staff to ensure that if inanimate moving and handling is required the current guidance is still relevant and care staff are following this to prevent injury, if there are issues that cannot be resolved by the field supervisor such as staff of service users not abiding to the guidance then this should be escalated to the senior field supervisor.

The **Senior Field Supervisor** is then responsible to reviewing the health and safety concerns that have been highlight to them. They must assess if further guidance is needed from additional bodies, such as environmental health or the occupational therapist, social worker, or care and repair to assist with the concerns. They are required to open an action log and set time frames in line with Care in Hand's risk matrix as to how long we will allow for a solution to be sought. If the risk is low this might be 14 days, medium might be 5-7 days and high might be 24/48hours and provide guidance for the care staff, field supervisor and call monitors on how to proceed.

If a senior field supervisor has tried to reduce the risk and there are still barrier remaining that may put the staff and service user at risk then this can be referred into our **Complex Care Board** and looked at under our service withdrawal policy.

However, at this time the senior field supervisor would be required to provide the complex care board with a copy of the:

* Incident reports
* Action plan and any communications with the MDT or service users/family.
* Risk assessments.
* Original Contract if it is private or Care and Support plan if they are funded by the local authority.

The complex care board will provide guidance for the senior field supervisor on what steps to take next to resolve the issue.

**All risks assessments should be reviewed following the report of any concerns by a field supervisor or senior field supervisor.**

# ****Environmental Risk Assessments****

## **Accidents**

Accidents are caused by the risks found in the particular area. Risk assessments will be available which identify all the potential risks and steps to reduce the likelihood of them happening and what has been done to reduce the risk.

These are completed by a Senior Field Supervisor or Field Supervisor at point of commencement of care.

If at this point hazardous are identified that cannot be resolved before the carers are due to visit then the Senior Field Supervisor may speak to the social worker and the complex care board to see if we could put in additional measures or delay starting a package until we are sure that it is safe the care staff to visit and not be exposed to harm

Potential accidents could include:

* slips and trips
* falls
* sharps injuries (an incident in which a sharp object e.g. needle, blade, broken glass or cannula penetrates the skin)
* burns and scalds
* injuries from operating machinery or specialised equipment
* electrocution
* Accidental poisoning.

As service users live in their homes, and often have family or friends visit or may have conditions such as dementia the risks in a property may change overtime.

It is important that any feedback that is provided by the staff to the **call monitors** is escalated to the field supervisor, senior field supervisor or senior on duty to reduce the risk of injury to staff or the service user, it must be also noted in handover and the client private notes on CM2000.

The environmental risk assessment should be reviewed and updated at least annually or sooner if any concerns have been highlighted by the staff, call monitors, field supervisors, and senior field supervisors. Often referrals, such as to the fire department, family, care and repair, SHAPES, occupational therapists or the social worker may be needed to assist.

Again if a risk is identified then the risk management plan needs to be implemented in line with Care in Hand's risk matrix and an action plan is opened, this is done by the **field supervisor or senior field supervisor.**

Should there be a reason why the risk cannot be adequately managed, such as fire risk or where a service user will not agree to the guidance set out then this would need to escalated to the social worker and a review may need to be organised, and escalated to the **complex care board** to review.

## **Environmental risk assessment**

An environmental risk assessment is a holistic approach to assess if somebody's home is safe for them to receive care in and for the staff to complete their work in.

When we look at environmental risk assessment we do not only look at the inside of the property itself but also the access to the property.

This is particularly important for lone working which is reflected in our [lone working policy](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset) and [personal safety at work policy](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset)

For example:

If a property is remote and there is a steep driveway or a large number of steps, poor outside lighting and poor telephone signal then we would need to ensure that this is reflected in the property assessment and the call monitor has been advised by the field supervisor or senior field supervisor to closely monitor the times at which the care worker has logged in to the call and the following calls in case there is an issue and we cannot access the care worker.

In towns there are often issues with parking permit zones and this might mean that the care staff are required to find an alternative area to park, this might be a few streets over so it is important that the care staff are aware of this and are advised to use the torches that are provided during induction.

Likewise when assessing accessing a house, take into any trip hazards such as steps, that might be broken or cracked, or handrails that are loose, always think of the time of the day the calls are and if they would be concerns in frost, snow, heavy rainfall etc.

Lighting - always ensure that outside lights work particularly for early morning or late evening calls to allow for safe access, it is important as a field supervisor that you continually check with your carers that they still have their torches provided during induction in case there are any issues.

In order to stop intruders and prevent individuals from becoming victims of crime, good security measures are important. 

Examples of security measures include:

* Reporting any strangers you find on the premises
* requiring visitors to a service user with dementia to sign a visitor book
* setting alarms where they are fitted
* Checking the identity of individuals who ring and ask for information.
* Outside doors should be locked and fitted with a door bell to ensure no unauthorised access.
* Never let in visitors or give out information unless you have consent to do so, this includes key safe codes.

Further information for service users could be sourced from [AgeUk](https://www.careinhand.co.uk/%20https:/www.ageuk.org.uk/information-advice/care/home-safety/)

Our [Home Security Policy](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset) discusses the procedures in accessing a service user's home safely in more detail.

In line with our moving and handling policies we will also look at space constraints, this is particularly important for service users require assistance for moving and handling and ensuring there is adequate space for the care staff to work without being at risk of injury from clutter or other items.

It is also worth looking at the extremes in temperature control, if there is no heating then the service user may be at risk of hypothermia likewise if it is too hot the service user may become unwell or staff may feel faint. Therefore any issues regarding heating not working reported by the care staff to the call monitors or field supervisors or senior field supervisors should be actioned immediately. This may not just be relating to heating, if there is not adequate ventilation in a shower or bathroom it may become too hot and put the care staff at risk of becoming weak or dehydrated from the heat.

Mould can also occur along with other signs of damp, this is more applicable to older houses, the presence of mould can cause respiratory concerns for staff and service users if they are exposed to this over time, this would need to be actioned very quickly to prevent the spread of this, but this is the responsibility of the family or service user to arrange. However the call monitor, could contact the family to make them aware and the field supervisor could make a referral if they had no family to environmental health section of the local authority with the service users consent.

## **Waste Disposal.**

Waste is considered hazardous if it is potentially harmful to humans or the environment. Disposal must be done in a way that avoids any danger or harm.

Inadequate waste disposal systems leads to a build-up of bacteria in a home and may also attract pest infestation. Therefore it is important to note of there are adequate space, and supply of water for handwashing and disposal of waste which is covered in more detail in our infection control section later on.

## 

## **Hazardous Substances**

Hazardous substances found in a health and social care environments include:

* cleaning materials
* disinfectants
* body fluids
* medication,
* clinical waste such as dressings
* Contaminated clothes, towels and bed linen.

These substances can enter the body via inhalation (breathing in), ingestion (swallowing), injection (needle stick) or absorption (through the skin).

For all products you use, read the hazard information found on the label; this will inform you about their hazards and help you to keep yourself and others safe.

It is important for the field supervisor or senior field supervisor to note on the risk assessment where the storage of hazardous substances are within a home so the care staff and call monitors have easy access to this.

All hazardous substances should only be handled when the worker is wearing personal protective equipment (PPE).

Our [policy on COSHH](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset)sets out our guidance for all staff on this.

Our [procedures on spillages](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset) also sets out how to clean up any spillages that may occur in a home.

* **Cleaning products and disinfectants** should be kept in their original containers as these give the manufacturer’s instructions for correct usage. These instructions must always be followed. An individual may choose to transfer products out of their original containers in their own home.  For your own safety you should only use products that are in their original containers.
* **Body fluids** such as blood, urine, vomit and faeces must be cleaned up immediately. Disposable items used for cleaning the spills, such as paper towels and gloves, should be double bagged before disposing in the black/grey or purple bin bags.
* **Clinical waste** includes contaminated waste such as used dressings and contaminated personal protective equipment.
* Some contaminated clinical waste can pierce the skin and should be stored in **sharps bins** rather than bags, to protect workers from injuries. If supporting a person who requires handling of sharps the field supervisor or senior field supervisor would have always documented this in their risk assessment. Sharps should normally be returned, in an approved sharps box, to the place they were prescribed.
* **Linen** which has been contaminated with body fluids should ideally be washed immediately. Which is why it is important to check if the washing machine is working.

## **Fire Safety**

 Fires are a hazard in any home and can lead to injury or death.  Basic fire prevention measures include:

* No smoking or naked flames within the building.
* Do not have fire doors propped open as this will increase the speed at which a fire spreads in a building, such as an apartment complex.
* Do not allow waste to accumulate which could provide fuel to a fire.
* Check escape routes are not blocked and keep them clear of furniture or boxes.
* Check that appliances and plugs are turned off to help prevent an electrical fire from starting.

You can support individuals to get advice to make their homes safer but you must respect the choices that they make; for example they may choose to smoke or not to have smoke alarms.

It is very important that all call monitors, field supervisors and senior field supervisors are familiar with the escape routes and guidance for staff in the event of a fire taking place, these should be reviewed regularly by the field supervisor and senior field supervisor to sure they are kept clear are all times. Sometimes there may be increased risks in an individual’s home that you need to be aware of; they may choose to smoke for example.

In Care in Hand we advise that service users should not smoke when they are in the presence of the care staff as this is their place of work.

Our[fire safety policy and smoking policy](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset) provide further guidance on this.

If we identify that there is a risk of fire or a service user has no fire alarms or safe escape route we may decide to complete a fire safety referral with the service users consent to the local fire service. The local fire service will often provide a free fire safety check for the service user and provide them with the essential alarms and aids they require free of charge, this is particularly important for service users who smoke or on oxygen.

Where service users may have solid fuel they may be at risk of carbon monoxide poisoning and should have a working alarm for this.

In Care in Hand we advise that care staff do not assist with any gas or solid fuel or wood burning heating appliances to reduce the risk of fire.

The fire service have provided us with further guidance on how to ensure fire safety in the home for our service users: [Safety at Home](https://www.careinhand.co.uk/index.php/download_file/view/951/625/)

## **Family Pets**

Many service users have pets and they are often a form of companionship for the service user.

However although a service user may describe a pet as friendly they may become unpredictable or protective of their owner when care staff attend this may increase a risk of injury or falls for both the service user and the staff members so risk reduction plans such as keeping them in another room during transfers.

It is also worth noting that some care staff may suffer from allergies to certain pets and therefore would not be able to attend or may require the pet to be kept in a separate room during their visits.

Certain activities such as vet bills and emptying litter trays will remain the responsibility of the family and service user.

As service users with certain conditions such as dementia or Parkinson's progress in their conditions they may not be able to see to the pet's needs as they used to before. We have a responsibility to report any concerns to family members or the RSPCA who may be able to assist with the care of the pet to allow them to remain with the service user for as long as possible as this remains the responsibility of the service user or family.

Our[Pets policy](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset) provides further guidance on the roles and responsibilities of care staff and service users in relation to pets.

## **Food Hygiene**

An essential part of the service user’s wellbeing is their nutritional status. Maintaining their nutritional status will be looked at under Nutrition and Hydration section. However, in this section we will look at food safety and food hygiene.

 Food safety is essential when preparing and handling food

Not all substances and objects that can cause harm or illness can be seen. This means that people can become ill from eating food that tastes normal and looks safe. Whether you occasionally make someone a snack such as a sandwich, or are regularly involved in preparing meals, you should always make sure that the food is safe to eat.

 If something becomes contaminated it means it will become dirty, infected, unclean or polluted. This includes ‘going off’ by being too old to consume.

Food must be prepared and stored in ways that prevent it becoming contaminated with things that can cause harm or illness. Food hazards could be:

* **Physical –** such as objects that can be harmful, for example bones or bits of packaging. These could be in food when bought or introduced when preparing food. Check for these as far as is possible.
* **Chemical** – such as pesticides, weed killers or cleaning chemicals that could be harmful if eaten, for example pesticides attached to fresh fruit and vegetables or cleaning products sprayed onto prepared foods. Ensure all fruit and vegetables are washed before preparation and avoid spraying cleaning products close to food.
* **Allergenic –** such as those that may cause reactions if an individual is allergic to the food, for example nuts, shellfish, milk or gluten. These may cause an itchy skin rash, breathing problems and/or stomach cramps with vomiting or diarrhoea. In the worst case the person may go into an anaphylactic shock. Always ensure foods that contain allergens are kept and prepared separately from foods that do not.
* **Bacterial –** such as pathogenic micro-organisms in food, for example raw foods that need to be cooked to remove the pathogens, or those found in the human gut, nose and mouth that can be transferred to food during the storage, handling and preparation process.

Effective food safety principles should be followed to remove these risks.

Some groups of people are more vulnerable to food-related illnesses because of a weakened immune system.

These groups can include:

* pregnant and breastfeeding women: childbearing and breastfeeding uses up a lot of the body’s iron and zinc which are important for immunity
* older people: their immune system becomes less effective in recognising contaminated food
* people living on a low income: they find it difficult to afford a healthy and  balanced diet
* People in hospital: illness weakens the immune system, and some medication may also affect the immune system.

Vulnerable Individuals may be more vulnerable to being affected by contamination than is usual if a smaller number of bacteria can cause them illness, or if the symptoms they experience may be more severe. These could be due to a variety of reasons.

It is essential that precautions are taken to ensure that food is safe to eat.

There are some basic principles you need to keep in mind to protect all individuals when handling, storing or preparing food, these include:

* remove jewellery before preparing food
* wash your hands thoroughly before touching food and ensure you change your PPE
* wash equipment in hot water between uses
* ensure food is cooked thoroughly
* store food in sealed containers and keep cooled
* food stored in a fridge should be labelled, dated and kept at 5ºC
* store raw meat below cooked food
* prepare raw and cooked foods separately
* Equipment should be washed in hot soapy water or a dishwasher if available.

The Care Inspectorate Wales requires that where food is provided to individuals that it is handled, stored, prepared and delivered in a way that meets the requirements of the Food Safety Act 1990. If your role includes preparing or handling food, you must have the knowledge and skills to do so safely.

Within Care in Hand we advise that a microwave is used for most food preparations

1. This reduces the risk of fires from grills or gas cookers.
2. Second reason is that care staff often have limited time in such as 15, or 30 minutes to complete their care calls and a lot of oven food may require longer to ensure it is cooked safely.

Should there be a reason why a cooker needs to be assessed for use by the care staff then this would need to be referred by the field supervisor or senior field supervisor through to complex care.

## **Substance Misuse**

It is important to remember that at all times our staff are visitors in service user’s homes, and we must respect their choices and living standards.

Some service users may take consume alcohol or drugs, which will be covered in our challenging behaviour section.

However, should a service user take part in illicit substances in their own time they must not expose the care staff to this during their visits as it may put our care staff at risk of harm.

We have a [substance misuse policy](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset) that provides further guidance for the care staff, call monitors, and field and senior field supervisors on what actions to take should they come into contact with any illegal substances in a service user's home.

This would need to be identified in the risk assessment and escalated by the senior field supervisor, field supervisor or call monitor  to the complex care board for review and to provide additional guidance.

# (Page pending approval) ****Infection Control****

Infection and infectious diseases in humans are caused when harmful germs, known as pathogens (or pathogenic micro-organisms), enter the body and grow. These micro-organisms are so small they can only be seen by using a microscope.

Infectious diseases, unlike other diseases such as heart disease and diabetes, can spread from person to person.

As with all illnesses,**prevention is better than cure**.

Following infection control policies that stop the spread of pathogens can help to prevent and control infection

* **Pathogens** A pathogen is something that causes a disease.
* **A host** could describe the organism from which the parasite feeds or in which it lives or grows.
* **Contamination** A thing is contaminated if it is dirty, infected, polluted or has ‘gone off’.

Pathogenic organisms can be:

**Bacteria** that can multiply quickly at body temperature and reach harmful levels very fast.

Examples of harmful bacteria include

* meticillinresistant Staphylococcus aureus (commonly known as MRSA)
* Clostridium difficile (known as C.Diff or C. Difficile).

These two types of bacteria caused or contributed to 9000 deaths in hospitals or primary care in 2007.

**Viruses** can survive on surfaces and in food but can multiply only in living cells.

It takes very few virus organisms to cause illness.

They can be spread from person-to-person and from environment-to-food.

Examples of viruses include

* Norovirus (also known as ‘winter vomiting disease’)
* Influenza (the flu virus).
* Coronavirus (COVID-19)

**Fungi** are organisms which live on hosts that can be alive or dead.

Examples of fungal infections include;

* athlete’s foot
* Ringworm.

**Parasites** live on or in another animal or a plant, known as the host.

* Scabies is caused by mites that burrow into the skin causing severe itching.

**Protozoa** are single-celled organisms that live in water and damp conditions.

* Malaria is an example of a disease caused by protozoa.

Some groups of people may be more vulnerable to infection, for example Because of age or general health or some particular illness. If these groups become infected the symptoms may be serious and life-threatening. If the micro-organisms which cause the illness are resistant to antibiotics, it can be difficult to treat the illness

## **The Chain of infection**

1. The first link in the chain is the **causative agent.** This is the harmful germ or pathogen that can cause infection, illness and disease. Examples include bacteria and viruses.
2. The second link is the **reservoir or source**. This is where pathogens live and multiply. Remember, that could be in or on a person or animal (host), or in soil or water or food.
3. The third link is the **means of exit**. This is how pathogens leave the source. For example, pathogens that live in the respiratory tract (the lungs, throat, etc.) can leave the body through the mouth or nose in saliva or mucus when coughing or sneezing. Other examples of means of exit are broken skin, mucous membranes such as the eyes, via the stomach and via the intestines and anus.
4. The fourth link is the **mode of transmission**. It refers to how the pathogen is passed on from one person to another. Contact transmission is the most common route of transmission of pathogens in a health and social care workplace. This can happen by direct contact (such as hand-to-hand) or indirect contact (via objects such as equipment). Pathogens such as those that cause influenza and chicken pox can stay in the air for a long time and can be breathed in by other people.
5. The fifth link is the**portal of entry**. This is the way that the pathogen enters the body of the potential host. Pathogens can enter the body by coming into contact with broken skin, being breathed in or eaten, coming into contact with the eyes, nose and mouth or, for example when needles or catheters are inserted.
6. The sixth and final link in the chain is the **person at risk**. A person at risk is the individual the pathogen moves to. The risk of a person becoming infected depends on factors such as their general health and the strength of their immune system (which is the body’s system for fighting germs and micro-organisms).

## **Breaking the chain**

Preventing infection means breaking the links in the chain so that an infection cannot spread.

Some links are easier to break than others. For example, it is easier to stop a pathogen from entering a person than it is to stop one leaving an infected person.

The steps taken to protect individuals and workers from infection are an important part of providing high quality care and support.

It is vital to remember that not everybody who carries harmful micro-organisms will be ill or show any symptoms, so you must work in ways that prevent infection at all times.

Standard precautions are the actions that should be taken in EVERY situation to reduce the risk of infection.

These include:

* good hand hygiene
* safe disposal of waste
* safe management of laundry
* Correct use of personal protective equipment (PPE).

In a person's home it may be necessary to take additional measures when supporting people who are known to be carrying some harmful microorganisms to protect others from contamination.

This can be particularly important if the pathogens travel through air and this guidance would come from the complex care board.

The call monitors are responsible for updating the care staff on any changes and the field supervisors and senior field supervisors are responsible for updating the risk assessments with the latest guidance.

## **Your health and hygiene**

You have an important role to play in preventing the spread of infections.

It is your responsibility to keep up to date with your own vaccinations in line with the UK vaccination schedule as it is part of your duty to protect the individual by not spreading infection.

If you are carrying pathogens, you can transmit them to the people you support directly or you can transfer them from other people or equipment if you do not follow correct hygiene procedures.

**Illness** - If you have cold or flu symptoms (such as a runny nose), an upset stomach or skin infections, you should speak to your senior before reporting for work. If you have diarrhoea or vomiting you should not attend work until you have been free from symptoms for 48 hours. This same principle applies for when the call monitoring team receives a phone call from care staff reporting to them that they are unwell either during or before their shift for work.

**Clothing** Your clothes can become contaminated with harmful microorganisms. Disposable aprons and gloves should be used when handling anything contaminated with body fluids to protect clothes from contamination. Changing your clothing and uniform daily reduces the risk of remaining contaminants being spread to the individuals you support. Uniforms should be washed on a hot wash, then tumble-dried or hot ironed, to kill any bacteria present.

**Personal hygiene** - Personal hygiene is extremely important for people who take care of others. Daily washing, showering or bathing will remove most of the microorganisms on your skin. Hand hygiene is also extremely important. Fingernails should be kept short. Rings (apart from plain wedding bands), wristwatches or bracelets should not be worn as they can make hand washing less effective.

**Skin health** Micro-organisms can live on the skin. The number of pathogens increases when skin is damaged. All cuts should be covered with waterproof dressings. Using hand cream, good quality paper towels and antibacterial soaps can help to protect the skin.

**Good hand habits** having good hand habits means not touching areas that can be a source of pathogens more than you need to. These areas include your nose, hair and mouth, and not biting nails. This also applies to work practices such as using foot operated bins rather than lifting bin lids with your hands.

## **‘5 moments’ for hand hygiene**

Hand hygiene is an important part of preventing infection.

Hands can be cleaned, or decontaminated by:

1. washing with water and soap that removes dirt and germs from the hands but doesn’t kill them
2. Using alcohol hand rubs and gels which kill most bacteria.
3. If hands are visibly dirty these rubs and gels will be less effective against Clostridium difficile and some viruses that cause vomiting and diarrhoea.

The World Health Organisation has identified ‘5 moments’ when health and social care workers should clean their hands. These moments are:   
1) before touching the individual you are supporting.

2) Immediately before carrying out a ‘clean’ procedure.

3) After exposure to body fluids and after removing gloves.

4) After touching the individual you are supporting.

5) After touching the area or objects surrounding the individual you are supporting.

Further Guidance on Care in Hand's procedures can be found on Hand hygiene policy and the handwashing below the elbows policy.

It is important that field supervisors observe the care staff completing handwashing techniques when they are completing their routine spot checks.

## **Personal protective equipment (PPE)**

Care in Hand has a responsibility to provide all staff with the equipment you need to protect you from injury and, as far as possible, from the risk of infection while you are at work.

That includes:

* enough uniforms for regular changing
* Disposable aprons to protect clothing and uniforms from contamination from blood and body fluids etc.
* Alcohol gels  (there are refillable bottles in every office)
* the correct type of gloves to reduce the risk  of cross-contamination of you and the individual  you are supporting
* masks and respiratory-masks to protect you  from breathing in harmful microorganisms
* Goggles, eye protection or face shields – if there is a risk of being splashed with body fluids.

## **Safe handling of waste**

It is important that you understand how different waste should be handled safely to protect you, your colleagues and the people that you provide support for.

‘Clinical waste’ is produced from healthcare and similar activities.

It is placed in either yellow or in the community it is normally put in nappy sacks before being placed in the grey/black or purple bin bags.

It should be kept separate from other waste.

Clinical waste can be either hazardous (waste that poses or might pose a risk of infection - for example, pads and dressings) or non-hazardous (which is non-infectious waste).

Waste containers should be handled carefully to avoid contamination. Staff should use PPE to protect themselves from contamination and infection at all times

## **Safe disposal of sharps**

Generally we are not required to handle sharps within the community, this is the role of the district nursing team, however there may be times under their guidance that we may need to assist.

If we are required to assist then the Complex care Board and the Senior Field Supervisor under the direction of the district nursing team are responsible for managing the risks of using sharps such as needles and blades, undertaking risk assessments where necessary.

The following guidelines in relation to sharps should be followed:

* They must be disposed of at the point of use into an approved container.
* All sharps bins should have the name of the person who assembled it and the date of assembly on the label. The same applies for the person closing full bins.
* Do not fill bins past the ‘full’ line marked on the bin. Sharps can fall out and cause injury.
* Use the temporary closure mechanism on the top of the bin when it is not being used, to prevent spillages if the bin is toppled over.
* Always keep bins above floor level to prevent children from reaching them.
* Store bins securely out of sight and reach of other people who may be present. If workers are transporting sharps by car, these should be kept in the car boot
* Do not pass sharps from one hand to the other.
* Do not handle sharps more than is essential.
* Do not put protective covering back on needles.
* Do not bend or break needles.
* Do not separate needles or syringes before disposal.

## **Soiled linen**

Linen that comes into contact with workers or individuals can become contaminated with harmful micro-organisms and body fluids.

Linen refers to anything that is made of cloth including bedding, towels and clothing.

Personal protective equipment (PPE) must be worn when handling infected linen as it can transfer pathogens to skin and clothing.

All infected linen (that is linen that is contaminated with body fluids) must be washed separately from other items.

* Clothing can be decontaminated in a 40°C-50°C wash followed by tumble-drying or hot ironing
* Bedding and towels should be washed in a hot wash to ensure that bacteria are killed
* Laundry should be moved to the washing area in sealed, colour coded bags

When supporting an individual in their own home you should ask permission to wash infected linen immediately.

Once linen has been decontaminated it must be stored separately from contaminated linen to prevent cross-contamination.

You must always follow your agreed ways of working. If you have any questions about these you should speak to your manager.

## **Infection Control Guidance within Care in Hand.**

Any serious infection control concerns will be overseen by the complex care board who will report to the RI as he oversees the Health and safety concerns.

All staff, including call monitors have a duty to report any infection control concerns to their senior.

Field Supervisors and Senior Field Supervisor are responsible to update the risk assessments and complete spot checks for the staff to ensure guidance is being followed.

This can also be addressed in supervisions and annual appraisals.

Further information on MRSA, COVID-19 and C-DIFF can be found on the links on the side of this page.

Care in Hand's Policies and guidance on infection control include:

* Infection control Policy
* Heat stress & PEE Guidance
* Infection Control Guidance Document

COVID-19 (default page)

# MRSA

**MRSA is a type of bacteria that's resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections.**

The full name of MRSA is meticillin-resistant Staphylococcus aureus. You might have heard it called a "superbug".

MRSA infections mainly affect people who are staying in hospital. They can be serious, but can usually be treated with antibiotics that work against MRSA.

## **How you get MRSA**

MRSA lives harmlessly on the skin of around 1 in 30 people, usually in the nose, armpits, groin or buttocks. This is known as "colonisation" or "carrying" MRSA.

You can get MRSA on your skin by:

* touching someone who has it
* sharing things like towels, sheets and clothes with someone who has MRSA on their skin
* touching surfaces or objects that have MRSA on them

Getting MRSA on your skin will not make you ill, and it may go away in a few hours, days, weeks or months without you noticing. But it could cause an infection if it gets deeper into your body.

People staying in hospital are most at risk of this happening because:

* They often have a way for the bacteria to get into their body, such as a wound, burn, feeding tube, drip into a vein, or urinary catheter.
* they may have other serious health problems that mean their body is less able to fight off the bacteria
* they're in close contact with a large number of people, so the bacteria can spread more easily

Healthy people, including children and pregnant women, are not usually at risk of MRSA infections.

## **Symptoms of MRSA**

Having MRSA on your skin does not cause any symptoms and does not make you ill.

You will not usually know if you have it unless you have a screening test before going into hospital.

If MRSA gets deeper into your skin, it can cause:

* swelling
* warmth
* pain
* pus
* redness, but this may be less visible on darker skin

If it gets further into your body, it can also cause:

* a high temperature
* chills
* aches and pains
* dizziness
* confusion

Tell a member of the complex care board if a service user get is tested positive for MRSA before discharge.

Call a GP or NHS 111 if a service user get these symptoms outside of hospital.

## **Screening and testing for MRSA**

If a service users’ needs to go into hospital and it's likely they will be staying overnight, you may have a simple screening test to check your skin for MRSA before you're admitted.

This is normally done at a pre-admission clinic or a GP surgery. A nurse will run a cotton bud (swab) over your skin so it can be checked for MRSA.

Swabs may be taken from several places, such as your nose, throat, armpits, groin or any damaged skin. This is painless and only takes a few seconds.

The results will be available within a few days.

If a service user is not carrying MRSA, it's unlikely they'll be contacted about the result and you should follow the instructions from the hospital.

If they are carrying MRSA, they'll be told by the hospital or a GP.

You may need treatment to remove the bacteria to reduce your risk of getting an infection or spreading the bacteria.

## **Treatments for MRSA**

### **Removing MRSA from your skin**

If screening finds MRSA on a service user's skin, they may need treatment to remove it. This is known as decolonisation.

This usually involves:

* applying antibacterial cream inside their nose 3 times a day for 5 days
* washing with an antibacterial shampoo every day for 5 days
* changing their towels, clothes and bedding every day during treatment – the laundry should be washed separately from other people's and at a high temperature

Treatment is normally done at home, but may be started after going into hospital if they need to be admitted quickly.

### **Treatment for an MRSA infection**

If a service user gets an MRSA infection, they'll usually be treated with antibiotics that work against MRSA.

These may be taken as tablets or given as injections. Treatment can last a few days to a few weeks.

During treatment, you may need to stay in your own room or in a ward with other people who have an MRSA infection to help stop it spreading.

You can normally still have visitors, but it's important they take precautions to prevent MRSA spreading.

## **Preventing MRSA**

If they're staying in hospital, there are some simple things they can do to reduce their risk of getting or spreading MRSA.

They should:

* wash their hands often (hand wipes and alcohol hand gel are also effective) – especially before and after eating and after going to the toilet
* follow the advice they’re given about wound care and looking after devices that could lead to infection (such as urinary catheters or drips)
* report any unclean facilities to senior field supervisors – do not be afraid to talk to staff if you're concerned about hygiene

If you're visiting someone in hospital, clean your hands before and after entering the ward and before touching the person. Gel or wipes are often placed by patients' beds and at the entrance to wards.

It's also a good idea to put a dressing over any breaks in your skin, such as sores or cuts, to stop MRSA getting into your body

Please refer to our [MRSA Policy](https://secure.activabsence.co.uk/util/switchboard.nsf/Frameset) for Care in Hand's procedures on this,**any confirmed cases need to be referred to complex care board.**

# ****Clostridium difficile****

Clostridium difficile, also known as C. difficile or C. diff, is bacteria that can infect the bowel and cause diarrhoea.

The infection most commonly affects people who have recently been treated with antibiotics. It can spread easily to others.

C. diff infections are unpleasant and can sometimes cause serious bowel problems, but they can usually be treated with another course of antibiotics.

## **Symptoms of a Clostridium difficile (C. diff) infection**

Symptoms of a C. diff infection usually develop when taking antibiotics, or when you have finished taking them within the last few weeks.

The most common symptoms are:

* diarrhoea several times a day
* a high temperature (fever)
* loss of appetite
* feeling sick
* tummy pain

In some cases, you may also have signs of dehydration.

## **Who's most at risk of a Clostridium difficile (C. diff) infection?**

C. diff mostly affects people who:

* have been taking antibiotics that work against several types of bacteria (broad-spectrum antibiotics) or several different antibiotics at the same time, or those taking long-term antibiotics
* have had to stay in a healthcare setting, such as a hospital or care home, for a long time
* are over 65 years old
* have certain underlying conditions, including inflammatory bowel disease (IBD), cancer or kidney disease
* have a weakened immune system, which can be caused by a condition like diabetes or as a side effect of a treatment such as chemotherapy or steroid medicine
* are taking a medication called a proton pump inhibitor (PPI) to reduce the amount of stomach acid they produce
* have had surgery on their digestive system

## **When to get medical advice**

See a GP if you think a service user has got C. diff then please refer to the Gp.

Having diarrhoea while taking antibiotics does not necessarily mean you have C. diff.

Diarrhoea can be caused by a number of conditions and is a common side effect of antibiotics.

A blood test may also be needed to help determine how severe the infection is.

Sometimes a service user may need other tests or scans in hospital to check if their bowel is damaged.

## **Treatment for Clostridium difficile (C. diff)**

The GP will advise if the service users need hospital treatment (if they're not already in hospital).

If the infection is mild, they should be able to recover at home.

If they're in hospital, they might be moved to a room of your own during treatment to reduce the risk of the infection spreading to others.

Treatment for C. diff can include:

* stopping the antibiotics thought to be causing the infection, if possible – in mild cases, this may be the only treatment that's needed
* taking a 10- to 14-day course of antibiotics that are known to kill the bacteria
* rarely, serious infections may require surgery to remove a damaged section of the bowel

C. diff infections usually respond well to treatment, with most people making a full recovery in a week or 2.

But the symptoms come back in around 1 in 5 cases and treatment may need to be repeated.

## **Looking after yourself at home**

If they're well enough to recover from Clostridium difficile (C. diff) at home, the following measures can help relieve their symptoms and prevent the infection spreading:

* make sure they finish the entire course of any antibiotics they're prescribed, even if they’re feeling better, any concerns should be reported to the GP
* drink plenty of fluids to avoid dehydration and eat plain foods, such as soup, rice, pasta and bread, if they feel hungry
* take paracetamol for tummy pain or a fever - only if this is written in a PRN protocol and advised from the GP
* do not take anti-diarrhoeal medication, as this can stop the infection being cleared from their body
* regularly wash your hands and contaminated surfaces, objects or sheets
* Stay at home until at least 48 hours after their last episode of diarrhoea - do not advise to attend day centres.

Their GP may contact them regularly to make sure they're getting better. Call them if their symptoms return after treatment finishes, as it may need to be repeated.

## **How you get Clostridium difficile (C. diff)**

C. diff bacteria are found in the digestive system of about 1 in every 30 healthy adults.

The bacteria often live harmlessly because other bacteria normally found in the bowel keep it under control.

But some antibiotics can interfere with the balance of bacteria in the bowel, which can cause the C. diff bacteria to multiply and produce toxins that make the person ill.

When this happens, C. diff can spread easily to other people because the bacteria are passed out of the body in the person's diarrhoea.

Once out of the body, the bacteria turn into resistant cells called spores.

These can survive for long periods on hands, surfaces (such as toilets), objects and clothing unless they're thoroughly cleaned, and can infect someone else if they get into their mouth.

Someone with a C. diff infection is generally considered to be infectious until at least 48 hours after their symptoms have cleared up.

## **How to stop Clostridium difficile (C. diff) spreading**

C. diff infections can be passed on very easily.

You can reduce your risk of picking it up or spreading it by practising good hygiene while in service user’s homes.

The following measures can help:

* stay at home until at least 48 hours after your symptoms have cleared up
* wash your hands regularly with soap and water, particularly after going to the toilet and before eating – use liquid rather than bar soap
* clean contaminated surfaces (such as the toilet, flush handle, light switches and door handles) with a bleach-based cleaner after each use
* do not share towels and flannels
* wash contaminated clothes and sheets separately from other washing at the highest possible temperature
* when visiting someone in hospital, observe any visiting guidelines, avoid taking any children under the age of 12, and wash your hands with liquid soap and water when entering and leaving ward areas – do not rely on alcohol hand gels, as they're not effective against C. diff
* avoid visiting hospital if you're feeling unwell or have recently had diarrhoea

**Any confirmed cases of C-DIFF needs to be reported to the Complex Care Board who will advise staff on the infection control procedures for the staff and complete a risk assessment**

(Page pending approval) Contingency Planning

Contingency Planning underpins a lot of what we do. In most areas of Care in Hand we look to operate effective contingency plans

Our Business Continuity Policy covers this requirement.

Adverse Weather Conditions

Staffing Reductions

Communication Difficulties

Traffic light system (default page)

Supervision and staff development (All Default page)

* [Induction & Probation Procedures](https://www.careinhand.co.uk/en/framework-training1/supervision-and-staff-development/induction-probation-procedures/)
* [Annual Appraisal](https://www.careinhand.co.uk/en/framework-training1/supervision-and-staff-development/annual-appraisal/)
* [Supervision](https://www.careinhand.co.uk/en/framework-training1/supervision-and-staff-development/supervision/)
* [Low level Capabilities & Conflict Management](https://www.careinhand.co.uk/en/framework-training1/supervision-and-staff-development/low-level-capabilities-conflict-management/)
* [Staff Wellbeing](https://www.careinhand.co.uk/en/framework-training1/supervision-and-staff-development/staff-wellbeing/)

[Personal Development and Life Long Learning](https://www.careinhand.co.uk/en/framework-training1/personal-development-and-life-long-learning/) (All Default page)

* [Registration with Social Care Wales](https://www.careinhand.co.uk/en/framework-training1/personal-development-and-life-long-learning/registration-social-care-wales/)
* [Interpersonal Skills](https://www.careinhand.co.uk/en/framework-training1/personal-development-and-life-long-learning/interpersonal-skills/)

[Quality Assurance](https://www.careinhand.co.uk/en/framework-training1/quality-assurance/) (All default page)

* [Annual Client Quality of Care Review](https://www.careinhand.co.uk/en/framework-training1/quality-assurance/annual-client-quality-care-review/)
* [Report Writing](https://www.careinhand.co.uk/en/framework-training1/quality-assurance/report-writing/)
* [Sustainability](https://www.careinhand.co.uk/en/framework-training1/quality-assurance/sustainability/)

[Day to Day Coordination of Service Provision](https://www.careinhand.co.uk/en/framework-training1/day-day-coordination-service-provision/) (All default page)

* [Call Monitor](https://www.careinhand.co.uk/en/framework-training1/day-day-coordination-service-provision/call-monitor/)
* [Field Supervisor](https://www.careinhand.co.uk/en/framework-training1/day-day-coordination-service-provision/field-supervisor/)
* [Senior Field Supervisor](https://www.careinhand.co.uk/en/framework-training1/day-day-coordination-service-provision/senior-field-supervisor/)