Clinical Care Core Skills Training Framework (CSTF)

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ACI Training
CPD CERTIFIED

This training course package contains the 7 core skills required for the healthcare profession as per the Clinical Care CSTF and includes:

1. Your healthcare career
2. Your duty of care
3. Person centred care
4. Communication
5. Consent
6. Privacy & Dignity
7. Fluids & Nutrition

These courses are to be taken once on induction/registration and refreshed as necessary.

There are 2 other core skills required for all healthcare professionals and these are Dementia Awareness and Blood Component Transfusion training. Both of these courses are to be refreshed every 3 years and are available separately as training packs from ACI.

Mapped and aligned to the Clinical Care CSTF you will at the end of this course:

Your healthcare career:

- Know how to identify the requirements of a work role including the use of relevant standards, codes of conduct and practice
- Understand why it is important to work in ways that are agreed with the employer
- Be aware of the key rights and responsibilities in employment and how a working relationship is different from a person relationship
- Understand why it is important to work in partnership with key people, advocates and others who are significant to patients/service users
- Know why continuing professional development is important
- Know why feedback from others is important in helping to develop and improve the way you work
- Understand the principles of reflective practice and why it is important
- Know how to identify development needs against relevant standards
- Understand the purpose and benefits of supervision and appraisal or similar arrangements
- Be aware of a range of learning opportunities and how they can be used
- Understand why it is important to be honest and identify where errors may have occurred and to tell the appropriate person
- Know when to escalate any concerns and the purpose of whistleblowing in an organisation.

It is essential when you start a new career that you explore and evaluate how your role fits in with the overall aims of the organisation for which you are working, how teams within the organisation work together and how you will be assisted in developing your career. This can help you to plan any support that you may need during and after your induction. You should be encouraged to evaluate your progress on a regular basis with your line manager

and reflect on how you are progressing, and what you can do to develop and enhance your skills further.

The first step that you should take is to understand the values, aims and objectives of the organisation you work for – these may be available on their website or their intranet system if they have one.

Secondly, you should have a job description which clearly defines your role and responsibilities within the organisation – this will describe what you should be doing and also what you should not be doing. You must be able to understand what is expected of you and how your role fits within the team and how your role contributes to the overall aims of the organisation.

If you are not clear or unsure you should talk to your line manager or HR department – maybe you will have a mentor or be shadowing a colleague who is more experienced who may be able to help you find out more about your role.

Every employer will have a set of protocols, policies and procedures to follow. Many of these are required in law and govern the way in which you work e.g.

- Health and Safety
- Equality and Diversity
- Consent
- Confidentiality

These policies and procedures are necessary to enable you to do your job and many of them will relate to providing good care practices and explain the ways in which your employer will expect you to conduct yourself.

Your employer's responsibilities and your responsibilities to your employer will be described within your **Employment Contract**. This contract should detail your hours of work, rate of pay, how sick pay is operated within the sickness/absence policy, your holiday entitlement, disciplinary and grievance procedures, codes of conducts and any other policies. This contract should also outline your job description, but you should also have a separate job description that goes into fuller details.

Induction is the general introduction to the workplace environment and the people who work within it, as well as the policies and procedures to be followed. An induction may take many forms e.g. a formal training course provided in a classroom environment or, working with other team members and shadowing them learning how to do the job. It may be formal or informal and will vary depending on the size and type of organisation you are working for.

Appraisal is the process by which your performance is evaluated between you and your line manager. You may at the start of your employment be given a set of key performance indicators or have agreed objectives that have been set between you and your line manager which will be reviewed on a regular basis to see how you are doing, and to identify any training needs that you may have. Appraisal should be seen as a positive event throughout

your career to assist you in your personal development. It should never be used as a disciplinary tool and should not be seen as such. It is a method of professional feedback from your employer and an opportunity for you to discuss the direction you wish to take in your career and plan further development.

Regulators are those organisations who ensure compliance with rules and regulations and established laws. An example of a regulator is the Care Quality Commission (CQC) who are the independent regulator of health and social care in England. They inspect health care providers who are registered e.g. NHS, Nursing and Care Homes etc. Some professional groups in health and social care e.g. Registered Nurses, Doctors and Social Workers have regulations which are specific to their profession and that means that they have to work to a specified code of practice, or have a minimum qualification to practice. Employers have to ensure that they are registered with the appropriate professional body and are eligible to work e.g. Nurses are registered with the NMC, and Doctors are registered with the GMC.

Code of Conduct a code of conduct can either be set formally by an employer as a set of standards that are the minimum they expect from you during your employment i.e. how you behave whilst on duty, wearing of uniform etc., or can be regulated in law. The code of conduct will help you to understand your role but also the limitations to that role. If a healthcare professional ever breaches their code of conduct they will be asked to account for their actions and/or omissions.

The NHS Constitution also sets out the objectives of the National Health Service in England and what can be expected by patients, the public and staff from the NHS and what the NHS can expect from them. For further information, please visit: https://www.gov.uk/government/publications/the-nhs-constitution-for-england

Standards – some health and/or social care staff do not have a professional code of conduct however they do have to adhere to standards e.g. the care certificate. The care certificate sets out the competencies required and behaviour expected by all healthcare assistants and those in similar roles.

If you feel that you have not received all the information and documentation necessary to assist you to perform your role effectively then you should take this up with your line manager as soon as possible.

Using any code of conduct appropriate to your profession and any standards and/or regulations to reflect regularly on your work and review your development will help immensely when it comes to appraisal and working on your own personal development and continuous professional development (CPD).

Core Values of Healthcare:

When delivering care, the following values should be acknowledged and respected:

- All people deserve to be treated as individuals and their personal history and wishes and preferences respected at all times.

- Healthcare staff may never make decisions about the people in their care without first consulting with the individual or their family unless in exceptional circumstances.
- Anyone receiving health and social care has the right to be treated with dignity and compassion
- Health and social care staff have a duty of care to protect patients / service users from abuse and maltreatment
- Any person in receipt of care has a right to be treated by staff who are competent

The Chief Nursing Officer has launched "Compassion in Practice" which outlines the values every nurse or midwife should work to and this is known as the six C's:

1. Care
2. Compassion
3. Competence
4. Communication
5. Courage and,
6. Commitment

More information on the 6 C's can be accessed here:
https://www.healthcareers.nhs.uk/about/working-health/6cs

The GMC (General Medical Council) publish advice to doctors on the standards that are expected of them in their document: "Good Medical Practice." 2013. This can be found here: http://www.gmc-uk.org/guidance/

The health & care professions council regulate health, psychological and social work professionals and further information on what they do and their various publications is available here: http://www.hcpc-uk.co.uk/

Another regulator in the health care profession is the General Dental Council
http://www.gdc-uk.org/Pages/default.aspx

If ever asked to perform a task that is not part of your job role and you are not competent at, you should refuse to perform it. Carrying out a task that is not part of your role could put a person's life at risk.

Working in partnership with other professionals, carers and volunteers is essential in order to provide the best standards of care. Your contribution to the team is key to delivering high quality services as a mix of skills and experience is needed in health and social care. You should always recognise and respect your colleagues' roles and expertise and work in partnership with them to actively promote and encourage good standards of care.

It is important to remember that professional relationships have boundaries. To ensure the effective delivery of care we have to work in close proximity with services users / patients and gain their trust. Sometimes though the line between personal and professional can blur and become unclear. That is why it is important that codes of conduct are followed.

In order to help keep clear professional boundaries at all times in relationships with individuals in your care, cares and your colleagues:

- Always have respect for personal space and privacy when giving personal care
- Respect the service user's way of life, their wishes and preferences
- Speak in a respectful manner
- Listen carefully to what the patient/service user has to say
- Keep personal information confidential unless there is a valid reason for disclosure to the appropriate authority

What is Diversity?

Diversity is the many distinct characteristics that staff, service users, carers and families bring to our organisation. These distinct characteristics bring variations of thinking, communication styles, skills and personalities that are respected and valued.

Diversity is:

- Recognising and valuing individual and group differences
- Ensuring many different types of people contribute to society

What is Equality?

Equality is recognising that discrimination is unacceptable regardless of people's gender, race, sexual orientation, nationality, religion, ethnic or national origin, marital status, age, colour, disability, carer status or social background.

Equality is not treating everyone the same, but:

- Making sure people are treated fairly
- Meeting individuals' needs appropriately
- Challenging the factors that limit individuals' opportunity

Other courses that ACI provide that go into more depth on these subjects are:

- *Equality, Diversity and Human Rights*
- *NHS Conflict Resolution*
- *Communication Skills*

Continuing Professional Development (CPD):

CPD is the term used for the process of tracking and documenting the skills, knowledge and experience that you gain both formally and informally as you work. It is a record of what you experience, learn and then apply. CPD helps to ensure that you keep up to date and continue to be professionally competent. It is not a one off event, but rather an ongoing process and continues throughout your career.

As a healthcare / social care worker it is your professional duty of care to keep your knowledge and skills up to date.

It is important that you reflect regularly on your professional standards. It is particularly important to reflect on CPD activities as soon as possible after the event. Reflection will help you to review and evaluate the CPD to ensure that it was appropriate and relevant. Reflection may assist you in planning further CPD activities. Some professional bodies e.g. The General Medical Council for doctors and The Nursing and Midwifery Council prescribe how much CPD activity should take place each year by its members. The NMC as part of its revalidation process for nurses requires that each nurse provides 5 reflective accounts covering CPD and / or practice related feedback, and, the NMC provide a particular form for this.

If you are not registered with a professional body you may wish to use the following headings to give you a guide of what to cover:

1. Details of the CPD activity – what were the intended learning outcomes and/or what prompted you to undertake this CPD e.g. feedback from patients / colleagues, a change in practice or policy, a complaint or compliment?
2. What was the learning objective of the CPD -how has this contributed to the development of your skills, knowledge or attitude?
3. What was the outcome of the activity? How does this fit in with your current practice or understanding? How can you incorporate any new learning or skill that you have gained into your day to day practice?
4. As a result of the learning activity, have you identified any new learning needs that you can put into your personal development plan (PDP)

Personal Development Plan (PDP):

This is the process of creating an action plan based on self-analysis, personal reflection and an honest appraisal of your strengths and weaknesses. It should involve setting goals for yourself which are SMART.

S – specific

M – measurable

A – achievable - agreed

R – realistic – relevant – reasonable -

T – time-bound – trackable

A PDP is a formal means by which you set out your goals, strategies and outcomes of learning and training. Your PDP should be reviewed regularly with your line manager and used as part of your appraisal.

The Royal College of Nursing have information for health care assistants which can be found here: http://rcnhca.org.uk/personal-and-people-development/personal-development-planning/

Duty of Care:

This is covered in more depth in the next module however, in brief, all health and social care staff have a duty to raise concerns about poor practice. Any staff member's behaviour, misconduct or anything that will put a person's health, safety and well-being at risk must be reported. This includes any behaviour which will have a negative impact on someone's dignity, privacy or neglects their human rights.

People often mistakenly believe that they will be victimised if they blow the whistle on poor practice.

Whistleblowing:

Whistleblowing is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest'.

A worker can report things that aren't right, are illegal or if anyone at work is neglecting their duties, including:

- Someone's health and safety is in danger
- Damage to the environment
- A criminal offence
- The company isn't obeying the law
- Covering up wrongdoing

How to 'Blow The Whistle'

- The way a worker can 'blow the whistle' on wrongdoing depends on whether they feel they can tell their employer.
- The worker should check their employment contract or ask human resources or personnel if their company has a whistleblowing procedure.
- If they feel they can, they should contact their employer about the issue they want to report.
- If they can't tell their employer, they should contact a prescribed person or body.

A worker can only tell the prescribed person or body if they think their employer:

- Will cover it up
- Would treat them unfairly if they complained
- Hasn't sorted it out and they've already told them

Dismissals and whistleblowing

A worker can't be dismissed because of whistleblowing. If they are, they can claim unfair dismissal - they'll be protected by law as long as certain criteria are met.

Types of Whistleblowing Eligible for Protection - these are called 'qualifying disclosures'.

They include when someone reports:

- That someone's health and safety is in danger
- Damage to the environment
- A criminal offence
- That the company isn't obeying the law (like not having the right insurance)
- That someone's covering up wrongdoing

Who is protected?

The following people are protected:

- Employees
- Agency workers
- People that are training with an employer, but not employed
- Self-employed workers, if supervised or working off-site

You're also protected if you work in a school or sixth-form college, whether you're an employee or an agency worker.

NHS workers who work under certain contractual arrangements, e.g. certain GPs and dentists, are also protected.

A worker will be eligible for protection if:

- They honestly think what they're reporting is true
- They think they're telling the right person
- They believe that their disclosure is in the public interest

Who Isn't Protected?

Workers aren't protected from dismissal if:

- They break the law when they report something
- They found out about the wrongdoing when someone wanted legal advice

Workers who aren't employees can't claim unfair dismissal because of whistleblowing, but they are protected and can claim 'detrimental treatment'.

Mapped and aligned to the Clinical Care CSTF you will at the end of this course:

Duty of Care

- Know what is meant by “duty of care”
- Understand how duty of care contributes to safe practice
- Be aware of dilemmas that may arise between the duty of care and an individual’s rights
- Understand the importance of learning from comments and complaints to improve the quality of service
- Be able to recognise and deal with adverse events, incidents and near misses
- Be aware of legislation relevant to reporting adverse events, incidents, errors and near misses
- Be aware of factors and difficult situations that may cause confrontation
- Know how to assess and reduce risks in confrontational situations

As aforementioned, all health and social care staff have a duty to raise concerns about poor practice. Any staff member’s behaviour, misconduct or anything that will put a person’s health, safety and well-being at risk must be reported. This includes any behaviour which will have a negative impact on someone’s dignity, privacy or neglects their human rights.

The Royal College of Nursing define duty of care as; “The "duty of care" refers to the obligations placed on people to act towards others in a certain way, in accordance with certain standards. The term is sometimes used to cover both **legal** and **professional** duties that health care practitioners may have towards others, but there are distinctions between the two.

Generally, the law imposes a duty of care on a health care practitioner in situations where it is "reasonably foreseeable" that the practitioner might cause harm to patients through their actions or omissions. This is the case regardless of whether that practitioner is a nurse, midwife, health care assistant or assistant practitioner. It exists when the practitioner has assumed some sort of responsibility for the patient’s care. This can be basic personal care or a complex procedure.

To discharge the legal duty of care, health care practitioners must act in accordance with the relevant **standard** of care. This is generally assessed as the standard to be expected of an "ordinarily competent practitioner" performing that particular task or role.

The standards to be expected are not generally affected by any personal attributes, such as level of experience. The legal standard of care to generally be expected of a newly-qualified nurse is the same as that expected of a more experienced nurse performing the same task.” Accessed online 01/11/16 https://www.rcn.org.uk/get-help/rcn-advice/duty-of-care

Therefore, as a health and social care professional you have a duty of care to:

- Always act in the best interests of individuals
- Only act within your levels of competency i.e. do not perform tasks that you are not trained to do so or if it is not part of your role
- Never act in a way that could harm or has the potential to harm or omit to do something safely.

There has been much press in recent times about how constant pressures on staff and services can lead to failures in the duty of care.

One example of this is the Francis Inquiry which examined the causes of failings at Mid Staffordshire NHS Foundation Trust between 2005 – 2009 and made 290 recommendations in its report. Further information can be found here: http://www.health.org.uk/about-francis-inquiry

There may be times that you feel that the expectations imposed upon you by your employer conflict with your duty of care. This could include an excessive demand on your workload; being asked to take on tasks that you are not competent to perform or, to work within an environment that is not safe. If you do something that you are not meant to do or fail to do something that you are meant to do and then something goes wrong, you could be held accountable for that failing. The consequences of not acting in the correct manner could be disastrous and in extreme circumstances result in serious harm to the health, safety and well-being of patients, service users or indeed colleagues.

Learning from Comments and Complaints to Improve Service Quality:

Professor Sir Mike Richards, Chief Inspector of Hospitals for the Care Quality Commission (CQC) stated in a CQC report in 2014: "A service that is safe, responsive and well-led will treat every concern as an opportunity to improve, will encourage its staff to raise concerns without fear of reprisal, and will respond to complaints openly and honestly."

People need to should know how to complain to service providers and service providers should take every expression of dissatisfaction seriously and act upon it accordingly. Patient / service user feedback is essential in evaluating the quality of a service.

Part of your duty of care is to make sure that every individual knows that they have a right to make a complaint, comment or indeed compliment about the care or support that they received.

You should become familiar with your employer's complaints policy and if someone wants to make a comment, complaint or compliment you should deal with it in line with the policy. People need to be assured that they will be taken seriously and have their concerns acknowledged, this in turn will reduce any further conflict.

Adverse Event, Error, Incident, Near Miss

Despite all best endeavours to prevent mistakes from happening they still do. This could be down to:

- Lack of knowledge, understanding or training
- Poor communication or failure to share sufficient or correct information
- Stress
- Rushing or being distracted
- Negligence.

Mistakes are categorised in the following:

1. **Adverse event** – this is something that is unexpected, unintended and preventable. The adverse event is not caused by an error and the individual has received the appropriate care but has suffered an unwanted effect. An example of and adverse event could be the adverse side effects from medication that somebody has been prescribed e.g. diarrhoea and vomiting.
2. **Error –** this is a mistake which involves human error such as not planning something sufficiently, making the wrong decision or taking the wrong action. If the error has the potential to cause harm, then it must be investigated formally. An example of an error would be if a patient received the wrong medication because a nurse failed to read the prescription correctly or gave the wrong dose of a medication.
3. **Incidents –** an incident is when an event requires investigation because it has caused severe harm or damage either to the patient or to the organisation. It is an unplanned event that could lead to serious injury, death, damage or loss to property etc. An example of this could be where a nurse or carer was not trained in how to deal with challenging behaviour and loses their temper with a patient who is becoming agitated and strikes them causing physical harm to the patient.
4. **Near Misses –** this is when a situation or action could have caused harm or damage but by chance or by purpose it was prevented from happening. For example, a patient recognises that the medication he has been given to take is not his usual medication and questions it before taking it. The nurse administering the medication admits it was meant for the patient in the next bed and takes it back from the wrong patient.

Health and social care organisations under the Health and Social Care Act 2008 (updated 2012) have a legal duty imposed upon them to report adverse events, incidents, errors and near misses.

In addition to this the legislation RIDDOR – Reporting of Incidents, Diseases and Dangerous Occurrences regulations 1995 (as amended) requires that some work-related accidents, diseases and dangerous occurrences must be reported to the appropriate authority. It applies to all work activities.

Reporting Incidents: you have a duty of care to report all adverse events, incidents, errors and near misses to your employer in line with their organisational policies and procedures.

It is important to also have a duty of candour and to be open, honest and transparent when a mistake is made. Staff should never try and conceal the fact that a mistake has been made.

In the Francis Report a duty of candour is defined as; "the volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

Internal Risk Assessment: an internal risk assessment is an informal way of evaluating if an activity you are about to perform is safe for all people concerned, including yourself. We all perform simple risk assessments on a daily basis but do not consider them to be as such e.g. looking to see if traffic is coming before we cross the road to avoid an accident.

Before you perform any task ask yourself:

1. What is it I am about to do and do I have enough information before I begin? i.e. have I received the appropriate training?
2. Do I have all the equipment that I need? Do I know how to use the equipment? Has it been tested / calibrated if necessary?
3. Will I, the patient/service user, my colleagues or anyone else be put at risk of harm if I perform this task?
4. Are there any adjustments that I need to make in the immediate environment before I begin or afterwards?
5. Have I explained it fully to the service user /patient? Do they understand? Have I taken into account their personal preferences and wishes?
6. Have I asked for consent?
7. Do I need anyone else to help me?

Communication

The effective communication of information and coordination of team activities is essential to providing safe patient care.

Healthcare requires many people to work together effectively to deliver safe and reliable care. This can only happen when people communicate in an effective and timely way, and when teams are able to work together to coordinate their activities to achieve their common goals. The social processes of communication and teamwork are therefore some of the most important in assuring patient safety.

Communication problems are routinely cited in patient safety incidents because communication is so central to everything healthcare professionals have to do.

Making sure that teams communicate effectively is therefore central to managing and improving patient safety – it binds people together and allows many individuals to act with a common purpose and with coordinated activity.

There are five communication styles, and while many of us may use different styles in different situations, most will fall back on one particular style, which we use as our 'default' style.

1. Assertive
2. Aggressive
3. Passive-aggressive
4. Submissive
5. Manipulative

(These will be discussed further in the Communication Module)

Effective communication is not just about providing the right information at the right time. It is also about anticipating the needs of others, packaging information in ways that are practical and relevant to the task at hand, and being mindful of the different perspectives and knowledge that others in a team might have.

It is important that care staff communicate with the service user at all times. Saying hello and goodbye are equally as important as asking the service user for information about their condition, day, feelings, or consent to care and treatment. It may be the difference between the person feeling they have been treated with dignity and respect, and received high quality care and treatment, or not.

When caring for someone it is important that you communicate as clearly and truthfully as possible. When service users are given inaccurate information or poor explanations, this can be very confusing and can hinder understanding of what is being said. To overcome this, ensure all the required information is available, or if the answer is not known, find out the answer and communicate this back to the person as soon as possible.

Strategies for overcoming communication difficulties

- Communicate when the service user is at their greatest level of alertness
- Give sufficient time for the conversation and take breaks to allow the service user to regroup if they become confused
- Make sure the place where you communicate has sufficient light and quietness to enable communication to take place;
- Face the person, maintain eye contact, speak clearly and address the service user by their preferred name
- Use simple language, keep instructions simple and give simple choices
- Check whether the service user understands what you are saying

There are various strategies that can be used to assess and reduce risks in confrontational situations and these will be discussed further in the communication module.

Mapped and aligned to the Clinical Care CSTF you will at the end of this course:

Person-centred Care:

- Understand the importance of person-centred values in providing on-going care and support to individuals
- Understand how to work in a person-centred way including:
    - The importance of finding out the history, preferences, wishes and needs of the individual
    - Why the changing needs of an individual must be reflected in their care and/or support
    - The importance of supporting individuals to plan for their future wellbeing and fulfilment, including end of life care
- Be aware of how environmental facts may have the potential to cause discomfort or distress and how to make changes to address such factors
- Be aware of signs that an individual may be in pain or discomfort and know how to take appropriate action where there is pain or discomfort
- Know how to make others aware of any actions they may be undertaking that are causing discomfort or distress to individuals
- Understand how to support individuals to maintain their identity and self-esteem
- Know how to support individuals using person-centred values including respect for individuality, dignity and choices
- Know how to report any concerns to the relevant person

There are many different perceptions of what person-centred care is. If we look again at the 6 C's that were developed and rolled out by NHS England are a good basis on which to build person-centred care:

1. Care
2. Compassion
3. Competence
4. Communication
5. Courage and,
6. Commitment

Each individual patient /service user must be placed at the centre of their care and support needs. This means valuing them as an individual and treating them at all times with respect and dignity. We should always treat everyone as an individual who has their own needs, wishes, choices, beliefs and values. We should not treat everybody in the same way as we all have differing needs.

Everybody has the right of privacy when they need it. Personal care tasks can be quite invasive particularly those around intimate procedures and personal hygiene. Every care should be taken at all times to provide a dignified and private environment as far as possible.

Every individual has the right to exercise choice and as health and social care workers you are encouraged to support patients / service users to make choices about their care and support. They should be given as much information as possible so that they can make informed choices. Where a patient/service user is not able to express their wants, needs and preferences verbally or in written words, another form of communication needs to be discovered e.g. picture boards etc.

Treating somebody with dignity means respecting and valuing their individual identity taking into account their ethical and moral beliefs. Never assume that a person wants to be treated in a certain way, take time to find out they wish to be treated. You need to have an open and positive attitude. Respecting a person means that you are showing them and that you believe that they have importance as an individual.

Working in partnership is involving the person you are caring for along with their family and other workers that may be a part of the care and support team. In order to work successfully in partnership there needs to be good communication and trust.

The consequences of working in a person-centred way means that the person being cared for:

- Feels valued and listened to
- Are more likely to cooperate with their care / treatment plans
- Can build a relationship with the health and social care team and establish trust within that relationship

In order to provide care and support that reflects the personal wishes, needs and preferences of the individual, you will need to find out about their personal history by talking to them and reading about them so that you can gain a deeper insight. This will formulate the care plan for that person which is a required document that sets out in details the care and support needs for that individual on a daily basis. Your organisation may have a different title for the care plan e.g. support plan.

Care plans are records that are constantly reviewed and updated in agreement with the individual and reflect the changing needs and preferences. The care plan is a legal document which could be used as evidence if an individual makes a complaint. The purpose of the care plan is to ensure that all workers have the latest and up-to-date information about a person thus enabling them to provide the best quality standard of care that is person-centred.

When supporting individuals to plan their care, the person-centred approach encourages individuals to think about what is important to them and to make decisions in a safe and non-judgemental environment. This means valuing and accepting the individual for who they are and to see them as being capable of making their own decisions and choices about their lives.

The Care Act 2014 defines the well-being of an individual as:

"Well-being", in relation to an individual, means that individual's well-being so far as relating to any of the following—

1. *personal dignity (including treatment of the individual with respect);*
2. *physical and mental health and emotional well-being;*
3. *protection from abuse and neglect;*
4. *control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);*
5. *participation in work, education, training or recreation;*
6. *social and economic well-being;*
7. *domestic, family and personal relationships;*
8. *suitability of living accommodation;*
9. *the individual's contribution to society.*

Accessed on line 01-11-16
http://www.legislation.gov.uk/ukpga/2014/23/section/1/enacted

In addition to the above, there are many aspects of an individual's life that relate to their well-being for example:

- emotional aspect – how we feel about ourselves and how we react
- cultural – our traditions, beliefs, hobbies
- social – our relationships in life – including personal, family, romantic, professional, community
- religious – faith or other beliefs
- sexual – intimacies, beliefs and preferences
- mental – achieving our potential and ability to contribute to society

All of these may as well as making up our own identity, contribute to a person's feeling of self-worth and self-esteem.

To promote an individual's well-being we need to respect their identity and empathise with them so that we understand things from their perspective.

Every person should be encouraged and understand that they are free to change their minds about anything when they want to - that is why is important to build a rapport based on trust within the care and support relationship.

Sometimes e.g. in end of life care, a person may no longer be able to express their wishes and preferences and alternative ways of communication will be needed. It may be necessary to work with an advocate who can assist. An advocate is an independent representing the wishes of the individual without judging or giving their personal opinion. The Care Act has specific requirements for the provision of advocacy which can be found here: http://www.scie.org.uk/care-act-2014/advocacy-services/commissioning-independent-advocacy/duties/independent-advocacy-care-act.asp

Preferably, advanced care planning (ACP) backed by the Mental Capacity Act 2005 would have been set up so that the individual can express what they would like to happen in terms of the care and support that they receive should they no longer be able to decide for themselves.

Promoting Well-being

The Environment: there are many things within the care environment that can cause discomfort and / or distress for the individual patient / service user e.g.

- Lighting – is it too bright or too dim
- Temperature – too hot or too cold – should be comfortable for the individual
- Noise – is it too noisy – ask – adjust TV /Radio volume, close windows and doors if necessary
- Cleanliness – are there any unpleasant odours?
- Cluttered / distractions

All of these if not considered or controlled can cause unnecessary discomfort and/or stress for the individual.

Pain:

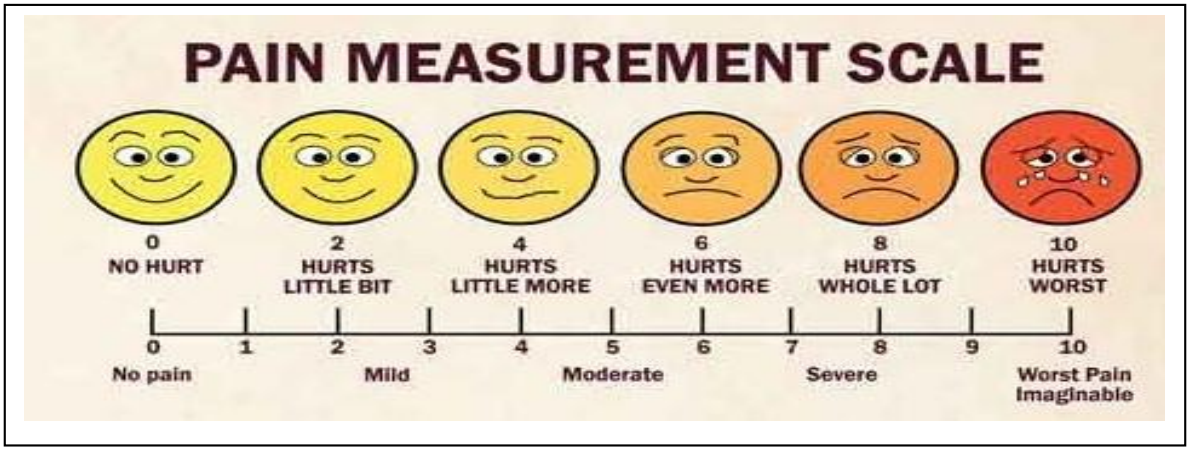
You may, as part of a person's care plan have to perform tasks that can prove uncomfortable or even painful for that person. You must always explain fully what it is that you about to do and gain their consent. Remembering that an individual may withdraw their consent at any time. Such tasks need to be approached with empathy and sensitivity.

McCaffrey and Beebe assert that pain is what the patient says it is. *1989 Pain: clinical manual of nursing practice.*

If a person can communicate and tell you how much pain they are experiencing, this is simple to record and report. If they cannot communicate verbally, you need to look for signs and symptoms.

A simple numeric scale of 0-10 is the most common assessment tool used with 0 being no pain and 10 being the worst pain imaginable. The patient / service user is asked to rate their pain between 0 – 10.

If assessing young children or adults who are non-verbal to describe their pain, the most commonly used tool is the Wong-Baker FACES Pain Rating Scale which may look like:



Each health care organisation will have their own policy

There are some signs and symptoms that a patient may exhibit if they are in pain :

- Facial grimacing
- Writhing or constant shifting in bed
- Moaning or groaning
- Restlessness and agitation
- Guarding the area of pain or withdrawing from touch to that area

The more symptoms a patient has and the more intense they are will give you a clue as to how much pain they may be in. You can then record their pain as "mild", "moderate", or "severe".

Other factors can impact on the pain that somebody is experience which can be quite simple to remedy i.e.:

1. Is the environment suitable – not to hot or too cold or too noisy?
2. Would changing position make the patient more comfortable?
3. Is the bed linen soiled or wet and in need of changing?
4. Is the patient anxious?

Reporting Concerns about an Individual:

It is usual within health and social care for teams to have “handover” sessions or team meetings where concerns about individuals are discussed. Always report your concerns as this aids improvement of quality of care.

It is your duty of care to report any concerns you have and any updates in the care of an individual to your line manager / team leader / person-in-charge as soon as possible.

Mapped and aligned to the Clinical Care CSTF you will at the end of this course:

Communication:

- Understand the importance of effective communication at work
- Understand the different ways that people communicate
- Know how to meet communication and language needs, wishes and preferences of individuals
- Know how to promote effective communication, including how to reduce barriers to communication and the importance of active listening
- Know how and when to use appropriate verbal and non-verbal communication
- Be aware of environments and approaches for communication effectively about difficult, complex and sensitive issues
- Understand the importance of effective communication in preventing or diffusing conflict or challenging behaviour
- Understand the reasons for being open and transparent with service users about their care and treatment
- Understand the principles and practices relating to confidentiality
- Know how to support the use of appropriate communication aids/technologies

What is Communication?

Communication is the imparting or exchanging of information by speaking, writing, or using some other medium.

It's nearly impossible to go through a day without the use of communication. Communication is sending and receiving information between two or more people. The person sending the message is referred to as the sender, while the person receiving the information is called the receiver. The information conveyed can include facts, ideas, concepts, opinions, beliefs, attitudes, instructions and even emotions.

Why is communication so important in healthcare?

The effective communication of information and coordination of team activities is essential to providing safe patient care.

Healthcare requires many people to work together effectively to deliver safe and reliable care. This can only happen when people communicate in an effective and timely way, and when teams are able to work together to coordinate their activities to achieve their common goals. The social processes of communication and teamwork are therefore some of the most important in assuring patient safety.

Communication problems are routinely cited in patient safety incidents because communication is so central to everything healthcare professionals have to do.

Making sure that teams communicate effectively is therefore central to managing and improving patient safety – it binds people together and allows many individuals to act with a common purpose and with coordinated activity.

Effective communication is not just about providing the right information at the right time. It is also about anticipating the needs of others, packaging information in ways that are practical and relevant to the task at hand, and being mindful of the different perspectives and knowledge that others in a team might have.

It is important that care staff communicate with the service user at all times. Saying hello and goodbye are equally as important as asking the service user for information about their condition, day, feelings, or consent to care and treatment. It may be the difference between the person feeling they have been treated with dignity and respect, and received high quality care and treatment, or not.

When caring for someone it is important that you communicate as clearly and truthfully as possible. When service users are given inaccurate information or poor explanations, this can be very confusing and can hinder understanding of what is being said. To overcome this, ensure all the required information is available, or if the answer is not known, find out the answer and communicate this back to the person as soon as possible.

A lack of understanding of service users can also create communication barriers. Empathy is an important aspect of caring for people and staff should try to understand things from the other person's point of view.

The communication process consists of several components:

- A sender encodes information
- The sender selects a channel of communication by which to send the message
- The receiver receives the message
- The receiver decodes the message
- The receiver may provide feedback to the sender

At any of these stages something can go wrong and the communication can breakdown.

The Five Communication Styles

Learning to identify the different communication styles and recognising which one we use most often in our daily interactions with service users and colleagues is essential if we want to develop effective, assertive communication skills.

There are five communication styles, and while many of us may use different styles in different situations, most will fall back on one particular style, which we use as our 'default' style.

1. Assertive
2. Aggressive
3. Passive-aggressive
4. Submissive
5. Manipulative

The Assertive Style

Assertive communication is born of high self-esteem. It is the healthiest and most effective style of communication, between being too aggressive and too passive. When we are assertive, we have the confidence to communicate without resorting to games or manipulation. We know our limits and don't allow ourselves to be pushed beyond them just because someone else wants or needs something from us. Surprisingly, however, Assertive is the style most people use least.

Behavioural Characteristics

- Achieving goals without hurting others
- Protective of own rights and respectful of others' rights
- Socially and emotionally expressive
- Making your own choices and taking responsibility for them
- Asking directly for needs to be met, while accepting the possibility of rejection
- Accepting compliments

Non-Verbal Behaviour

- Voice – medium pitch and speed and volume
- Posture – open posture, symmetrical balance, tall, relaxed, no fidgeting
- Gestures – even, rounded, expansive
- Facial expression – good eye contact
- Spatial position – in control, respectful of others

Language

- "Please would you turn the volume down? I am really struggling to concentrate on my studies."
- "I am so sorry, but I won't be able to help you with your project this afternoon, as I have a dentist appointment."

People on the Receiving End Feel

- They can take the person at their word
- They know where they stand with the person
- The person can cope with justified criticism and accept compliments
- The person can look after themselves
- Respect for the person

The Aggressive Style

This style is about winning – often at someone else's expense. An aggressive person behaves as if their needs are the most important, as though they have more rights, and have more to contribute than other people. It is an ineffective communication style as the content of the message may get lost because people are too busy reacting to the way it's delivered.

Behavioural Characteristics

- Frightening, threatening, loud, hostile
- Willing to achieve goals at expense of others
- Out to "win"
- Demanding, abrasive
- Belligerent
- Explosive, unpredictable
- Intimidating
- Bullying

Non-Verbal Behaviour

- Voice – volume is loud
- Posture – 'bigger than' others
- Gestures - big, fast, sharp/jerky
- Facial expression – scowl, frown, glare
- Spatial position - Invade others' personal space, try to stand 'over' others

Language

- "You are crazy!"
- "Do it my way!"
- "You make me sick!"
- "That is just about enough out of you!"
- Sarcasm, name-calling, threatening, blaming, insulting.

People on the Receiving End Feel

- Defensive, aggressive (withdraw or fight back)
- Uncooperative
- Resentful/Vengeful
- Humiliated/degraded
- Hurt
- Afraid
- A loss of respect for the aggressive person
- Mistakes and problems are not reported to an aggressive person in case they "blow up'. Others are afraid of being railroaded, exploited or humiliated.

The Passive-Aggressive Style

This is a style in which people appear passive on the surface, but are actually acting out their anger in indirect or behind-the-scenes ways. Prisoners of War often act in passive-aggressive ways in order to deal with an overwhelming lack of power. People who behave in this manner usually feel powerless and resentful, and express their feelings by subtly undermining the object (real or imagined) of their resentments – even if this ends up sabotaging themselves. The expression "Cut off your nose to spite your face" is a perfect description of passive-aggressive behaviour.

Behavioural Characteristics

- Indirectly aggressive
- Sarcastic
- Devious
- Unreliable
- Complaining
- Sulky
- Patronising
- Gossips
- Two-faced - Pleasant to people to their faces, but poisonous behind their backs (rumours, sabotage etc.) People do things to actively harm the other party e.g. they sabotage a machine by loosening a bolt or put too much salt in their food.

Non-Verbal Behaviour

- Voice – Often speaks with a sugary sweet voice.
- Posture – often asymmetrical – e.g. Standing with hand on hip, and hip thrust out (when being sarcastic or patronising)
- Gestures – Can be jerky, quick

- Facial expression – Often looks sweet and innocent
- Spatial position – often too close, even touching other as pretends to be warm and friendly

Language

- Passive-aggressive language is when you say something like "Why don't you go ahead and do it; my ideas aren't very good anyway" but maybe with a little sting of irony or even worse, sarcasm, such as "You always know better in any case."
- "Oh don't you worry about me; I can sort myself out – like I usually have to."

People on the Receiving End Feel

- Confused
- Angry
- Hurt
- Resentful

The Submissive Style

This style is about pleasing other people and avoiding conflict. A submissive person behaves as if other peoples' needs are more important, and other people have more rights and more to contribute.

Behavioural Characteristics

- Apologetic (feel as if you are imposing when you ask for what you want)
- Avoiding any confrontation
- Finding difficulty in taking responsibility or decisions
- Yielding to someone else's preferences (and discounting own rights and needs)
- Opting out
- Feeling like a victim
- Blaming others for events
- Refusing compliments
- Inexpressive (of feelings and desires)

Non-Verbal Behaviour

- Voice – Volume is soft
- Posture – make themselves as small as possible, head down
- Gestures – twist and fidget
- Facial expression – no eye contact

- Spatial position – make themselves smaller/lower than others
- Submissive behaviour is marked by a martyr-like attitude (victim mentality) and a refusal to try out initiatives, which might improve things.

Language

- "Oh, it's nothing, really."
- "Oh, that's all right; I didn't want it anymore."
- "You choose; anything is fine."

People on the Receiving End Feel

- Exasperated
- Frustrated
- Guilty
- You don't know what you want (and so discount you)
- They can take advantage of you.
- Others resent the low energy surrounding the submissive person and eventually give up trying to help them because their efforts are subtly or overtly rejected.

The Manipulative Style

This style is scheming, calculating and shrewd. Manipulative communicators are skilled at influencing or controlling others to their own advantage. Their spoken words hide an underlying message, of which the other person may be totally unaware.

Behavioural Characteristics

- Cunning
- Controlling of others in an insidious way – for example, by sulking
- Asking indirectly for needs to be met
- Making others feel obliged or sorry for them.
- Uses 'artificial' tears

Non-Verbal Behaviour

- Voice – patronising, envious, ingratiating, often high pitch
- Facial expression – Can put on the 'hang dog" expression

Language

- "You are so lucky to have those chocolates; I wish I had some. I can't afford such expensive chocolates."
- "I didn't have time to buy anything, so I had to wear this dress. I just hope I don't look too awful in it." ('Fishing' for a compliment).

People on the Receiving End Feel

- Guilty
- Frustrated
- Angry, irritated or annoyed
- Resentful
- Others feel they never know where they stand with a manipulative person and are annoyed at constantly having to try to work out what is going on.

The Benefits of Understanding the Different Styles of Communication

A good understanding of the five basic styles of communication will help you learn how to react most effectively when confronted with a difficult person. It will also help you recognise when you are not being assertive or not behaving in the most effective way. You always have a choice as to which communication style you use. Being assertive is usually the most effective, but other styles are, of course, necessary in certain situations – such as being submissive when under physical threat (a mugging, hijacking etc.).

Good communication skills require a high level of self-awareness. Once you understand your own communication style, it is much easier to identify any shortcomings or areas which can be improved on, if you want to start communicating in a more assertive manner.

Communication Methods

There are six main communication methods:

1. Listening
2. Non – verbal
3. Verbal
4. Questioning
5. Written
6. Signs and symbols

In healthcare, staff use all of these methods daily.

Listening

Curiously, some people don't consider 'listening' as 'communication'. To them, it seems odd that part of communication involves being quiet. But listening is vital to good communication and is especially important when working in healthcare.

When working closely with a service users and they will often tell you important things. So really hearing what a service users are saying – really listening and attending to what they say – is a key skill.

It means paying attention to what the person is saying and working out what it really means. And the best way to do this is to:

- Follow the advice in the sections on non-verbal communication and verbal communication
- Remain quiet, but encourage the service users to speak with gentle head nodding and, when appropriate, positive words ('yes', 'do continue') and simple questions ('and how did that make you feel?').

As you listen, try to identify key words that might sum up how the person is feeling, words like:

- Frightened, or scared
- Lonely
- Fed up, or 'a bit down'
- Pain, or discomfort
- Worried.

When the person has finished speaking, reflect back to him or her what you've understood. For instance, you might say something like this:

'It sounds from what you're saying, Mr Smith, that you've got some concerns about the test you're going for tomorrow, especially about whether it will cause you any discomfort. Would you like me to get staff nurse to speak to you about it?'

Often service users will not tell you directly what is troubling them so you must be aware of other subtle signs they might display in their tone of voice or body language that might indicate their feeling.

When listening to colleagues it equality important that we listen carefully and play great attention. Especially when they are passing on information regarding a patient. This is to minimise errors and promote good quality care.

Verbal Communication

Communication is simply the act of transferring information from one place to another. Although this is a simple definition, when we think about how we may communicate the subject becomes a lot more complex. There are various categories of communication and more than one may occur at any time.

Verbal communication refers to the use of sounds and language to relay a message. It's important to recognize, though, that it's our nonverbal communication—our facial expressions, gestures, eye contact, posture, and tone of voice—that speak the loudest.

The way you listen, look, move, and react tells the other person whether or not you care, if you're being truthful, and how well you're listening. When your nonverbal signals match up with the words you're saying, they increase trust, clarity, and rapport. When they don't, they generate tension, mistrust, and confusion.

It's not just what you say, it's how you say it. When we speak, other people "read" our voices in addition to listening to our words. Professor Albert Mehrabiam (1971) undertook research that found that only a small percentage of our communication related to the words we spoke and most of our communication was through non-verbal means. Mehrabiam found that words only accounted for 7% of communication and our tone 38% and nonverbal communication 55%.

When we are speaking to service users or colleagues we need to ensure that what we say is:

- Clear
- Accurate
- Honest
- Appropriate

But just as important is how we say it. At all times we must be:

- Courteous and respectful: we need to make sure we address people as they wish to be addressed.
- Encouraging: we should try to prompt services to communicate with us by saying encouraging things to them – 'yes, do go on', 'can you tell me a bit more about that?'

Non-Verbal Communication

Staff need to be aware that most of their communication is portrayed non-verbally and they can do this unintentionally. This may differ depending on a person's culture or background and this also needs to be taken into account.

There are many different aspects of non-verbal communication including:

- Body Movements (Kinesics)
- Posture
- Eye Contact
- Para-language
- Closeness or Personal Space (Proxemics)
- Facial Expressions

Body Language or Body Movements (Kinesics)

Body movements include gestures, posture, head and hand movements or whole body movements. Body movements can be used to reinforce or emphasise what a person is saying and also offer information about the emotions and attitudes of a person. However, it is also possible for body movements to conflict with what is said. A skilled observer may be able to detect such discrepancies in behaviour and use them as a clue to what someone is really feeling.

Research work has identified the different categories of body movement that are detailed below with each category describing the purpose they commonly serve:

Emblems: Gestures that serve the same function as a word are called emblems. For example, the signals that mean 'OK', 'Come here!', or the hand movement used when hitch-hiking. However, be aware that whilst some emblems are internationally recognised, others may need to be interpreted in their cultural context.

Illustrators: Gestures which accompany words to illustrate a verbal message are known as illustrators. For example, the common circular hand movement which accompanies the phrase 'over and over again', or nodding the head in a particular direction when saying 'over there'.

Affect Displays: These are facial expressions or gestures which show the emotions we feel. These are often unintentional and can conflict with what is being said. Such expressions give strong clues as to the true emotional state of a person.

Regulators: Gestures used to give feedback when conversing are called regulators, for example head nods, short sounds such as 'uh-huh', 'mm-mm', and expressions of interest or boredom. Regulators allow the other person to adapt his or her speech to reflect the level of interest or agreement. Without receiving feedback, many people find it difficult to maintain a conversation.

Adaptors: Non-verbal behaviours which either satisfy some physical need such as scratching or adjusting uncomfortable glasses, or represent a psychological need such as biting fingernails when nervous. Although normally subconscious, adaptors are more likely to be restrained in public places than in the private world of individuals where they are less likely to be noticed. Adaptive behaviours often accompany feelings of anxiety or hostility.

Posture

Posture can reflect people's emotions, attitudes and intentions. Research has identified a wide range of postural signals and their meanings, such as:

Open and Closed Posture: Two forms of posture have been identified, 'open' and 'closed', which may reflect an individual's degree of confidence, status or receptivity to another person. Someone seated in a closed position might have his/her arms folded, legs crossed or be positioned at a slight angle from the person with whom they are interacting. In an open posture you might expect to see someone directly facing you with hands apart on the arms of the chair. An open posture can be used to communicate openness or interest in someone and a readiness to listen, whereas the closed posture might imply discomfort or disinterest.

Mirroring: Notice the way a loving couple relate to each other. You might like to observe a close relationship in person or on television. You will see that the partners' postures will match, as if one partner is a mirror reflection of the other. For example, if one partner drapes an arm over the back of a chair this might be replicated in the other person's position. If one partner frowns, it could be reflected in the other partner's facial expression. This 'mirroring' indicates interest and approval between people and serves to reassure others of interest in them and what they are saying.

Eye Contact

It is normal and usually encouraging for the listener to look at the speaker. Eye contact can however be intimidating, especially for more shy speakers – gauge how much eye contact is appropriate for any given situation. Combine eye contact with smiles and other non-verbal messages to encourage the speaker.

Eye contact can also serve three purposes:

1. **To give and receive feedback:** Looking at someone lets them know that the receiver is concentrating on the content of their speech. Not maintaining eye contact can indicate disinterest. Communication may not be a smooth process if a listener averts their eyes too frequently.
2. **To let a partner know when it is their 'turn' to speak:** This is related to the above point. Eye contact is more likely to be continuous when someone is listening, rather than speaking. When a person has finished what they have to say, they will look

directly at the other person and this gives a signal that the arena is open. If someone does not want to be interrupted, eye contact may be avoided.

3. **To communicate something about a relationship between people:** When you dislike someone, you tend to avoid eye contact and pupil size is often reduced. On the other hand, the maintenance of positive eye contact signals interest or attraction in a partner.

It is worth remembering that different cultures have different views on eye contact, some cultures discourage it. Therefore, lack of eye contact should not necessarily be interpreted as negative.

Para-language

Paralinguistics refers to vocal communication that is separate from actual language. This includes factors such as tone of voice, loudness, inflection, and pitch. Consider the powerful effect that tone of voice can have on the meaning of a sentence. When said in a strong tone of voice, listeners might interpret approval and enthusiasm. The same words said in a hesitant tone of voice might convey disapproval and a lack of interest.

Consider all the different ways simply changing your tone of voice might change the meaning of a sentence. A friend might ask you how you are doing, and you might respond with the standard "I'm fine," but how you actually say those words might reveal a tremendous amount of how you are really feeling. A cold tone of voice might suggest that you are actually not fine, but you don't wish to discuss it. A bright, happy tone of voice will reveal that you are actually doing quite well. A somber, downcast tone would indicate that you are the opposite of fine and that perhaps your friend should inquire further.

If you place emphasis on a particular word in a sentence it can change the meaning of the sentence.

Place of the Emphasis	That it Means
I did not tell John you were late	Someone else told John you were late
I did **not** tell John you were late.	This did not happen.
I did not **tell** John you were late.	I may have implied it.
I did not tell **John** you were late	But maybe I told Sharon and José.
I did not tell John **you** were late	I was talking about someone else.
I did not tell John you **were** late	I told him you still are late.
I did not tell John you were l**ate**	I told him you were attending another meeting.

Closeness and Personal Space (Proxemics)

Every culture has different levels of physical closeness appropriate to different types of relationship, and individuals learn these distances from the society in which they grew up.

In today's multicultural society, it is important to consider the range of non-verbal codes as expressed in different ethnic groups. When someone violates an 'appropriate' distance, people may feel uncomfortable or defensive. Their actions may well be open to misinterpretation.

In Western society, four distances have been defined according to the relationship between the people involved, the study of personal space is termed proxemics.

The Four Main Categories of Proxemics

1. Intimate Distance (touching to 45cm)
2. Personal Distance (45cm to 1.2m)
3. Social Distance (1.2m to 3.6m)
4. Public Distance (3.7m to 4.5m)

It is worth noting that these distances are considered the norm in Western Society:

Intimate Distance: this is an invited zone; you would normally feel comfortable with children or a spouse at this range. This is the space you would usually be in whilst performing personal care. Entering the intimate space of another person with whom you do not have a close relationship can be extremely disturbing.

Personal Distance: This distance is considered to be the most appropriate for people holding a conversation. At this distance it is easy to see the other person's expressions and eye movements, as well as their overall body language. Handshaking can occur within the bounds of personal distance.

Social Distance: This is the normal distance for impersonal business, for example working together in the same room or during social gatherings. Seating is also important; communication is far more likely to be considered as a formal relationship if the interaction is carried out across a desk. In addition, if the seating arrangements are such that one person appears to look down on another, an effect of domination may be created. At a social distance, speech needs to be louder and eye contact remains essential to communication, otherwise feedback will be reduced and the interaction may end.

Public Distance: Teachers and public speakers address groups at a public distance. At such distances exaggerated non-verbal communication is necessary for communication to be effective. Since subtle facial expressions are lost at this distance so clear hand gestures are often used as a substitute. Larger head movements are also typical of an experienced public speaker who is aware of changes in the way body language is perceived at longer distances.

Understanding these distances allows us to approach others in non-threatening and appropriate ways. People can begin to understand how others feel about them, how they view the relationship and, if appropriate, adjust their behaviour accordingly. Managing distance is also important if a patient starts to display challenging behaviour. This is not only because when a person becomes angry their personal space increases but for you own safety.

Facial Expressions

Small smiles can be used to show that the listener is paying attention to what is being said or as a way of agreeing or being happy about the messages being received. Combined with nods of the head, smiles can be powerful in affirming that messages are being listened to and understood.

You could be furrowing your eyebrows because you are concentrating on what someone is saying but it could be interpreted as disapproval or disagreement.

Communication and Culture

Communication contains verbal and nonverbal behaviours, and these two types are clearly influenced by culture.

In most of Europe and in the USA, this sign symbolises the word 'ok'. However, in other cultures it means something different. For example, in Japan it can mean 'money'.

In countries such as Germany, it is used offensively (in the same way 2 fingers are in the UK). In Brazil the sign has a sexual meaning.

Conflict can occur though misunderstanding. It can be easy for a person when English is not their first language to misunderstand what you have said.

When speaking try to:

- Speak clearly and pronounce your words correctly. Exaggerated pronunciations will not help your listener and may cause more confusion.
- Don't shout. Unless it's really noisy, speaking louder won't help understanding and it may offend or embarrass. (However, do not speak too quietly).
- Do not cover or hide your mouth because listeners will want to watch you as you pronounce your words. This helps them figure out what you are saying in many cases.
- Do not use baby talk or incorrect English. This does not make you easier to understand. It will confuse your listener and may give the wrong impression about your own level of competence.

- Avoid running words together (Do-ya wanna eat-a-pizza?) One of the biggest challenges for listeners is knowing where one word ends and the next one begins. Give them a small pause between words if they seem to be struggling.
- When possible, opt for simple words instead of ones that are complex. The more basic a word is, the better the chance is that it will be understood. ("Big" is a better choice than "enormous" for example. "Make" is a better choice than "manufacture.")
- As much as possible, avoid using filler and colloquialisms ('um...', 'like...','Yeah, totally.') as non-native speakers, especially ones of lower proficiency levels, may get hung up on these thinking the filler language is vocabulary that they don't possess. Colloquialisms are likely to be unknown as well, especially if they are not easy to find in the dictionary.
- If asked to repeat something, first repeat it as you said it the first time. Then again. It could be that they simply didn't hear you. If your listener still doesn't understand, however, change a few key words in the sentence. It may be that they couldn't understand one or two of the words. Also repeat the whole sentence and not just the last couple of words. It's time consuming, but it helps prevent confusion.
- Consider the fact that your dialect may not be what the other person has learned in school. For example, pronouncing the second T in the word "twenty".
- Avoid using contractions or short forms. Use long forms. “Can’t” is one word you must use the long form with. It is difficult for a non-native speaker to understand the difference between “can” and “can’t” in a sentence. For example, “I can’t take you on Friday” and “I can take you on Friday”. Use the long form, “cannot”. “I cannot take you on Friday”.
- Be explicit: Say “Yes” or “No”. Do not say: “Uh-huh” or “Uh-uh”.
- Listen and try not to form your response while the other person is talking. Wait until the person is done so that you can clarify if needed and give correct information based on all they have said.
- Be aware that other cultures have different standards regarding touching, eye contact and personal space. Someone standing too close or not looking you in the eye is merely following their own cultural standard and not trying to offend.
- Be patient and smile. The more relaxed you are, the more relaxed the other person will be.

Questioning

There are two kinds of questions we can use to help us understand what the service user wants and needs or when communicating with a colleague:

- Closed questions
- Open questions.

Closed Questions

We use closed questions when we need a simple 'yes' or 'no' answer or confirmation of something. For instance:

'Would you like an extra pillow?'

'Can you tell me your address?'

Closed questions are very useful if we need a quick and simple answer whether that be from a service user or a colleague.

Open Questions

Open questions encourage service users to speak in more depth about something. They are open because they invite the person to open up.

The best example of an open question in health care is: 'How do you feel?' The service user can respond briefly by saying 'fine', but if he or she says 'not great', or 'awful', it means we can begin to ask some more open questions to find out what is going on – 'what do you feel is wrong?' Asking one open question often leads to asking another.

Similarly, if the service user responds with 'well, funnily, I've had quite a bit on my mind recently', or some other indication that things aren't quite right, we can begin to ask more open questions to help us identify the problem.

Written Communication

Health services need to keep good written records of the care given to service users for three main reasons:

1. To make sure the care and treatment can continue to be given safely no matter which staff are on duty, 24 hours a day, seven days a week
2. To record the care that has been given to the service users
3. To make sure there is an accurate record to be used as 'evidence' when there is a complaint from a service user about the care they have received.

The principles of written communication are that you should:

- Write as near as possible to the time you've delivered the care
- Write simply and clearly
- Write legibly (if hand-written) and as error-free as possible if keyed into a computer
- Insert dates and times as accurately as possible when specific events and circumstances occurred
- Avoid giving personal opinions

- Avoid writing anything judgemental or which may seem personally abusive or insulting. Report factually what you have observed.

And remember, as part of the health care team, you have a responsibility to make sure that anything you write about service users remains confidential and cannot be accessed by any unauthorised person.

Record-keeping

There are many reasons for keeping records in health care, but two stand out above all others:

- To compile a complete record of the service users journey through services
- To enable continuity of care for the service users both within and between services.

The records we keep in health care need to be clear, accurate, honest and timely.

Different means of record-keeping are used in health care settings. Some workplaces use hand-written records, others have moved to computer-based systems, and many use a combination of both. You'll be expected to be able to comply with whatever requirements your employer sets for record-keeping, be it hand-written or electronic. That means you'll need to:

- Know how to use the information systems and tools in your workplace
- Protect, and do not share with anyone, any passwords or 'Smartcards' given to you to enable you to access systems
- Make sure written records are not left in public places where unauthorised people might see them, and that any electronic system is protected before you sign out.

We should be aware that apart from being clear, accurate, honest and timely about what we write, we also need to be careful. This means we have to ensure that nothing we write is, or could be interpreted as being:

- Insulting or abusive
- Prejudiced
- Racist, sexist, ageist or discriminatory in any way.

Legal Issues in Record-Keeping

Health departments in the UK make two things clear about the legal aspects of record-keeping in health services:

- Individuals who work for health care organisations are responsible for what they write
- Anything an individual writes in relation to their work as a health care employee becomes a public record.

Clearly, therefore, you must take care about what you write. Not only will you be asked to formally explain your records in the event of, for instance, a complaint from a service user, but service users will be able to apply to see what you have written about them through the Data Protection Act.

Principles of Record-Keeping

The overall principles of record-keeping, whether you are writing by hand or making entries to electronic systems, can be summed up by saying that anything you write or enter must be honest, accurate and non-offensive and must not breach patient confidentiality.

You should always try to ensure that you:

- Handwrite legibly and key-in competently to computer systems
- Sign all your entries
- Make sure your entries are dated and timed as close to the actual time of the events as possible
- Record events accurately and clearly – remember that service users may wish to see the record at some point, so make sure you write in language that he or she will understand
- Focus on facts, not speculation
- Avoid unnecessary abbreviations –e.g. 'DNA' means 'deoxyribonucleic acid' in some places, but 'Did Not Attend' in others – avoid abbreviations if you can!
- Record how the service users is contributing to his or her care, and quote anything he or she has said that you think might be significant
- Do not change or alter anything someone else has written, or change anything you have written previously; if you do need to amend something you have written, make sure you draw a clear line through it and sign and date the changes
- Never write anything about a service user or colleague that is insulting or derogatory.

If you are giving written information to a service user, such as medication instructions you must ensure that it is given in a way that they can understand. This would include:

- In their chosen language
- The print is large enough for them to read

- In braille if necessary
- Using words that they can understand
- Reading it through with them to ensure that they understand
- Giving it to an advocate if necessary
- Answering any questions

Signs and Symbols

Sign Language which is most commonly used by people with hearing difficulties is a language which uses manual communication and body language to convey meaning.

Communication Cards are typically the size of a credit card and each one contains a symbol and phrase for use in a specific situation. Some users have a chain on which they keep all of their cards but others group the cards by activity and keep them on separate key rings. Service users are then able to show the card corresponding with their need.

Communication Boards are similar to communication cards but the symbols are on a board that the service user can point to or to look at the particular symbol (eye pointing)

Alphabet Boards are the same as communication boards but instead of symbols there are letters which the service user can spell out words.

Voice Output Communication Aids (VOCAs) or Speech Generating Devices (SGDs) are devices which enable a service user to speak.

The simplest VOCAs store a single pre-recorded message, which is produced in the form of digitised speech when the person using the device presses a button, switch, or key.

The most elaborate VOCAs include software that allows the service users to create and combine words to produce novel utterances in the form of computerised synthetic speech.

Computer/Tablet – The service user can type out their message.

Written – the service user can write out their message

Communication Breakdown

There are many factors that can lead to a breakdown in communication.

Language. Try to avoid using language that will exacerbate a situation don't generalise. Don’t use words like "never" or "always." Such generalisations are usually inaccurate and will heighten tensions

Noise. We often exacerbate a situation without realising it, don't speak too loudly or too quietly. A calm tone of voice will ease the situation

Stress. Strong emotions trigger stress. When emotions are running high it will be difficult to successfully resolve conflict. Keep your emotions under control and don't be baited once you start to argue you have lost control.

Alcohol or drugs. The use and misuse of alcohol and other non-prescription drugs is one of the more controversial issues in our society, and often a source of conflict. Learn how to recognise when someone is under the influence for drugs and alcohol and how to deal with the situation

Confusion. When someone is confused it is not uncommon for him or her to be angry.

Cultural differences. Cross cultural communications is very often hampered by lack of understanding between the participants and even when both parties want the same outcome these differences can lead to conflict. Be aware that what you say and how you say it can be misunderstood.

Anger. When met with anger, one tends to either react with anger or with the desire to flee. Remaining calm, professional and empathetic to the emotions of the other person can be very difficult for any of us, but there are communication skills that can be used to defuse a situation.

Stereotyping. Stereotyping occurs when a person classifies a person or group based on oversimplified notions, conceptions or beliefs. This can cause you not listen to what the person has to say, as you have already judged them.

Conflict between what you say and how you say it. Is called Non-matching behaviour. People pick up on this. You will find that genuineness, being open and honest reduces the probability of conflict.

Educational background. Dependant on educational background may hinder the understanding of the listener and cause confusion or anger. Avoid using technical language or acronyms for instance.

Strategies for overcoming communication difficulties

- Communicate when the service user is at their greatest level of alertness
- Give sufficient time for the conversation and take breaks to allow the service user to regroup if they become confused
- Make sure the place where you communicate has sufficient light and quietness to enable communication to take place;

- Face the person, maintain eye contact, speak clearly and address the service user by their preferred name
- Use simple language, keep instructions simple and give simple choices
- Check whether the service user understands what you are saying

Communication Models for Conflict Resolution

L.E.A.P.S. is one communication model that might help if you are confronted with aggressive behaviour:

Listen to the other person, it shows you are interested and that you care

Empathise. This will help diffuse the situation. Use phrases such as "I can understand why you are upset", or "I can see that this has made you angry"

Ask questions. This may help discover the facts which may be different to what you initially thought

Paraphrase this shows the person that you are listening and trying to understand their problem and they will respond to this

Summarise an agreement and a way forward

PALMS

The open PALMS model is a non-aggressive stance designed to ensure that you communicate to the patient that you do not want to fight but that you want to help.

Position – Think about how you position yourself to the other person, do not block the exits

Attitude – be positive and helpful

Look & Listen – Make normal eye contact and display actively listening skills

Make Space – Consider personal space for both yourself and the patient

Stance – Relaxed posture

The 5 Step Appeal

Another model that can help to resolve a difficult situation, or one in which a person refuses to comply with a request, is the 5-step appeal.

This is a method of communication that, when used effectively, can de-escalate conflict.

Step 1 – Ethical Appeal – Ask the person to carry out the task

Step 2 – Reasoned Appeal – Reinforce the rules. Explain why you have made the request

Step 3 – Personal Appeal – 'How would you feel if….?'

Step 4 - Practical Appeal – The final appeal 'you may be asked to leave'

Step 5 – Action – This depends on the threat as you see it

The main aim of a communication model is to resolve the conflict however you have to be aware of your own safety and the safety of others.

De-Escalating Conflict

If a conflict does arise your aim will be to de-escalate it as soon as possible. Below are two de-escalation models that you could use. Before deciding on any approach there are some factors you will need to consider as every situation is different and your safety is paramount.

Before deciding on how you react to the situation you will need to assess the following:

- **Policies and Procedures,** are you aware the guidelines for dealing with conflicts in your workplace?
- **Patterns of Behaviour**, is the person likely to physically attack you?
- **The patient**, do they have a medical or mental health issue that needs to be considered? Are they on medication?
- **Communication**, could you use a communication model? Will there be any communication difficulties?
- **Other people**, are there other people in the area? Do you need to consider their safety?
- **The environment**, where are the exits? Is there is an audience? If so can you remove them as a person is much less likely to back down in front of other people?
- **Staffing,** what staff do you have around you? Are you on your own?
- **Security,** can you raise the alarm and get further help if necessary?
- **Moving,** if you move to a different room allow the person to go into the room first and you to follow. This will ensure that you are the one closest to the exit.

R.E.L.A.T.E

A structured approach to de-escalating conflict.

Step 1: Resist reacting and stay calm

Step 2: Establish a structure for the conversation

Step 3: Listen and ask questions

Step 4: Acknowledge the key facts and feelings

Step 5: Tell the customer what you have heard them say

Step 6: Explain your position/point of view.

De-Escalating conflict - F.L.A.G.

The FLAG model is an approach to handling single issue conflict situations. Sometimes staff can get involved in a conflict situation when there are limited opportunities to investigate why the customer is angry (e.g. customer complaining that the car par is full).

F - Face the person.

By stopping what you are doing and facing the customer you are indicating that they have your full attention and you are not ignoring them.

L - Listen to the customer and ask a question if appropriate. Be willing to listen to the customer and ask a question if appropriate in the situation. Again by asking questions you are demonstrating that you are interested in what they are saying.

A - Acknowledge that you have heard and understood their complaint. Acknowledge or repeat what you have heard - "Yes, parking outside is a nightmare today", "I understand you are really upset about…", "I can hear this is very important to you…", "Watching your Dad being lifted like that can be distressing".

G - Give an explanation sometimes an explanation is needed and sometimes it is not. If a person is just trying to tell you they are unhappy then giving lots of reasons why something has happened can sound like an excuse (particularly if they already know why it has happened which is often the case).

References:

- *Guidance on provisions to deal with nuisance or disturbance behaviour on NHS premises in England Version 2 – March 2012*
- *NHS Security Management Service - Tackling violence against staff*

- *Not Part of the Job Part 1: A guide to reporting assaults and violent incidents at work June 2012*
- *Meeting needs and reducing distress Guidance on the prevention and management of clinically related challenging behaviour in NHS settings*
- *Conflict resolution training: implementing the learning aims and outcomes July 2013*
- *Explanatory notes for NHS Security Management Roles and Responsibilities April 2009 Helpguide .org*
- *Conflict Resolution Core Skills Framework for the North West Health Sector*
- *NHS, Security Management Service*
- *Tackling crime against the NHS: A strategic approach*
- *Royal College of Nursing*

Mapped and aligned to the Clinical Care CSTF you will at the end of this course:

Consent:

- Understand the requirements for seeking valid consent
- Know about different ways a person may give (or refuse) consent
- Know the types of circumstance where a written record of consent (or refusal) must be obtained
- Be able to communicate effectively about proposed treatment or care to enable individuals to make informed choices
- Be aware of potential implications of providing insufficient information about proposed treatment or care
- Understand the right of individuals to refuse consent and ways to respond to refusal of consent
- Understand the types of circumstances in which adults may lack capacity to consent
- Understand the types of action that may be taken in emergency situations where an individual may be temporarily unable to consent
- Know how advanced decisions can be used to provide information about the wishes of an individual
- Be aware of the protocols and legislation for obtaining consent for children and young people
- Be aware of the protocols and legislation regarding consent for people who are mentally incapacitated
- Understand how "best interest" decisions may need to be made for those lacking capacity
- Be aware of the key principles in legislation relevant to mental capacity and consent.

What is Consent?

The NHS State that *'Consent to treatment is the principle that a person must give permission before they receive any type of medical treatment, test or examination. This must be done on the basis of an explanation by a clinician.'*

Consent must be given voluntarily, this mean it's should be given without any undue pressure or influence to give or withhold consent. Influence can be from anyone including a partner, family member or healthcare professional. Practitioners must be vigilant to of any signs of pressure and be assured that the decision that the person makes is genuinely their own.

Informed Consent

Informed consent can only be given by a person if they have been given all the information to make that decision. That includes the benefits as well as any risks, complications or side effects. It should also include any alternative options or treatments that are available. To withhold or misrepresent the facts will make the consent invalid.

The information should be given to the person in a way that they can understand. This may include verbal explanation or written, such as a booked or pictures. The person should be given sufficient time to make that decision and not feel pressured. If the information that is given is inaccurate, bias or based on the healthcare professional's views on what is best, it can lead to the person making a decision that is not right for them. The person would also have the right to make a complaint.

The Royal College of Nursing state that valid consent can be given by a person as long as they have sufficient understanding to fully comprehend the treatment being proposed.

This includes:

- Having the capacity to make treatment decisions
- Being able to weigh the risks and benefits involved
- Understanding in broad terms the nature and purpose of the treatment.

Some people do not wish to know all the facts, if that is the case then this must be clearly documented in the person's notes. The person should also be made aware that they can change their mind at any time and the information with be explained to them.

Gaining Consent

When gaining a person's consent to a treatment or a procedure it must be informed. Consent can be:

Explicit – obtaining explicit consent is good practice; can be expressed orally or, preferably, in writing

Implicit – consent can legitimately be implied if the context is such that information sharing is intrinsic to the activity, especially if that has been explained at the outset – e.g. a nurse asks the person if they can take their blood pressure and the person holds out their arm.

Written – when a person consents to a procedure or operation then they must give written consent. This is usually in the form of a consent form. The doctor would document on the form what the procedure or operation the person will undergo and the risks. The person will then have to sign and date the consent form.

Verbal – for more simple and repetitive care and treatment it is acceptable to gain verbal consent, such as to personal care or medication.

The seeking and giving of consent is usually a process, rather than a one-off event. (Department of Health) For a major intervention it would be best practice to start the process well before the procedure.

If a person gives valid consent, in general the consent remains valid for an unlimited period or until the person withdraws consent.

Refusing or Withdrawing Consent

If an adult who has mental capacity make a voluntary and informed decision to withhold consent to treatment, even if that treatment is lifesaving, this must be respect. In all events the healthcare professional must make sure that the decision has been documented in the person's notes and the person is aware that they can change their mind at any time.

A person with mental capacity is permitted to withdraw their consent at any time, including during the treatment or procedure.

Absence of Consent

There are some circumstances in which consent may not be required, they are:

- In an emergency situation where treatment is required to preserve health or life. Any treatment must be in the best interest of the person until they are able to give consent for themselves. Please note that this is not the case if and Advanced Decision has been made.
- The Mental Capacity Act 2005 is in place to safeguard people who cannot make a decision for themselves. In making a decision for a person who lacks capacity that decision must be in their best interest.
- A child or young person under 16 years old - If there is no one with parental responsibility prepared to consent and no time to make an application to the court, the child should be treated if the is a danger of serious disability or death.

The Royal College of Nursing suggest the following points should be considered before commencing treatment without consent:

It is essential that:

- The decision is made carefully in consultation with the multi-disciplinary team and with relatives where appropriate
- The patient/client's best interests are weighed up against the interests of the public at large
- All decisions are made in line with local guidelines and protocols and based on professional and evidence based practice
- Any decisions are carefully documented. This includes clear reasons for the decision to treat without consent, how the decision was reached including details of assessment and outcome.

The Mental Capacity Act 2005 (MCA)

The Mental Capacity Act 2005 is a law that protects and supports people who do not have the ability to make decisions for themselves. The act applies to people aged 16 and over in England and Wales. Northern Ireland has different laws around capacity.

Mental capacity is the ability to make decisions for yourself. People who cannot do this are said to 'lack capacity'. This might be due to illness, injury, a learning disability, or mental health problems.

Who Might Be Affected?

Many people with the following:

- Dementia
- Learning disability (especially severe learning disability)
- Brain injury / Stroke
- Someone suffering from trauma, loss and physical health problems
- Severe mental illness
- Temporary loss of capacity, for example because somebody is unconscious because of an accident or anaesthesia or because of alcohol or drugs

Anyone planning for the future i.e. Advance decisions to refuse treatment in the event of an individual losing their capacity at some stage in the future.

What is Mental Capacity?

Mental capacity is the ability to make decisions for yourself. People who cannot do this are said to 'lack capacity'. To have capacity a person must be able to:

- Understand the information that is relevant to the decision they want to make
- Retain the information long enough to be able to make the decision
- Weigh up the information available to make the decision
- Communicate their decision by any possible means, including talking, using sign language, or through simple muscle movements such as blinking an eye or squeezing a hand.

What is Lack of Capacity?

- A person lacks capacity if they are unable to make a particular decision
- This inability must be caused by an impairment or disturbance in the functioning of the mind or brain, whether temporary or permanent
- Capacity can vary over time and depends on the type of decision

If a person lack capacity healthcare professional must act in that person best interest at all times.

Advanced Decisions and Advanced Statements

Advance decisions and advance statements ensure that a person's wishes are considered in the future. There are collectively as 'advance care planning'. The purpose is to enable a person to make choices and decisions about their future care, in case there is a time when they cannot make these decisions for themselves. This can ensure that they are not given

treatment that they do not wish to receive, or that their family have power to act on their behalf if they wish them to.

What is an Advance Decision?

An advance decision gives someone the opportunity to make decisions now about specific treatments that they may not want to receive in the future. The purpose is to ensure that, if they are not able to make decisions about treatment or consent in the future, they are not forced to receive treatment that they would not want.

Treatment that can be refused includes life-sustaining treatment. For example, some people may write an advance decision to refuse a blood transfusion for religious or spiritual reasons, even if this will hasten their own death.

Advance decisions are legally binding if they fulfil certain requirements, meaning that they must be followed by doctors and other medical professionals.

What is an Advance Statement?

Advance statements are like advance decisions, but they are not the same thing. It is important to note that a person can make both an advance statement and an advance decision.

An advance statement can be made verbally, or they can choose to write it down, which can be better because it is a permanent record. An advance statement gives the person the chance to make more general statements about their wishes and views for the future, whereas an advance decision is about refusing certain treatments. Often an advance statement is referred to as a 'statement of wishes and care preferences'.

Advance statements are not legally binding, so doctors and medical professionals do not have to follow it. However, it should still be considered by health and social care professionals when making decisions about care and treatment.

Advance Decision

All medical professionals, including doctors, will have to follow an advance decision. However, this is only when the advance decision is 'valid' and also 'applicable'.

- **Valid** – In order to be valid, an advance decision must have been made at a time when the person was able to make this decision. This is referred to as having mental capacity.
- **Applicable** – In order for the advance decision to be applicable, the wording has to be specific and relevant to the medical circumstances. If the wording is vague or there is a concern that it does not refer to medical conditions and/or practices that the person is actually experiencing, then the advance decision may not influence the doctors' decisions at all.

An advance decision cannot be used to:

- Refuse treatment at a time when the person still has capacity to give or refuse consent
- Refuse basic care essential to keep the person comfortable, such as washing or bathing
- Refuse the offer of food or drink by mouth (but it can be used to refuse feeding by tube, for example)
- Refuse the use of measures solely designed to maintain comfort – for example, painkillers (which relieve pain but do not treat the condition)
- Demand specific treatment
- Refuse treatment for a mental disorder in the event that you are detained under the Mental Health Act 1983
- Ask for anything that is against the law, such as euthanasia or assisting you in taking your own life.

People should be assessed on whether they have the ability to make a particular decision at a particular time. The mental capacity of a person can fluctuate. As an example, there might be times of the day when a person is able to think more clearly.

Making Decisions in a Person's 'Best Interests'

Anyone making a decision on behalf of a person they believe to lack mental capacity must do so in that person's best interests. To work out what is in the person's best interests, the decision maker must:

- Not assume the decision should be based on the person's age, appearance, condition or behaviour
- Consider if the decision can be postponed until the person has sufficient mental capacity to make the decision themselves
- Involve the person who lacks mental capacity in the decision as much as possible
- Find out the person's views (current or past), if possible, and take these into account
- Consider the views of others, such as carers and people interested in the person's welfare, where appropriate, and take these into account
- Not be motivated by a wish to bring about the person's death if the decision relates to life-sustaining treatment.

Once the decision maker has considered the relevant information, they should weigh up all the points and make a decision they believe to be in the person's best interests.

Communication

For a person to be able to make an informed decision the healthcare professional must communicate the information effectively and accurately. When a person is given inaccurate information or poor explanations, this can be very confusing and can hinder understanding of what is being said. To overcome this, ensure all the required information is available, or if the

answer is not known, find out the answer and communicate this back to the person as soon as possible.

A lack of understanding can also create communication barriers. Empathy is an important aspect of caring for people and healthcare professionals should try to understand things from the other person's point of view.

The person should be given help and time to be able to communicate their decision back the healthcare professional.

There are many ways to give and receive information, and these have been covered earlier in the communication module, **(verbal Communication, non-Verbal Communication)**

Written Information

Written information can come in the any form, such as a booklet or leaflet. The advantage of written information is that the person can take their time to read it and make a decision. They can take it home with them and reread it. It can also be given in advance of a decision needing to be made.

Children and Young People

Young people aged 16 or 17 are presumed to be competent for the purposes of consent to treatment and are therefore entitled to the same duty as adults. Children under the age of 16 can also consent or withhold consent if they are deemed to understand fully the decision they are making. For example, do they full understand of the consequences of giving consent or refusing consent. This is known as being 'Gillick Competent'

In other cases, consent should be sought from a person with parental responsibility if such a person is available. It is important to check that persons have proper authority (as parents or guardians). Ideally, there should be notes within the child's file as to any unusual arrangements.

Reference List

- *Department of Health – Reference guide to consent for examination or treatment*
- *The Royal College of Nursing – Consent*
- *NHS Consent to Treatment*

Mapped and aligned to the Clinical Care CSTF you will at the end of this course:

Privacy and Dignity:

- Understand the principles that underpin privacy and dignity in care
- Know how to maintain privacy and dignity of individuals when providing personal care
- Understand why it is important not to disclose information that an individual may wish to be kept private, unless it is appropriate to do so
- Understand an individual's rights to make choices (including choices about their care) and how to support individuals to make their own decisions
- Know how risk assessment processes may be used to support the right of individuals to make their own decisions
- Understand how to support the active participation of individuals in their care.
- Know how to report concerns to the relevant person

What is Dignity?

Dignity is difficult to define but has close associations with respect. The definition given by NHS Essence of Care 2010 is 'Dignity is being worthy of respect'

The care that we give demonstrates to others how we value dignity.

Royal College of Nursing definition of dignity (2008) 'Dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others. To treat someone with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals. In care situations, dignity may be promoted or diminished by: the physical environment; organisational culture; by the attitudes and behaviour of the nursing team and others and by the way in which care activities are carried out.'

What is Privacy?

Generally speaking, privacy is the right to be left alone, free from interference or intrusion, including the state.

This would cover:

- Your personal identity e.g. the way you dress
- Your body
- Your relationships with others
- Your sexuality

The definition given by NHS Essence of Care 2010 refers to 'freedom from intrusion and relates to all information and practice that is personal or sensitive in nature to an individual'

In relation to your personal information, privacy is the right to have control over how your personal information will be used and collected.

Legislation

Human Rights Act 1998

In the UK, human rights are protected by the Human Rights Act 1998. The Act gives effect to the human rights set out in the European Convention on Human Rights. **Article 8** is 'the right to respect for your family and private life, your home and your correspondence.'

Family life is your right to have and maintain family relationships. This means your right not to be separated from your family and if you are, you have the right to maintain contact. Same sex couples are protected under article 8 but their protection falls under their private life rather than family life.

Your right to respect for your home means you have the right to live in peace without intrusion. Because of this right the public authority must take measures to ensure you can live peacefully e.g. reduce noise pollution.

Your correspondences include your letter, telephone calls and emails.

Breaches of Article 8 include:

- Being separated from your family
- Forced to have medical treatment
- Being badly treated in a care or nursing home
- Reading your correspondence without permission
- Entering or searching your home without permission

The Equality Act 2010

The Equality Act 2010 makes it unlawful to discriminate against people with a 'protected characteristic'. Each characteristic is addressed in the new Act in summary as follows:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity

- Race
- Religion or belief
- Sex
- Sexual orientation

Equality is not treating everyone the same, but:

- Making sure people are treated fairly
- Meeting individuals needs appropriately
- Challenging the factors that limit individuals' opportunity

The Act states that meeting different needs involves taking steps to take account of disabled people's disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups. It states that compliance with the duty may involve treating some people more favourably than others.

The Care Act 2016

The Care Act 2016 state that safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.

The Care Act 2016 states that the safeguarding duties apply to an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing, or at risk of, abuse or neglect
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Also, that organisations should always promote the adult's wellbeing in their safeguarding arrangements. People have complex lives and being safe is only one of the things they want for themselves. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved. Professionals and other staff should not be advocating "safety" measures that do not take account of individual well-being.

The Mental Capacity Act 2005

The Mental Capacity Act 2005 is a law that protects and supports people who do not have the ability to make decisions for themselves. Mental capacity is the ability to make decisions for yourself. People who cannot do this are said to 'lack capacity'. This might be due to illness, injury, a learning disability, or mental health problems.

The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005 and only apply to people who are lacking capacity. The Deprivation of Liberty Safeguards have been written so that people who are staying in hospital or living in a care home should be treated or cared for in a way that means they are safe but they should be free to do the things they want to do.

The Mental Capacity Act applies to all people making decisions for or acting in connection with those who may lack capacity to make particular decisions. The staff who are legally required to have regard for the Code of Practice when acting in relation to a person who lacks, or who may lack capacity.

Anyone making a decision on behalf of a person who lacks mental capacity must do so in that person's best interests. To work out what is in the person's best interests, the decision maker must:

- Not assume the decision should be based on the person's age, appearance, condition or behaviour
- Consider if the decision can be postponed until the person has sufficient mental capacity to make the decision themselves
- Involve the person who lacks mental capacity in the decision as much as possible
- Find out the person's views (current or past), if possible, and take these into account
- Consider the views of others, such as carers and people interested in the person's welfare, where appropriate, and take these into account
- Not be motivated by a wish to bring about the person's death if the decision relates to life-sustaining treatment.

Once the decision maker has considered the relevant information, they should weigh up all the points and make a decision they believe to be in the person's best interests.

Factors That Affected Dignity

The research carried out by the RCN identified 3 main factors that maintained or adversely affected dignity in care. They were:

1. **Place** - The physical environment and the culture of the organisation
2. **Process** - The nature and conduct of care activities
3. **People** - The attitudes and behaviour of staff and others

(RCN, 2008)

Place

In regards to the physical environment, to promote dignity and privacy it should be ensured that:

- There are curtains that shut or screens
- Lockable doors for toilets and bathrooms
- That the environment is clean and has sufficient room
- That there is single sex rooms, toilets and bathrooms

Process

In regards to the nature and conduct of care activities, to promote dignity and privacy it should be ensured that:

- All staff knock before entering the room
- When entering a room ensure the person is not exposed for others to see
- Doors are shut (if preferred) when staff leave
- Ask for consent to carry out a procedure and give explanation if required
- You give choice to whether a person participates in activities as some person find activities intrusive and leaves them feeling vulnerable or embarrassed.
- There is careful care planning with the person's involvement (if possible, if not then with family)

People

In regards to the attitudes and behaviour of staff and others, to promote dignity and privacy it should be ensured that:

- Staff should introduce themselves and ask which name the person would like to be addressed
- Staff should demonstrate respectful verbal communication
- Staff should be aware of their non-verbal communication e.g. their facial expression, body language
- Staff should demonstrate that there are actively listening to the person and allow time for the person to respond.
- Staff should maintain confidentially unless in exception circumstances e.g. they suspect abuse
- Staff should ensure that systems are in place to safeguard against any discrimination against people with a 'protected characteristic'

Maintaining Privacy and Dignity When Providing Personal Care

Keeping a person clean is vital for good health, not only to prevent discomfort, infections and skin conditions but to promote self-esteem. Normally a person would take responsibility for their own personal hygiene but there are times that they may need assistance. It is important

to approach this sensitively, for some it will be the first time as an adult they have needing help with personal care. Many people find needing assistance with person hygiene very embarrassing and some can feel ashamed. There are many steps staff can take that will help to elevate this embarrassment and promote privacy and dignity, they include:

- Reading the person's care plan and familiarising yourselves with the person's requirements
- Make yourself aware of any religious or cultural requirements the person may have
- If you are unsure ask a senior member of staff
- Knock and introduce yourself
- Explain to the person what you are going to do and ask permission
- If you are assisting someone of the opposite sex, ask the person if they are comfortable with you washing them and if not get someone of the same sex to assist them.
- Ask them what they would like to do for themselves e.g. can they wash their face and hands
- Encourage the person to do as much as they can
- Ensure you have everything you need, such as toiletries, towels or change of clothes. This will prevent you from having to leave the person unattended to get items.
- Ensure the door or curtains are closed
- Talk to the person and explain everything you are doing as you go along
- Ensure that the person is always covered, for example if you are washing their legs, use a towel to cover their top half.
- Ensure the water is warm and change it when necessary
- Use the toiletries the person prefers
- Staff should be aware of their facial expressions and body language. It can be very embarrassing if staff wrinkle up their nose at a bad smell or hold a dirty item of clothing at arm's length.
- Washing should be gentle, it can be painful if a person is washed too vigorously
- When the person is dry help them to dress in clothing of their choice
- Help them to apply any creams or perfume/aftershave if requested
- Help the person to put on any glasses or hearing aids
- Ensure any dirty or soiled clothing or bedding is removed
- Before leaving make sure the person is comfortable

Choice

A person has the right to choose how to be care for, this includes refusing care. Staff should respect and help people with their choices providing it does not pose a risk to the healthcare staff or others.

If an adult who has mental capacity make a voluntary and informed decision to withhold consent to treatment, even if that treatment is lifesaving, this must be respect. In all events the healthcare professional must make sure that the decision has been documented in the person's notes and the person is aware that they can change their mind at any time.

A person with mental capacity is permitted to withdraw their consent at any time, including during the treatment or procedure.

Protect Patient Information

Patients' health information and their interests must be protected through a number of measures:

- Procedures to ensure that all staff, contractors and volunteers are at all times fully aware of their responsibilities regarding confidentiality;
- Recording patient information accurately and consistently;
- Keeping patient information private;
- Keeping patient information physically secure;
- Disclosing and using information with appropriate care.

The duty of confidentiality arises out of the common laws of confidentiality, professional obligations, and also staff employment contracts. Breach of confidence, inappropriate use of health records or abuse of computer systems may lead to disciplinary measures, bring into question professional registration and possibly result in legal proceedings. Staff should ensure that they are aware of the requirements and standards of behaviour that apply.

Confidentiality can be breach if the staff member feel the person is at risk e.g. there is a risk to ill health or abuse. In those circumstances, they should inform a senior member of staff.

Risk Assessments

In some cases, a risk assessment may be used to support the right of individuals to make their own decisions. The important thing to decide from a risk assessment is whether a hazard is significant and whether it is covered by satisfactory precautions so that any risk is acceptably low.

A **hazard** is something that has the potential to do harm. A **risk** is the chance (high, medium or low) of that harm occurring

There are 5 steps that need to be taken in risk assessment:

1. Identify potential hazards
2. Decide who might be in danger
3. Evaluate the risks arising from the hazards and decide whether the existing precautions are adequate or whether more should be done to get rid of the hazard or to control the risks

4. Record the findings and details of any actions taken
5. Keep the assessment under review and revise it as necessary

Person-Centered Approach to Care

In a person-centred approach the person is an equal partner in the approach to care, which involves the assessment, planning, implementation and evaluation of the care given. The person and their family (if appropriate) is at the centre of the decisions made. Seeing the person as an individual and working together.

When you encourage a person to be involved in the decision making they then can receive care that is appropriate for their needs.

Essence of Care 2010 – Benchmarks for Respect and Dignity

Agreed person-focused outcome **People experience care that is focused upon respect**	
Factor	**Best Practice**
Attitudes and behaviours	People and carers feel that they matter all of the time
Personal world and personal identity	People experience care in an environment that encompasses their values, beliefs and personal relationships
Personal boundaries and space	People's personal space is protected by staff
Communication	People and carers experience effective communication with staff, which respects their individuality
Privacy – confidentiality	People experience care that maintains their confidentiality
Privacy, dignity and modesty	People's care ensures their privacy and dignity, and protects their modesty
Privacy – private area	People and carers can access an area that safely provides privacy

Dignity in Care

The government's 'Dignity in Care' campaign was launched in 2006 with the aim of eliminating tolerance of indignity in health and social care services through raising awareness and inspiring people to take action. The Campaign incorporates the 'Dignity in Care Challenge', which comprises ten dimensions for the delivery of high-quality care services that respect people's dignity:

1. Have a zero tolerance of all forms of abuse

2. Support people with the same respect you would want for yourself or a member of your family
3. Treat each person as an individual by offering a personalised service
4. Enable people to maintain the maximum possible level of independence, choice and control
5. Listen and support people to express their needs and wants
6. Respect people's right to privacy
7. Ensure people feel able to complain without fear of retribution
8. Engage with family members and carers as care partners
9. Assist people to maintain confidence and a positive self-esteem
10. Act to alleviate people's loneliness and isolation

Whistleblowing

This is where staff can raise a concern about bad practice so that action can be taken. If you have concerns that a person's privacy or dignity is not being respected, you have a duty to raise it so that it can be resolved.

The word whistleblowing refers to the disclosure by staff of any incidents of malpractice, negligence or serious omissions of duty at work. The word whistle-blower refers to the person making the disclosure. Under the Public Interest Disclosure Act (PIDA) 1998 people now have protection against any form of retribution or victimisation as a result of disclosing information. This allows care workers to raise at an early stage any concerns about any malpractice being witnessed.

If possible the whistle-blowers' anonymity will be respected if required, however, the whistle-blowers must remember that this may affect the manager's ability to investigate the matter.

Anonymity cannot be respected if this would have an adverse effect on any serious criminal proceedings, or infringement of code of conduct. Once you have reported your suspicions it will be the responsibility of the manager to investigate the circumstances and to determine the next course of action to be taken.

References

NHS Essence of Care 2010 – Benchmark for Respect and Dignity
NHS England
Health innovation Network – South London
NHS Highland – Policy on privacy, Dignity and Respect
Human Rights Act 1998
The Equality Act 2010
The Care Act 2016
The Mental Capacity Act 2005

Mapped and aligned to the Clinical Care CSTF you will at the end of this course:

Fluids and Nutrition:

- Understand the importance of good hydration and nutrition in maintaining health and wellbeing
- Know the signs and symptoms of poor hydration and nutrition
- Understand the importance of food safety, including hygiene, in the preparation and handling of food
- Know how to promote adequate hydration and nutrition
- Understand the effects of culture and religion on individuals' dietary requirements and preferences
- Know how individuals can be supported and encouraged to access fluids in accordance with their preferences, requirements and/or plan of care
- Know how individuals can be supported and encouraged to access food and nutrition in accordance with their preferences, requirements and/or plan of care
- Know how to report any concerns to the relevant person

Hydration (fluid intake) and nutrition are vital for health and well-being. The food and drink that we eat must provide all the nutrients that we require for our bodies to work properly and to maintain a healthy status.

We need a healthy balance of Carbohydrates, Vitamins, Minerals, Fibre and Protein. Our food and drink intake must include all of these nutrients otherwise we will not get everything in our diet to keep us healthy and function properly.

- Carbohydrates – these are needed to give the body energy. There are 2 types of carbohydrate – starch and sugar. Starch is found in cereals, cornflour, potatoes, pasta and flour. Sugar is found in fruit, vegetables, honey, milk and malt products.
- Vitamins – these are needed in very small amounts for growth and health. The main vitamins are vitamin A, the B complex vitamins, vitamin C and vitamin D
- Minerals are needed in small amounts to help the body function properly and to stay strong. Calcium and Iron are 2 important minerals:
    - Calcium is required for the growth and maintenance of healthy teeth and bones. Calcium can be found in milk, cheese, eggs, wholegrain cereals, green vegetables, bread and tofu.
    - Iron is needed for the formation of red blood cells. Iron can be found in red meat, green vegetables, eggs, lentils and bread
      Other minerals that the body needs include potassium, sodium, magnesium and zinc.
- Fibre – only found in foods that come from plants. There are 2 types of fibre – soluble and insoluble. Soluble fibre dissolves in the water within your digestive system. Insoluble fibre does not dissolve in water – it passes through your gut without being broken down and helps other foods move through the digestive system more easily. A normal healthy diet should contain both types of fibre to help prevent heart disease, diabetes, weight gain, some cancers and also to improve

digestive health. Soluble fibre can be found in oats, barley, rye, bananas, apples, carrots, potatoes and golden linseeds. Insoluble fibre can be found in wholemeal bread, bran, cereals, nuts and seeds.

- Protein – necessary to assist with growth and repair of the body. Proteins are found in animal products such as meat, fish, cheese, milk and eggs. Vegetable proteins can be found in soya-bean products, pulses and nuts
- Fats – are necessary to help provide concentrated sources of energy and they help to insulate the body in the cold weather. There are 2 main types of fat – saturated and polyunsaturated. Saturated fats usually come from animal sources e.g. butter and lard. There are exceptions to this though with coconut and palm oils. Polyunsaturated fats come from vegetable sources e.g. sunflower oil

The Five Food Groups

The five main food groups are:

1. Bread, rice, potatoes, pasta and other starchy foods
2. Fruit and vegetables
3. Milk and dairy foods
4. Meat, fish, eggs, beans and other non-dairy sources of protein
5. Foods and drinks high in fat and/or sugar

The Nutritional guidelines and menu checklist 2014 for residential and nursing homes gives guidance on the food groups.

Food Group	What's Included	Important for	How Much to Choose
Bread, rice potatoes, pasta and other starchy foods	All breads Rice Potatoes Pasta and noodles Breakfast cereals Porridge oats Couscous, pearl barley	Energy B vitamins Fibre Some Calcium Some breakfast cereal are fortified with vitamins and minerals including iron Where possible, choose wholegrain varieties	At least one food from this group should be served at each meal As a guide, include six or more servings daily. The number of portions of food from this group will vary according to age, physical activity and appetite.
Fruit and vegetables	All fruit, including fresh, frozen, canned and dried fruits, fruit juices and smoothies All vegetables, including fresh, frozen, canned and dried vegetables.	Fibre Carotenes (Vit A) Folate (Vit B) Vitamin C Vitamin E Iron form green leady vegetables.	Five or more servings per day. Fruit juice only counts as one a day. Add extra fruit and vegetables into normal everyday meals e.g. salad in sandwiches and veg in stews
Milk and dairy foods	Milk Cheese Yogurt Fromage Frais Butter milk Cottage cheese Cream cheese This group does not contain butter, eggs or cream	Calcium Protein Vitamin B12	Eat or drink 3 servings a day **A serving is:** 200ml (1/3 pint) milk 30g (1oz) cheese 150g (1 medium pot) of yogurt 200g (1 large pot / half a can) of custard, rice pudding, semolina, tapioca etc.

Meat, fish, eggs, beans and other non-dairy sources of protein	Meat Poultry Fish Eggs Pulses Nuts and seeds TVP & soy protein Quorn	Protein Iron B vitamins Zinc Omega fatty acids from oily fish Essential fatty acids from seeds and nuts	Eat 2 servings per day
Foods and drinks high in fat and/or sugar	Cooking oil, butter, margarine, low fat spread Mayonnaise, salad cream and oily salad dressings Creamy sauces Gravy Chocolate & sweeties Ice lollies	Energy Vitamin A & D Essential fatty acids from certain oils	Cooking fats, oils and spreading fats should be used sparling Choose those high in unsaturated fat This food should be limited to mealtimes when possible to minimise tooth decay

Nutritional guidelines and menu checklist for residential and nursing homes 2014 recommend residents should be encouraged to eat three meals and day and two to three snacks between meals.

NHS Choices define malnutrition as: "a serious condition that occurs when a person's diet doesn't contain the right amount of nutrients". They state that in the UK there are over 3 million people malnourished at any time with many more being at risk of being malnourished. Further information can be accessed here: http://www.nhs.uk/Conditions/Malnutrition/Pages/introduction.aspx

The 2 main groups of people at greatest risk of malnutrition are young people and older people. Young people require additional nutritional support due to their rapid growth and older people may not be able to care for their nutritional needs adequately due to various medical conditions with reduced mobility or cognitive problems. Those people who are unwell also may well lose their appetite or have difficulty swallowing.

As healthcare professionals we have a duty to provide patients with optimal nutritional care as part of their care and this means ensuring the provision of adequate fluids and nutrition to promote well-being.

Patients / service users should have unrestricted access (unless for medical reasons) to fluids at all times. Feelings of thirst are usually the early signs of dehydration so they should not wait until they are thirsty before drinking or being offered fluids.

Hydration

Without enough fluid in our bodies the body cannot perform the following basic functions:

- Enabling nutrients to be absorbed from the digestion of foods
- Enabling blood to circulate around our bodies and reaching all the cells
- Waste product removal via our urine and faeces
- Fighting infection
- Controlling body temperature
- Maintaining brain function

The Department of Health (England) recommends that people should drink approximately 1200ml of fluids per day to prevent dehydration. This amounts to 6 of 200ml glasses or 8 of 150ml glasses, cups or mugs of fluid each day. Some of the fluid can come from the food that the persons eat.

Fluid intake requirements increases when:

- The person has diarrhoea and/or vomiting
- The person is involved in physical activity
- Hot weather
- High temperature
- Exudating wound

Fluid maybe restricted for some people for medical reasons e.g. renal or liver disease or heat failure. These reasons must be clearly documented in the care plan.

Dehydration can be mild, moderate or severe and can quickly become a medical emergency if not treated.

Signs of Dehydration

- Dark and strong smelling urine
- Low urine output
- Dry lips and tongue – feeling thirsty
- Confusion and dizziness - headaches
- Sunken eyes
- Constipation
- Dry skin & brittle hair
- Wounds not healing well

If dehydration is not recognised or treated then the individual will have increased risk of suffering with confusion, falls, ulcers or urine infections. The consequences for certain patient groups such as the elderly, those with a low immune system or the very young can have long term damaging effects on their general health and well-being.

Causes of Dehydration and Malnutrition

- As a person ages, thirst decreases
- Difficulty in swallowing
- Poor Mobility
- Poor Memory
- Sensory impairment
- Loss of Dexterity
- Poor oral health
- Limiting fluids to prevent incontinence
- Medical conditions such as Parkinson disease or chronic obstructive airways disease

Certain groups of individuals are more vulnerable to illnesses related to food because of a weakened immune system and these are:

- Babies, toddlers and children
- Pregnant women and those who are breastfeeding
- People who are older
- Those people who are on a lower income find difficulty in affording a healthy balanced diet

Promoting Adequate Hydration and Nutrition

Assessment and Monitoring

Any persons who receive care should have an assessment made on their nutritional status. This will include their likes, dislikes, wishes and preferences including any cultural / religious

status which disallows certain foods / drinks from the diet or any religious festivals for example, that include fasting.
As well as likes and dislikes we need to include within the assessment the following:

- Is any help required with eating and drinking e.g. cutting up food? Feeding? It is not good to simply leave a tray in front of a person with food and drink on it not knowing if they are able to feed themselves or not.
- How is the person's swallowing reflex? Is an assessment required by speech therapist?
- Is any special diet required e.g. soft, or pureed, vegetarian, high protein, low carbohydrate etc.
- Does the person have their own teeth or dentures – if dentures are they fitting well or do they need attention?
- The timing of meals – does it depend on medication – before, with or after food?
- Are there any food stuffs that should not be given due to medication?
- Is any special crockery or cutlery required or any other modifications e.g. non slip pads?
- Do they have any food allergies?
- Are there any health conditions that we need to be aware of to limit certain food stuffs e.g. low cholesterol; diabetes etc.

The above list is not exhaustive and a full assessment should be made and ongoing particularly in long term care scenarios. This is an important part of the care plan. At all times we must be mindful of providing dignity and respect.

Some people may be particularly embarrassed at meal times within a "public" care environment if they are experiencing difficulties due to a medical condition e.g. Stroke which has left them unable to feed themselves and also swallowing difficulties.

Other conditions which may prompt extra assistance from health care staff could be:

- Patients who have Dementia who may forget to eat or possibly need to eat when they are moving around and have nutritional "finger" food meals prepared
- Depression may cause a person to have a poor appetite
- People with sight impairment will need to have explained to them where on the plate the food is e.g. Meat is at 12 o'clock, vegetables at 3 o'clock etc.

There is much that we can do to ensure that a person receiving care also receives healthy balanced diet which includes not only providing the food but also monitoring intake and recording intake. We should never rush people and give them plenty of time to eat and finish their meals in a calm and pleasant environment. Meals are usually a social event and should be maintained as such. If you are assisting a person with their diet and fluids you should encourage them to be as independent as possible. Note exactly what the diet and fluid intake is and report any concerns that you may have to your line manager. It may be necessary to involve other members of the multi-disciplinary team such as a dietician, speech therapist or occupational therapist.

There are many devices available to help a person with eating and drinking so that they can remain as independent as possible. These include:

- Adapted cutlery – e.g light weight, padded, angled
- Non slip plates, dishes and bowls
- High sided plates
- Non slip table mats
- Plate surrounds and guards
- Portion plates
- 2 handled mugs
- Cups / glasses with lids

Food Safety:

It is important that health care workers' / food handlers are aware of the members of the population that are most vulnerable to the risk of food poisoning.

These are:

- Under 5s
- Over 60s
- Pregnant and breastfeeding women
- People already ill or in hospital

The main reason that these people are most at risk because their immune system may be affected in some way. This could be because:

- It is not yet developed sufficiently to fight of germs (under 5s)
- It has begun to deteriorate (over 60s)
- It has been impaired by other illnesses (those already ill)

Anyone working with food must understand the importance of ensuring high standards of food handling with these categories. The elderly are more at risk when they are together in large groups e.g. care homes, hospital, day centre.

The Care Environment should be kept clear of infection and contamination wherever possible.

When many people live together there is the risk of infection being spread through direct and indirect contact – and cross contamination when harmful bacteria are spread onto food from other food, surfaces, hands or equipment. These harmful bacteria often come from raw meat/poultry and eggs.

Other sources of bacteria can include:

- Staff
- Pests (insects, vermin, cockroaches etc.)
- Equipment
- Cloths

Food should also be protected from **physical** contamination such as broken glass, pieces of packaging, dust etc. and also **chemical** contamination where chemicals from cleaning products or pest control can get into food.

Allergens can be a hazard for those who have allergic reactions to them e.g. nuts, shellfish. They can result in breathing problems, itchy skin rash and in the worst case scenario result in anaphylactic shock which can be fatal without emergency medical treatment. Foods that contain allergens should be stored and prepared separately. It is vital that you know if your patients have any food allergies.

Bacterial hazards are caused by micro-organisms e.g. bacteria that can be found in raw foods, or in the nose and throat that can be transferred into food during the storage, handling and preparation of food

Direct Contact:

This could be through inhaling infected air droplets, e.g. coughing or sneezing near another person, this could be through direct physical contact.

Indirect Contact:

This occurs when infected objects come into contact with the hands, nose, mouth or skin. Examples are clothing, food, cutlery, crockery etc., which have been contaminated with germs.

It is essential that any protective clothing worn for food handling is NEVER worn when visiting the toilet or when going outside.

It is essential that both care workers and service users ensure that hands are washed correctly before handling food.

NO soiled linen should be taken through kitchen and food preparation areas.

Some foods are considered high risk foods. These are the foods that food poisoning bacteria prefer to grow on. These are generally perishable foods with a short shelf life.

High risk foods are:

- Cooked meat and cooked poultry products
- Milk, cream and ice cream
- Sauces and gravies
- Cooked dairy products

- Fish and shellfish
- Rice
- Pulses if not tinned and cooked already
- Any foods containing the above.

Managing high risk foods:

- Control temperature – storage and cooking temperatures
- Ensure the heating process is thorough
- Avoid handling high risk foods
- Keep separate from raw foods
- Keep covered or wrapped when storing

FACILITIES AND EQUIPMENT

All facilities and equipment should be designed to minimise risk and for ease of cleaning.

Separate areas for storage and preparation of raw and cooked food are ESSENTIAL, as are separate utensils.

Many organisations colour-code their equipment and utensils making it clear which is to be used for raw meat, cooked meat, dairy, vegetable etc.

It is important that all equipment can be moved to ensure that areas can be adequately cleaned and disinfected. Whenever a piece of equipment is static, dust and dirt will accumulate and can pose an infection risk.

Food handlers and care worker have a responsibility to ensure any damaged equipment or facilities are reported to their supervisor and detailed in the relevant record book. This demonstrates 'Due Diligence'

All organisations have a legal duty to provide hand washing basins designed for only that purpose. There should be hot water, bactericidal soap, a nail brush (either disposable or disinfected daily) and disposable paper towels.

Refuse

All indoor refuse bins should be foot operated, to minimise contamination by hands. All outdoor bins should have secure fitting lids. Wherever refuse are deposed the area should be cleaned and disinfected regularly.

PERSONAL HYGIENE AND HEALTH

High standards of personal hygiene are essential. The food handler is the key to good hygiene.

It is the responsibility of all care workers to maintain their own personal hygiene and health.

Points to remember:

- Many care workers will be involved in handling and/or serving food and/or food equipment, and therefore have a legal and moral responsibility for maintaining high standards.
- All care workers MUST follow organisational policies and procedures for personal hygiene and maintain high standards at all times.
- When working with others, care workers should work to minimise the risk of others poor personal hygiene.

WHEN TO WASH HANDS

It is essential that regulations relating to hand washing are followed at all times.

1. When arriving on duty
2. After any contact with a service user
3. After using the toilet
4. After a break
5. After blowing nose, coughing, sneezing, touching face or hair
6. Before and after handling both raw and cooked food
7. After handling rubbish or personal waste
8. After picking something of the floor
9. After cleaning and disinfecting
10. After smoking

Far more detail on Food Hygiene Safety is included within our Food Hygiene Course.