Christies Care
Est. 1987
Living independently at home

Christies Care Ltd
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www.christiescare.com
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Inspected and rated Outstanding
CareQuality Commission

THE CARER'S GUIDEBOOK

Version Nine: July 2019

PRINCESS ROYAL TRAINING AWARD 2017
MINDFUL EMPLOYER
INVESTORS IN PEOPLE | Silver Until 2020
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THE CARER

As a carer you do one of the most important jobs in the community today. You help other people to retain as much independence as possible. At the same time, your presence indicates your client's dependence. Preserving one and providing for the other is not easy, and skill, sensitivity, kindness and above all humour are required. While assisting your client to wash or dress or care for their home you will be:

- Supporting your client's wishes to remain at home
- Making your client feel wanted and valued
- Encouraging your client's individuality and independence
- Helping your client to maintain relationships with neighbours, the neighbourhood and familiar activities and surroundings
- Keeping your client physically comfortable
- Assisting other carers to provide care for your client
- Doing for your client what they cannot do for themselves
- Providing social contact, especially for clients who live alone
- Being the face of "care in the community"
- Acting as a Christies Care representative

You may, for many of your clients, be the only person providing care. Some clients may have family members and friends who also help. As the paid, professional, carer you will be expected to provide high standards of skilled care. This means we advise you to do the following for yourself and your client:

For yourself

- Maintain your own health with a proper diet, sufficient sleep and exercise and learn to deal with stress by maintaining personal interests, and enjoying sufficient relaxation.
- Ensuring that you have sufficient rest breaks in between your introductions and whilst you are working for a client.
- Know yourself and be prepared to spend some time getting to know yourself better as you work with your clients.
  How you react may have a lot to do with your personality and your past experiences. How you respond is part of being a professional worker. You may have to control or change your reactions and learn new ways of responding.
- Make a practice of reviewing your work, think of your successes and failures.
- Look after yourself by learning how to deal with natural feelings of weariness, sadness or frustration at the end of the day, so that you do not carry them into the next day's work or from one client to another.
- Never allow your political or religious opinions to affect your professional judgement in your work. Likewise, the political or religious opinions of your client must not unfairly affect anything you do for them.
- Always observe health and safety requirements e.g. only lift or move someone in accordance with your training.

For Christies

- Keep your side of the agreement made when accepting an introduction.
- Keep yourself informed and updated about all aspects of the work that you are doing. Professionals are usually defined by the special knowledge they have. To be professional, it is your responsibility to keep up-to-date and extend your knowledge, skills and understanding of your job by undertaking in-house training provided by our training department.
- Be prepared for emergencies. See section 3 of this handbook. We advise that you read it from time to time in readiness for the day when you may need to take emergency action or give First Aid.

For your client

- Remember that your job is to do all you can to extend your client's independence and to enable your client to exercise as many choices as possible. Some people refer to this as an empowerment. In their enthusiasm, carers may sometimes find they are taking too much control over a client's life. This may satisfy the carer but is seldom in the real interests of the client.
- Recognise when you should not go to work and ask us to find a substitute for you, i.e. when you do more harm to your client by 'soldiering' on than giving up.
- Acknowledge the fact when you do not know something and need to ring your Carer Support Team. Being professional does not mean knowing everything, but it does mean knowing your limitations and, for your client's sake seeking help when you need it.
- Your personality and individuality will influence your work but the care you provide for any client should not be influenced either by your personal problems, or your likes or dislikes.
- Respect your client's confidentiality.

YOU AND CHRISTIES CARE

Christies Care Ltd was founded in 1987 and is owned by its directors. We specialise in live-in, continuous care at home. We do not supply hourly care nor do any other type of work. We are now one of the half dozen largest companies in Britain, which specialise in this work.

We have a very wide range of clients, ranging from 18 to over 100 years old, and can offer carers work that will suit them, their skills and their personality. Our head office is in Saxmundham, Suffolk, where the directors work with the Booking Team, Carer Support, Recruitment Team and Administrators, introducing suitable carers to work for their clients all over the UK.

To support our clients, many of whom live a long way from Saxmundham, we have a team of Local Area Advisors. Living close to clients and carers, they help us with assessments, reviews, and support wherever needed. In this way, our Suffolk-based office is supported well at local level.

This handbook gives advice as to how the successful carer will behave towards her client. Although you will work under the direct control of your client, we require you to reach a minimum standard of competence, set by us, before we can introduce you to a client: that is why this guide contains some firm recommendations.

We have our own obligations to meet governing the delivery of care such as Health and Safety at Work Act 1974. Data Protection Act 1998, Competition Act 1998, & Equality Act 2010.

Your first weeks

Your Carer Support Team is available to offer you support and advice, especially in your first few weeks. They will call you weekly to begin with, provided your client agrees.

A Local Area advisor will visit you during your first four weeks of work after induction, with your client's consent. As part of this visit, the Advisor will retest you on your medication knowledge with a practical scenario for you to complete while they are there.

If you fail you will be required to undertake further training at our head office. We would need to inform your client and you may be removed from your introduction depending on your client's needs and wishes.

Bookings

Once you have accepted an introduction you will receive a booking confirmation. If this is the first time you have cared for this client or you have not been to this client within the last six months it will be a full support plan a week before your arrive via your portal, their address, contact numbers and suggested fee for this engagement. We recommend that if you have confirmed this introduction within the last 8 weeks that you contact the booking co-ordinator one week before the engagement in case there are any updates that you need on your client's condition.

Personal Appearance

The way you look when the client first sees you will be the biggest impression you make on them.
We advise that your personal appearance should be acceptable, pleasing and give a professional impression to your client. We suggest you wear flat-soled shoes, full skirts or trousers and smart, comfortable and practical shirts, jumpers or blouses. Jewellery should be kept to a minimum. Large rings and earrings can be dangerous for your client and for you and we advise they are not worn whilst you are working. We suggest that long hair is tied back neatly.

We suggest you take care with your personal hygiene and cleanliness. It is unprofessional to smell of cigarettes if you are going to a non-smoking client. Strong perfume or aftershave can also be off putting to some clients.

Your Post (As per point 5 in the Code of Conduct for Carers)

We advise clients not to allow carers to use their address for personal correspondence to be forwarded to. We have a post forwarding service at Christies Care for your use. For an annual subscription renewable every November you can have your post forwarded to you and, should you return home, it will continue to be forwarded to you for the remainder of the year.

Recording of Calls

All external calls made to and from Christies Care Ltd are recorded, and may be used in any fact finding investigations we may have.

Email Address

We strongly recommend that you have an email address so that we may keep in contact with you. This is especially helpful when you return home, and if home is other than the UK, due to delays in the postal system and time differences when phoning.
This will also mean that you can access Christies Care's website, for Carers – www.christiescarers.com

Christies Care Portal and Electronic Documents

Christies Care sends as many documents as possible electronically. To retrieve these documents each carer has their own private portal library.
The portal is a secure document store and each person has their own unique username and password. These are provided when a carer attends induction or update training.

The documents that will be sent include, payslips (if paid by Christies Care), P60 tax report, activity report, confirmations, cancellations and care plans, other documents will be sent in the future.

The management of these documents is controlled by Christies Care IT department and these cannot be deleted by carers, they are handled using a retention policy that will remove documents remotely when they are no longer relevant.

Also accessed through the portal is the carers extranet, a global document repository containing documents such as the carer handbook, the cookbook, training schedules and forms to allow carers to send requests to the office.

If you have any questions about your portal library or the portal in general then email portalsupport@christiescare.com

HEALTH AND SAFETY AT WORK (As per point 7 in the Code of Conduct for Carers)

The Health and Safety at Work Act 1974 contains most of the rules which have been agreed to protect the health and safety of workers in the UK and those affected by work activities e.g. clients. (The general duties of the Act are supported by specific regulations e.g. the Management of Health and Safety at Work Regulations 1999, Manual Handling Operations Regulations 1992.)

A copy of our best practice guidelines, which explain our arrangements to ensure that the work you are asked to undertake does not put your own health and safety and that of others at risk, are in Chapter 4 of this handbook. These include:-

- Manual handling
- Violence, verbal and physical
- Infection control
- Hazardous substances
- Electricity
- Accident reporting
- Medication

You will already have been provided with the relevant training and instruction to enable you to follow the best practice guidelines which apply to your work when you attended our 10 day induction training. Christies Care is required by law to assess the risks that you face when you carry out your work activities in the client's home.

There may be occasions, however, when we are asked to provide care urgently and there is not adequate time to undertake an assessment before you start work. In such cases, we will inform you that no assessment has yet been done and you should exercise special care.

We strongly advise that you should inform your Carer Support Team if you feel the situation is one in which it is not safe and healthy to work or if there are particular hazards.

You are strongly advised to:

- Co-operate with Christies Care and follow the instructions and training provided for your health and safety
- Use any piece of equipment or protective clothing provided for your use e.g. gloves and aprons
- Be observant yourself and look out for risks or hazards and report them to your Carer Support Team
- Inform your Carer Support Team so that the situation can be reassessed if you feel that conditions have altered so that there is an increased risk to your health and safety.

It is strongly advised that you follow this household safety information

Chemicals and Dangerous Substances

Household chemicals include: medicines, cosmetics, decorating products, car products, garden chemicals, craft products and household cleaners. Clients may also store very flammable products (petrol, paraffin etc.) although these should not be in the house. Most household products which you are likely to use in a client's house do not create a significant risk to yourself or your client, provided the products are used and stored in accordance with the manufacturer's instructions.
You should never mix products together even if you think that they are similar and perform a similar function, as they may produce toxic fumes, e.g. bleach and some toilet cleaners.

All products should be kept in their original containers. If you are in any doubt as to what is in the container or are unable to read the instructions you should not use it. Particular care should be taken when storing substances if your client is blind or partially sighted. Remember also that when someone has lost their sense of smell they will be less easily able to identify substances.

If you are unhappy with the storage of any chemicals at your client's home and your client refuses to allow you to store in a safer place, we suggest that you contact your Carer Support Team and if necessary they may seek permission for the local area advisor to visit and carry out a risk assessment.

Disposal of Chemicals

DO NOT pour waste chemicals down the drain, toilet or sewer, or throw them in the rubbish bin. If you are in doubt please contact the local council for advice on disposal.

Electricity

Before we introduce a carer to a client, we will seek to assess the electrical equipment in the house. If you have concerns about any electrical equipment, including the wiring, and your client is unwilling to help, we suggest that you contact your Carer Support Team.

It is advisable always to know where the main switch is for the electricity in your client's home.
If a piece of equipment smells, appears to be overheating, or is sparking, turn the electricity off at the main switch first before unplugging the item.

If you notice anything within the list we strongly advise you DO NOT USE and we advise that you contact your Carer Support Team.

- Damaged cable covering e.g. cuts, abrasions (apart from light scuffing) or taped joints in cables
- Damage to plugs e.g. the casing is cracked or the pins are bent
- Signs of overheating e.g. burn marks or staining around the pins of a plug or socket
- Any plug or socket where the plug is not right up against the socket
- Any wires that are uncovered i.e. not insulated
- Any piece of equipment which has damage to the outer cover or obvious loose parts or screws
- Normal domestic electrical equipment, other than equipment fixed directly to the wall without a plug and socket, should never be used in bathrooms
- Any socket overloaded with multi-point adaptors to operate several appliances at one time
- Cables that trail across the floor which are likely to get trapped or stretched by furniture or doors, or cables that trail across sources of heat such as fires or cookers

For emergency electrical problems, you should contact your client's electrician, with the client's consent (the number should be on the contact list in the guide to client's wishes). NEVER attempt any electrical repairs yourself.

Gas

If your client has a gas supply in the house or flat, check that the gas burners are off when not in use, especially if your client is not very mobile. You should also find out where the main gas valve is (this will be stated in the client's guide).

- If you find unlit gas burners turned on in the fire or oven, open windows immediately to allow the gas to escape and turn off the source. Do not attempt to relight the pilot light.
- Report such events e.g. unlit gas burners to your Carer Support Team.
  It may be necessary for other action to be taken for the safety of the client and others in the vicinity in the future.
- If you suspect a gas leak DO NOT switch on any electrical appliances or lights.

If your client is a tenant, either private or council, annual maintenance should be carried out on the safety of the gas installation.

Water

- Water can be a hazard because it is invisible, can be slippery on floors and may cause damage to other materials
- Spilled water on bathroom, lavatory and kitchen floors must be mopped dry
- Dripping taps waste water and energy, especially if it is a hot tap which is dripping
- Leaking radiators, if they are unnoticed may lead to damp carpets and floorboards, which can cause serious damage
- It is always useful to know where the stop-cock or mains tap is in any house (this should be stated in the client guide) so that the main water supply can be cut off in the event of a leak or flood

Fire

You are not expected to act as a fire-fighter. Some clients keep fire extinguishers or fire blankets in their homes and these may help you to put out a small fire. NEVER attempt to put out a large fire. If you are ever in any doubt, leave the house with your client (if mobile) and call the Fire Services (free call 999 or 112).

People sometimes think that a fire can start only if matches are lit, a domestic fire is alight or someone is smoking. Remember that heat energy, fuel and oxygen are all that are needed to start a fire.
There are plenty of sources of heat energy in the average home e.g. radiators, electrical appliances, chemical reactions (when two substances mix intentionally or unintentionally), sunlight (especially focused through glass), friction (created when two materials or objects rub against each other).
The average home contains a lot of fuel – paper, fabrics, furniture, cushions, bed clothes – and oxygen is freely available. It is important to prevent any likelihood of fire.

- Clothes should not be put to dry on fire guards
- Tea towels should not be hung over the cooker to dry
- Clothes should not be hung where they trail over radiators

- Some homes have smoke alarms, although they can be set off when danger is slight (e.g. the toast burns) and your client may need to be warned of this. The batteries of smoke alarms also need to be checked regularly and replaced when necessary
- Domestic fire extinguishers also need servicing annually

Fire Blankets

Fire blankets are usually kept in the kitchen for pan fires but can be used in other rooms in the house. If you are putting out a pan fire or similar, pull the blanket from its casing and drape fully over the fire. You can use the top of the blanket to cover your hands. Try not to let the edges of the blanket dip in the burning liquid. Leave the blanket over the pan until it is quite cold. If you take the blanket off too soon, the fire may start up again as oxygen will again be present.

Use of Fire Blanket for a Clothing Fire

To put out a fire on someone's clothing, make sure they are lying on the floor then roll them in the blanket. You can gently pat the blanket to help put the flames out more quickly. Leave the blanket in position and call a doctor or ambulance. The number of your client's doctor should be in the client guide. You can call an ambulance on 999. Dry powder extinguishers can also be used to put out a fire on someone's clothes.

Moving and Handling

The health and safety aspects of Moving and Handling are particularly relevant to carers. This subject is dealt with in Section 3 of this handbook.

EMERGENCY PROCEDURES

Whilst attending induction you will have been given training on emergency procedures. You should revise emergency procedures from time to time to keep yourself familiar with them. **In case** you need them in an actual emergency the instructions below are set out as briefly as possible. We strongly advise that you follow them.

Fire precautions

In the event of a fire, observe the following:

- Raise the alarm
- If appropriate, assist your client to leave the premises if safe to do so
- Telephone 999 and ask for the Fire Brigade – giving clear instructions of the location of the fire
- If safe to do so, close windows and doors to prevent fire and smoke spreading
- Do not enter the building to collect personal belongings
- Do not return to the building until the Fire Brigade has confirmed it is safe to do so
- We suggest that you report the incident to your Carer Support Team
- Keep calm yourself and reassure your client at all times

Water leak or flooding

- Put a bucket or bowl underneath the flow of water if possible
- Turn off the **stop cock** for the water supply to the house or flat to cut off the supply of water from the mains
- If the water is coming from the main water tank in the house, leave the bath tap running. If the stop cock has been turned off and the main tank is empty, there will be no more water to leak into or flood the house.
- Telephone the emergency number of the water company which supplies water in your client's area
- If water has to be mopped up, use towels or other absorbent materials, e.g. natural fibres (cotton, wool, silk). Nylon, polyester, fibreglass and other man-made fibres will not absorb water to any great extent. Do not use client's favourite towels.
- Keep calm and reassure your client.

Gas or fumes

- If you can smell gas or fumes, open a window to let it escape. Turn off any fires or cookers and DO NOT LIGHT matches, candles, tapers or cigarette lighters.
- Turn off the main gas supply where it enters the house or flat.
- Telephone the emergency number of the gas company supplying your client's home.
- Identify the source of any fumes coming from something other than domestic gas, e.g. chlorine gas from mixing cleaning fluids.
- If you or your client are having difficulty breathing or coughing, hold a damp cloth over the nose and mouth to help ease the condition, and make your way outside.

Electricity

- DO NOT touch your client whilst they are in contact with the electrical supply.
- Turn off the electricity supply at the mains.
- If you are unable to do this, stand on a dry rubber mat or dry wooden block or book (e.g. telephone directory).
- Use a wooden broom handle or something similar to push your client's limbs away from the electric source (NEVER USE ANYTHING CONDUCTIVE e.g. anything metal).
- Treat for shock and get help from a GP or call 999.

THE STRESS FACTOR (As per point B1 in the Code of Conduct for Carers)

Definition of Stress

"Stress has to do with stimulus". What happens? When we get stimulated, chemicals such as adrenalin are released into our blood flow, blood pressure increases, heart rate increases, we have a greater oxygen intake, more blood flows to our muscles and all this combines to provide us with the necessary strength, energy and clear thinking if we are to cope with the challenge that is facing us.

This stimulus is normal and healthy provided it was justified in the first place and we can use the energy that is produced.

However, when it is inappropriate or kept up too long it may start to generate harmful stress and nervous tension.

In this situation what began as a normal and positive set of reflexes becomes unhealthy and counterproductive.

Some people may thrive on a particular situation while others will find the same situation terrifying and highly stressful. Too little stimulus can be just as stressful as too much. Stress only becomes harmful when we cannot control our responses to it.

Recognising this fact is a vital first step to reducing the harmful effects of stress in your life.

The stage at which manageable, positive stress turns to unhealthy over-stress is different for all of us. Our personality, behaviour and lifestyle all have important influences on our stress level. Stress occurs through emotions such as aggression, impatience, anger, anxiety and fear. Our behaviour – eating an unhealthy diet, smoking, drinking and taking drugs – can also contribute further to stress.

Sources of stress within live-in care

- The way the client lives may not be to your liking
- Clients set in their ways and unaware that their behaviour can amount to abuse
- Clients telling you all day how much you are costing them
- Clients in early stages of dementia may have mood swings and be abusive
- Unfavourable comparison made by client between one carer and another
- Clients relatives/family
- Cultural differences
- Tiredness
- Communication problems
- Feeling of lack of support from head office
- Inaccurate handover information
- Homesickness
- Being a lone worker
- New client, new routine
- Travel and changeover
- The feeling you aren't coping with your client
- Your client saying that you are no good at being a carer

Can you remove the cause of this stress?

Before you can cope with stress effectively, you must become aware of your own stress responses.

What are typical stress responses? This is not as straightforward as it seems. The effects of stress creep up on you.

You may fail to notice. Both mind and body have a tremendous capacity to adapt. The more we adapt, the greater the temptation to drive yourself even harder. This is the dynamic of increasing stress.

For some people, it may be a sudden headache, for others an inability to sleep even though you are tired. Others may be, more tired when away from the pressure of work than at work itself.

If you think you are possibly starting to be overtaken by stress, sit back and think about it hard, think what symptoms you have that ought not to be there. Are they symptoms of stress that need to be relieved?

Learn to recognise what is causing you stress. Learn to observe yourself more. Take a step back. You will know how you feel when you begin to get stressed, so stop and recognise the stressors. What happened to make you feel like this? Is there a pattern you can notice – that this type of thing always stresses you?

The most obvious way of reducing stress is to remove the factors that cause it. However, many everyday stressors cannot be easily removed – work, relationships, financial pressures etc. are all part of our lives. We have to learn to manage the stress level within the everyday life we have chosen.

How to reduce stress

- Make good use of free and standby time
- Prayer
- Relaxation and making time for yourself
- Exercise
- Find a buddy
- Stress counselling

How not to cope with stress

Many people wrongly assume that a good stiff drink is just the thing to combat stress – it isn't – in fact it can add to the stress that you already feel. Smoking too, is often regarded as an antidote to stress. Nicotine works on the brain by creating the need for more nicotine, it *temporarily* relieves then leaves you needing more – hence, the addiction to smoking.

If you are feeling stressed you should avoid food and drinks that contain caffeine and other stimulants such as alcohol.

If you are so stressed that your health is being affected you may choose to consult your doctor. Your doctor may suggest counselling or other forms of help and, in some cases, he may prescribe you drugs.

LOOKING AFTER YOURSELF

We strongly recommend that you have at least one week without work in every 6.

In order to provide the best possible service to your clients we introduce you to and to enable you to establish a regular rota of clients we strongly advise that you frequently evaluate your tiredness and take adequate rest weeks off to recharge your batteries. This ensures that you are providing the best possible service to your clients as well as boosting your chances of staying fit and being regularly available for work.

We recommend to clients that they give carers at least two hours per day as time off where the carer is free to do as they wish and a good night's rest, as well as standby time, if possible. Your client may offer you financial compensation if you are not able to take these breaks. We strongly recommend that you find a way of negotiating so that you get breaks and your client gets the service they require. Financial gain cannot make up for a good break to refresh your body and mind. If you are unable to take your time off and the client's family cannot help we have some Partners in Care that we can suggest the client contacts to provide you with your time off. Please see section 2, page 3 for further information regarding time off and recommended charges.

Tiredness can lead to mistakes and places you and / or your client at risk. If due to circumstances at your clients you find yourself more tired than usual and feel that you cannot perform to the best of your abilities, we strongly advise that you immediately discuss with your client and your Carer Support Team.

Carers who do not give themselves adequate rest breaks between introductions and consequently do not perform to the best of their abilities are highly likely to be considered unsuitable for introduction to clients. Please consider this carefully when discussing your availability with your Carer Support Team and negotiating time off with your clients.

EXPECTING A BABY (As per point A1 in the Code of Conduct for Carers)

If you become pregnant whilst working as a carer, as soon as it is confirmed by your GP, we strongly advise that you inform your Carer Support Team. If you are booked to clients with moving and handling requirements this will need to be reassessed and may lead to these introductions being reallocated, should they pose a significant risk to you or your unborn child and reasonable adjustments cannot be made to overcome these risks.

A Local Area Advisor will come and visit you during your pregnancy to assess your duties and ensure you are not carrying out any duties which may harm you or your baby.

Your GP or midwife will issue you with a MATB1 certificate 20 weeks before the estimated date of the birth. You may be able to use this form to claim maternity pay through the Job Centre Plus.

Returning to work

If you wish to return to work after the end of your maternity leave, we suggest that you give Christies Care at least eight weeks' notice of your date of return. It is a requirement of your return that you undertake two days at head office to attend update training on moving and handling, food hygiene, medication and safeguarding before we can reintroduce you to clients, if your previous training has expired.

A. CONFIDENTIALITY AND DATA PROTECTION (As per point 5 in the Code of Conduct for Carers)

1. Introduction

1.1 Christies Care Ltd processes information about people with whom it works. These will include members of the public and current, past and prospective staff, clients and suppliers.

1.2 Information is processed to enable Christies Care Ltd to operate its business, deliver services and to comply with legal requirements.

1.3 Christies Care Ltd aims to maintain confidentiality and respect for the privacy of information as required by legal requirements and best practice.

1.4 The law and best practice recognise that there are exceptions to this general aim where there is a need to comply with other legal requirements or to act otherwise in the best interests of the individual. Assessment of whether a situation falls within permitted exceptions will be made by the Registered Manager, Director or Data Processing Officer (DPO).

2. Confidentiality

2.1 Confidential information will be used only for the purposes that it was provided for.

2.2 It will only be disclosed in accordance with legal requirements and best practice.

2.3 The authorisation of the Registered Manager, Director or DPO will be required for disclosure of a client's confidential information to 3rd parties not involved in the care of the client.

2.4 If there is any doubt in your mind about security matters, you should immediately seek the advice from you carer support team.

2.5 All staff, whether permanent, temporary or contractors are required as a condition of employment to sign a confidentiality agreement.

3. Data Protection

The General Data Protection Regulations 2018 (GDPR) contains principles affecting employees' and other personal records. Information protected by GDPR includes not only personal data held on computer but also certain manual records containing personal data, for example employee personnel files. The purpose of these rules is to ensure that you do not breach GDPR. If you are in any doubt about what you can or cannot disclose and to whom, do not disclose the personal information until you have sought further advice from the Company's Data Protection Officer.

You should be aware that, under GDPR, you are personally accountable for your actions and can be held criminally liable if you knowingly, or recklessly, breach it.

The GDPR applies to processing carried out by organisations operating within the EU. It also applied to organisations outside the EU that offer goods or services to individuals in the EU.

3.1 The processing of personal information is governed by GDPR legislation that is processed wholly or partly by automated means; or

the processing other than by automated means of personal data which forms part of, or is intended to form part of, a filing system.

can be identified or who are identifiable, directly from the information in question; or

who can be indirectly identified from that information in combination with other information.

Personal data may also include special categories of personal data or criminal conviction and offences data. These are considered to be more sensitive and you may only process them in more limited circumstances.

Pseudonymised data can help reduce privacy risks by making it more difficult to identify individuals, but it is still personal data.

If personal data can be truly anonymised then the anonymised data is not subject to the GDPR. It is important to understand what personal data is in order to understand if the data has been anonymised.

Information about a deceased person does not constitute personal data and therefore is not subject to the GDPR.

3.2 As required by GDPR Christies Care Ltd is registered with the Information Commissioner to process personal information for specified purposes. These are:-

- Staff Administration,
- Administration and Services,
- Accounts & Records.

3.3 The GDPR sets out seven key principles:

1. Lawfulness, fairness and transparency
2. Purpose limitation
3. Data minimisation
4. Accuracy
5. Storage limitation
6. Integrity and confidentiality (security)
7. Accountability

3.4 Personal information should only be processed for these purposes. The Registered Manager will monitor the purposes for which personal information is processed and will notify the Information Commissioner of any changes if appropriate.

You must identify valid grounds under the GDPR (known as a 'lawful basis') for collecting and using personal data.

You must ensure that you do not do anything with the data in breach of any other laws.

You must use personal data in a way that is fair. This means you must not process the data in a way that is unduly detrimental, unexpected or misleading to the individuals concerned.

You must be clear, open and honest with people from the start about how you will use their personal data.

3.5 Processing includes obtaining, disclosing, recording, holding, using, erasing or destroying personal information.

You must ensure the personal data you are processing is:

adequate – sufficient to properly fulfil your stated purpose;

limited to what is necessary – you do not hold more than you need for that purpose

3.6 Personal information is information relating to a living individual who can be identified from that information alone or in conjunction with other available information.

3.7 GDPR requires that the following principles must be followed when processing personal information. They are:

1. The right to be informed
2. The right of access
3. The right to rectification
4. The right to erasure
5. The right to restrict processing
6. The right to data portability
7. The right to object
8. Rights in relation to automated decision making and profiling

3.8 In respect of all personal information, processing is only fair and lawful if it is with the consent of the individual or is necessary for any one of the following:-

- in relation to a contract with the individual,
- to comply with a legal requirement,
- to protect the individual's vital interests,
- for the performance of public functions,
- for the purposes of legitimate interests pursued by the data controller unless prejudicial to the interests of the individual.

3.9 Personal information relating to racial or ethnic origin, political opinions, religious or similar beliefs, trade union membership, health, sex life and criminal convictions is known as sensitive personal information.

3.10 In respect of sensitive personal information, processing is only fair and lawful if it is with the explicit consent of the individual or an additional condition is met. Christies Care Ltd's New Client Assessment will ask clients to give their explicit consent to sharing of sensitive personal information with others involved in their care.

3.11 Individuals (e.g. carers, clients, staff) have a right under GDPR legislation to copies of personal information about them held on computer and in some manual filing systems. This is known as the right of subject access. Christies Care Ltd will respond to subject access requests promptly in accordance with Data Protection legislation.

3.12 There are exceptions to the obligations and rights under GDPR legislation, for example where disclosure to the police might be permissible. However, whether a situation falls within an exception is a matter that should only be decided by the Registered Manager, Director or Data Protection Officer.

4. Transferring information to other services

4.1 Christies Care Ltd will ensure that when information about a client is passed to another person involved in care of the client or in respect of a safeguarding issue, it will be transferred promptly, securely and all available relevant information will be provided.

4.2 Christies Care Ltd will notify a client of the information transferred and will provide a copy if requested, unless it is decided by the Registered Manager, Director or Data Protection Officer that it is not in the client's best interests to do so.

4.3 If a client asks for information to be passed to another service, Christies Care Ltd will comply with the request or explain to the client why it cannot comply.

A. CONFIDENTIALITY AND DATA PROTECTION PROCEDURES

1. The following procedures aim to promote confidentiality and the high standards expected within the GDPR in the handling of personal information and so respect an individual's rights.

2. General

2.1 All clients should be asked for their consent to the processing of all personal information including sharing that information with others involved in their care. Under the GDPR regulations, this information must be requested separately from paperwork and then stored in a specific location.

2.2 Where a client gives instructions to restrict the information that is shared with any other person, these instructions will be held as a client V&C. Any restriction should be complied with unless there is authorisation from the Registered Manager, a Director or DPO.

2.3 There is a risk that personal information in digital or paper form can be lost, stolen or passed to the wrong person.

2.4 There is a risk that a 3rd party will try to obtain personal information they are not entitled to obtain. Staff, carers and clients should be made aware of this possibility.

2.5 There are steps that can be taken to minimise these risks. However, the steps that can be taken need to be balanced against the interests of clients being able to use services in a manner that is accessible to them. Christies Care Ltd has identified the following steps as reasonable and proportionate steps to minimise these risks. Staff should follow these steps.

3. Telephone Call Security

3.1 If you do not recognise the person you are speaking to, you should check that person's identity. This can be done by ringing back on an identified number/a number identified from Christies Care Ltd's records and/or asking for information which it is reasonable to expect would check the identity of the person you are speaking to, e.g. carer number and date of birth.

3.2 You should limit the amount of personal information given out over the telephone to what is necessary at that time and to follow up with further information or confirmation in writing to a known address if appropriate

3.3 You should terminate any call which appears to be an attempt to wrongly obtain personal information and report the incident to your Carer Support Team. Your Carer Support Team will report these to the Registered Manager or DPC who will monitor such incidents.

3.4 You will be asked by the Registered Manager or DPO to carry out call identity checks from time to time

4. Company Computer and Mobile Device Security

You should

4.1 Keep passwords secure, change these regularly and do not share passwords with others staff except your Head of Department or the IT Manager if this is needed for a specific purpose. Passwords need to meet the password policy and should be different across different applications.

4.2 Lock/log off computers when away from your computer.

4.3 Prevent virus attacks by taking care when opening emails and attachments or visiting websites. There must not be any personal internet access from staff computers. Personal access to the internet on private devices is allowed using the public Wi-Fi during staff breaks, in the canteen.

4.4 Position computer screens away from windows or entrances that permit public observation, to prevent accidental disclosures of personal information. Where this is not possible privacy screens will be purchased to prevent public observation.

4.5 Encrypt personal information that is being taken out of the office.

4.6 Collect only the personal information they need for a particular business purpose.

4.7 Update records promptly.

4.8 Delete personal information the business no longer requires.

4.9 Not to share USB keys with others.

4.10 Password protect any personal information taken out of the office in any digital form.

4.11 Mobile devices should be password protected.

4.12 Texts, emails and attachments containing personal information which are received or sent on mobile devices should be deleted as soon as no longer needed.

4.13 We recommend that you do not to store clients' telephone numbers in your personal mobile devices unless you are booked to return to that client and should not store any other personal information on mobile devices.

4.14 You should not share your portal passwords with other members of staff of family members.

5 Security of Paperwork

In the office

5.1 We recommend that old Support Plans should be securely destroyed, but check with client or family first.

5.2 We recommend that personal information relating to clients (including booking confirmations) should be kept secure and should be contained in a file so that it is not visible to other people, particularly when kept in another client's home.

5.3 Public photocopiers should not be used to copy personal information.

5.4 We recommend that any emails sent into the office by you relating to your clients should not contain any identification of the client apart from their client reference number and initials.

Car

5.5 We recommend any personal information should only be carried in a vehicle in a locked boot and not left on display inside the vehicle.

5.6 We recommend files and mobile devices containing personal information should not be left in any vehicle overnight.

6 Subject access request under GDPR

You have the right, on request, to receive a copy of the personal information that the Company holds about you, including your personal file and to demand that any inaccurate data be corrected or removed.

6.1 If anyone requests a copy of personal information held by Christies Care Ltd relating to them, this must immediately be referred to the Registered Manager, a Director or DPO to deal with.

6.2 If Christies Care Ltd receives a subject access request, it must respond promptly and at most in 30 days after receipt. Christies Care Ltd is entitled to ask for any information reasonably required to find the information and check the person's identity for responding to a request. The 30 day time limit will run from when any further information requested is received.

6.3 There are some circumstances when personal information need not be supplied and there are also circumstances when information about other people should not be given.

6.4 If you are asked to provide information and have any doubt about what to do, speak to your Carer Support Team, the Registered Manager, a Director or DPO before providing any information. Keep a record of any information provided and to whom it was given to in a V&C. Support Team.

6.5 If you wish to make a complaint that these rules are not being followed in respect of personal data the Company holds about you, you should raise the matter with the Registered Manager or DPO.

ADMINISTERING MEDICATION AND INVASIVE PROCEDURES (As per point 7.1 in the Code of Conduct for Carers)

Christies Care Ltd Policy

Most clients in domiciliary care settings are prescribed some form of medication at some time and many have multiple medications which they must manage. The majority of clients are able to safely look after their own medicines and doing so is an important part of their being able to live with dignity, independence and self-determination. However, many cannot and require assistance.

Any administration of medicines should be handled in accordance with current best practice guidelines and legal frameworks, including:

- Guidelines of the Royal Pharmaceutical Society
- Medicines Act 1968
- Misuse of Drugs Act 1971
- Misuse of Drugs (Safe Custody) Regulations 1973
- NICA Guidelines

It is important to understand that the provision of safe and effective medicine management and administration systems for clients is an important part of compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the *Essential standards of quality and safety*, and is necessary to satisfy the registration requirements of the Care Quality Commission.

Professional Advice: The Administration of Medicines in Domiciliary Care, was published by the Commission for Social Care Inspection (CSCI), now the Care Quality Commission, in January 2009. Its purpose was to clarify the roles that domiciliary carers can offer in meeting the medication needs of their clients.

Clients will be encouraged to administer their own medication if they want to and if they are capable of doing so safely.

Community pharmacists can undertake assessments under the Equality Act 2010 and may be able to adjust the way that medicines are packed or labelled for individual people in order to promote self-administration. Examples include large-print labels if their eyesight is poor, containers with ordinary caps instead of child-resistant closures that are difficult to open, and monitored dosage systems/compliance aids.

The guidance defines 3 categories of support with the administration and management of medication:

First tier (formally 'assist')
The client is independent but needs physical assistance only with their medication. Carers must be asked by the client for assistance. Carers may be asked to:

- Open bottles/removing lids from bottles
- Shaking bottles
- Pouring out medicines
- Opening packets
- Popping tablets out of packages

Second tier (formally 'prompt')

The client is not totally independent but they can manage their medication independently at times. At other times they may need reminders from the carer to take their medication. The carer may need to ask the client whether they have taken their medication or remind them to take it.

Third tier (formally 'administer')

At this level the client actually needs help from a Carer to manage, monitor and administer their medication. This may include some or all of the following:

- Selecting and preparing medicines for the client, including selection from a monitored dosage system or compliance aid
- Selecting and measuring a dose of liquid medication for the client to take
- Applying a medicated cream or ointment, instilling drops to the client's ear, nose or eye, or administering inhaled medication
- Putting out medication for the client to take themselves at a later time

At this level the client must give their consent for the carer to administer the medication and we recommend this should be documented. If the person is unable to communicate informed consent then steps should be taken to ensure that the arrangements comply with the requirements of the Mental Capacity Act 2005.

In exceptional circumstances, and following an assessment by a healthcare professional, a carer may be asked to administer medication by a specialist technique including:-

- Rectal administration, e.g. suppositories, diazepam (for epileptic seizure)
- Insulin by insulin pen
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG)

Important - Where such a task is delegated to a carer then the healthcare professional must first train the carer and be satisfied that they are entirely competent to carry out the task safely.
The healthcare professional should sign the professional record book, kept at the client's home to confirm the carer is competent. If a carer does not feel competent to administer the medication then carers may refuse to assist with the task.

The assistance required with medication by clients will be detailed in the clients individual care plan and/or the Medication Risk Assessment, and carers may only assist to the level described in these documents. If the carer is working in partnership with family or another agency in matters relating to medication, all details of the shared arrangements should be clearly set out and recorded in writing on the Guide to Clients Wishes.

In addition, these documents must contain full details of obtaining prescriptions and administering medication, as well as agreed suitable storage arrangements. It should also give details of how and where to dispose of unused or out of date medication.

Administering medication – good practice

When administering medication, carers should always follow a set procedure:

- Ensure that the client is either sitting or standing to receive medication that requires swallowing. Do not attempt to administer oral medication to someone whilst they are lying down unless specific training has been given to do so. Check that the need for the medication is recorded in the medication administration record (MAR/E-MAR).
- Know the therapeutic use of the medication administered, its normal dose, side effects, precautions and the contra-indications of its use.
- Check that the prescription or the label on the medication is clear and unambiguous and relates to the client in person.
- Check the expiry date of the medication.
- Check that the client is not allergic to the medication.
- Keep clear and accurate signed records of all medication administered, withheld or refused.

All clients taking medication should be closely monitored. If a client develops an adverse reaction to any medication then the person's doctor should be informed, and Christies Care Ltd.

Carers should only administer medication from the original container, dispensed and labelled by a pharmacist or dispensing GP. This includes monitored dosage systems and compliance aids.

Medicines prescribed to one person must never be given to another person.

The giving or withholding of medicines must never be used by carers for social control or punishment.

Side Effects of Medication

Some of the most common side effects are rashes, stiffness, breathing difficulties, shaking, swelling, headaches, nausea, drowsiness, vomiting, constipation and diarrhoea, this is not an exhaustive list.

Any adverse reactions must be recorded and the GP must be contacted immediately or as soon as is reasonably possible. The carer should also inform Christies Care as soon as is reasonably possible.

Assessing the level of support needed

A medication risk assessment will be undertaken by the Local Area Advisor when carrying out a new client assessment and at every review and recorded in the clients care plan.

Where a client is assessed as needing level 1 support but in practice requires persistent reminders of the need to take their medication then this may indicate that they do not have the ability to take responsibility for their own medicines at this level and may need additional support.

Any need for medication to be actually administered by carers should be identified at the care assessment stage and recorded in the clients care plan.

Once the level of assistance required has been identified, Christies Care will book a carer with the appropriate training and competencies to meet the needs of the client.

Keeping documentation

Christies Care Ltd, through the client's assessment, will document the following in the client's plan:

- the nature and extent of help that the client needs with their medication
- a current list of medicines prescribed for the client, including the dose and frequency of administration is documented on the MAR.
- the method of assistance, arrangements for the filling compliance aids if used, details of arrangements for medication storage and access by the person, relatives or friends and a statement of the clients consent for carers support with medication are all documented in the Medication Risk Assessment.

Training

Carers
Christies Care Ltd will provide training that will meet the needs of carers operating at all three levels described above. A system is in place to ensure that only competent, confident and appropriately trained carers are assigned to clients who require help with their medicines. Carers are appropriately trained and have the right to refuse to help to administer medication if they have not received suitable training. When a client's needs require the carer to administer medicines at levels 2 or 3, appropriate training in the safe handling of medicines is given. The training includes the following essential elements:

- preparing the correct dose of medication for ingestion or application
- administering medication that is not given by invasive techniques, including tablets, capsules and liquid medicines given by mouth, ear, eye and nasal drops, inhalers and external applications

- the responsibility of the carer is to ensure that medications administered are given in the right (prescribed) dose, of the right medicine, given to the right person, at the right time by the right route.
- checking that the medication 'use by' date has not expired
- checking that the person has not already been given the medication by anyone else, including a relative or carer from another agency
- recognising and reporting possible side effects
- reporting refusals and medication errors
- administering medicines prescribed 'as and when required' (PRN), for example, pain killers or laxatives
- what carers should do when clients request non-prescribed medicines
- understand Christies Care Ltd policy for record keeping of medication.

Christies Care Ltd ensures that the trainer is appropriate, knowledgeable in the subject and has relevant, current experience of handling medicines in a domiciliary care setting.

Carers will undertake a medication test and attain at least a 75% pass mark before they are allowed to work unsupervised with our clients.

Procedure for Carers:

When assisting with medication, the carer should place medication where it can easily be reached by the client and offer a drink of water to go with it.

1. May remind clients to take their own medicines, when they are due.
2. May help clients to take their own medicines and should always encourage clients to be independent in taking their own medications.
3. May assist with oral (by mouth) or topical (external - skin creams etc.) medicines, by agreement with the client or family carer. Creams, ointments and lotions should only be applied where the skin area to be treated is unbroken. Disposable gloves should be worn when applying external preparations.
4. May assist with prescription medicines only under specific instruction from a doctor, nurse or other appropriate prescriber who must take full responsibility in writing.
5. Should make sure clients are aware of any regular or prescribed routine of medication.
6. Should prepare a drink for the client – preferably water. Follow instructions. It is important to know that some medications should not be taken with certain drinks such as milk or grapefruit juice.
7. Should make sure they understand the following:
    1. What medicines they have been asked to assist with?
    2. What is the correct dosage?
    3. How the medicine should be taken?
    4. Know any side effects.
    5. What medicines other people administer?
8. Should get accurate information by questioning the client, family carer, doctor, nurse etc., and by carefully reading any instructions or labels.
   If in any doubt, insist on written, signed instructions. Do not accept unclear or variable instructions such as "one or two tablets" or "as required".
9. Should carefully follow any special instruction on the medication such as ensuring the medication is taken as directed i.e. before, after or with food.
10. Should store medicines in a safe, agreed place, taking care to follow instructions on refrigeration etc. This should be in the client's care plan. Do not store immediately adjacent to the ice box of a refrigerator or in the freezer compartment of a combined fridge freezer. Do not store medicines adjacent to uncooked meats or other foods.
11. Should keep medicines only in the correct original container and never alter the label. Carers must only administer medication from the original dispensed container supplied by a pharmacist, hospital pharmacy or dispensing GP.
12. Should always check the record to make sure the medicine has not already been given.

13. Should always make a written record of medicines given. Whenever a carer assists a client with medication a record should be made on the MAR sheet. The record should be made immediately after the assistance has been given.
    Include:
    1. What medicines were assisted with?
    2. The dosage.
    3. How the medicine was given?
    4. When the medicine was given? (or if it was refused)
    5. When the medicine was changed or stopped by the GP.
14. Must immediately inform their Carer Support Team, and any nurse or GP if they have any uncertainty, if any difficulty or incident has arisen when assisting with medicines. This includes medication given in error.
15. Should keep all information about a client's medicines and treatment confidential.
16. Should preserve the dignity and respect the wishes of the client including any cultural practices when assisting with medication. These should be recorded.
17. Should not give any medicines by a method other than by mouth (orally) or external application, (other than in exceptional cases where they have been given specific training by a doctor or nurse who must take full responsibility in writing).
18. Should not, give medicines against the wishes of the client. If the client refuses to take prescribed medicines record the refusal on the MAR sheet and consult your Carer Support Team immediately, and inform the client's GP.
19. A refused or spoilt dose should NOT be returned to the container. The client should be given the opportunity to take or refuse this dose. If the client requests not to take the spoilt dose, this should be recorded appropriately on the MAR sheet and the medication returned to the pharmacy.
20. Should not sell, recommend, advise, introduce to clients any form of medication or remedy, including homeopathic, herbal or other preparations. If asked to assist with the administration of non-prescribed medication or to purchase non-prescribed medication it must be of a brand name and follow advice of the pharmacist.
21. Should not perform or take part in any invasive procedures except in very exceptional circumstances and only then when appropriately trained to do so.
22. Should not take responsibility for filling dosset boxes/compliance aids. Carers must not administer medication from dosset boxes/compliance aids made up by family members or friends of the client.
23. Carers should be aware of any possible side effects or reactions to medication. It is important to note that alcohol will interfere with the action of many drugs.
24. All prescribed medication should be reviewed regularly by the prescriber, at least every six months or more frequently if the client takes 4 or more medicines. Carers should monitor these review dates and prompt a review if one has been missed or is late.
25. Carers should discreetly monitor self-administering clients and note if the client needs help or if they are becoming incapable of self-medication. Such clients should be reviewed and, where appropriate, it should be suggested that it might be safer if their medication was administered by the carers.
26. Some religious practices, such as fasting, may affect the timing of a client's medication. In this situation, follow guidance given by the prescriber.

Liquid Medicines

1. Carefully check the label on the bottle to make sure that the correct dose is given at the correct time and that the medicine is intended for the client and is not out of date.
2. Carefully measure the prescribed amount into a clean medicine pot/spoon. When using a medicine pot, hold it at eye level when pouring the medicine to ensure that the correct dose is dispensed.
3. Hold the bottle with the label uppermost when pouring so medicine spills do not damage the label. If the label becomes detached or illegible do not administer the medication.
4. Give the medicine to the client with a drink of water to wash it down.
5. Where the client experiences difficulty in taking liquid medication an oral syringe maybe required.
6. Record all medicines given on the client's MAR sheet and put your initials on the entry.

Carers should only instil eye, ear or nose drops or other preparations i.e. ointment after they have been properly trained to do so, this training should be recorded. Medication in patches to be applied to the skin is as above.

Assistance with nebulisers and inhaler devices must only be given if you have received instructions on the use of the particular device and have written authorisation, this would also include assistance given with oxygen. This training should be recorded.

Disposal of unused medication

All unused or out of date medication should be disposed of by returning it to the dispensing pharmacy. Do not flush down the toilet. You will need to obtain the client's consent for the medication to be returned.
Record such disposal in the red MAR sheet file on the 'Record of disposal of unwanted medication' form. The pharmacy will sign the MAR sheet or give you a receipt.

Classification of Medication

PRN Medication – "PRN" is an abbreviation of the Latin phrase for "pro re nata", meaning "when required". Some groups of medication can be given on an as and when required basis for example, analgesics, antacids, laxatives and anti-histamines.

If these medications are to be given, the medication instructions should include a dose to be taken and also a maximum frequency. If PRN is administered the carer will need to note in the Care Record book why this medication was administered and in the case of pain relief what the pain characteristics were. If a carer is assisting with medication, these medicines should be treated in the same way as any other medication, i.e. they should be recorded on the medication administration record sheet and form part of the care plan.

Prescription only medication (POM) – These are medicines that are available only via a prescription issued by an appropriate practitioner. Pharmacists' can only sell these medicines if they have a prescription. Possession of 'Prescription Only' medicine without having received a prescription is an offence.

General sales list medication (GSL) – General sales list medication allows medication to be sold without the need for a prescription in a shop, for example at a pharmacy or supermarket.

Over the counter medication (OTC) – These are General Sales List medicines, but are more commonly known as over the counter medicines. These can be sold without the need for a prescription in a shop, for example at a pharmacy or supermarket. If carers administer OTC medications they should be agreed by the client's GP or prescriber and added to the MAR and administered in the same way as prescribed medications. Carers are responsible for ensuring that any OTC medication given does not interact adversely with prescribed medication.

Controlled drugs (CDs) – A Controlled Drug is a medication that appears on one of the five schedules in the Misuse of Drugs Regulations 2001.
A controlled drug is a medication that has a therapeutic value (although controlled drugs on Schedule 1 reportedly have no medicinal value) but also has the potential to be misused. These medications require a prescription. It is unlawful to possess, supply or hold a controlled drug without a prescription. It is also an offence for a prescriber to issue an incomplete prescription and a pharmacist is **not** allowed to dispense a Controlled Drug unless all the information required by law is given on the prescription.

Carers are lawfully allowed to administer controlled drugs to a client, provided they are acting upon the instructions of a doctor (see The Misuse of Drugs Regulations 2001 7(1) and 7(3). However, some local authorities restrict the administration of controlled drugs from some of the schedules of their contracts. Controlled drugs medications should be stocked controlled on the MAR sheet, this is a total running amount of each controlled drug medications stored in the client's house at any one time. If

controlled drugs medication are in a dossett box/compliance aid these will also need to be stock controlled in the same way.

In response to the Shipman Inquiry, there have been some amendments to the regulations covering the Misuse of Drugs Act 1971. Within domiciliary care, if a carer goes to a pharmacy to collect a prescription containing a controlled drug, the pharmacist may ask for authorisation that the carer can collect the medicine on behalf of the client and may be asked for ID and their name and address (and definitely for controlled drugs that are on Schedule 2 of the Register).

Carers are legally allowed to collect controlled drugs from the pharmacist and deliver these to the client's premises (see The Misuse of Drugs Regulations 2001 6(7)(f)). These should be conveyed directly (and not by way of the carer's home). Also, carers should not hold on to part of the controlled drug prescription 'for safe keeping' as this would be deemed unlawful possession.

Complementary/homeopathic remedies – These medicines are also classed as 'over the counter' or 'General Sales List' medication. They can be purchased over the counter at a pharmacy or health food shop, ordered over the internet, picked from the garden or given by friends. They normally contain herbs and natural products. However some of these can be quite potent so they should be treated in the same way as other medicines. There has been an increase in interactions between complementary therapies, such as St John's Wort over the last 10 years (see Mathijssen et al. Journal of the National Cancer Institute, Vol. 94, No. 16, August 21 2002).

Oral routes of administration – This is a route of administration that uses the gastro-intestinal tract for the absorption of the medicine.

Included in this classification are sub-lingual medicines (under the tongue) and buccal medicines (inside the mouth between the gum and cheek).

Ingestion – This means taking medication by mouth and can include tablets, capsules, medicine (or elixir and linctus), lozenges and pastilles.

It is the most convenient route, the least expensive and, usually, the safest method of administration. As such, it will be the most common route of administration carers are asked to help with.

Help can also be given with taking medication orally with the use of soluble tablets; many tablets are often available in liquid form making it easier for a client to swallow. Oral syringes are also available to assist with the administration of medicine.

Topical routes of administration – This is a route of administration that uses the skin or mucous membranes for the local effect it causes.

Topical – This means applying creams and lotions to the skin to be absorbed, for example, creams to treat eczema. Transdermal patches (often adhesive patches that contain a medication) are used if slower absorption through the skin is required for example, patches containing a pain killer. However, these are not as effective as oral medications as absorption can be variable.

If creams, lotions and patches are prescribed it is important that the Medicine Administration Record (MAR) contains information about where these are to be applied and the quantity of each application.
PPE (particularly gloves) should be used when applying creams and lotions. Care should be taken to ensure that the skin where the cream is to be applied is not sore or broken as this can affect the absorption rate. Broken skin should be reported to the prescriber. Also, the skin should be clean and dry before application, so the skin may need to be washed and thoroughly dried prior to treatment.
A note should be made on the MAR of when the cream was opened and lids or caps should be closed as soon as possible after application to prevent contamination.

Instillation – This means applying drops or ointments into the eye: drops, sprays or ointments into the ear; or drops or sprays into the nose. Drops into the eye will probably be the most common instillation that carers assist with.

Eye drops can quickly become contaminated so the lid should be placed on the dropper as soon as possible after use and bottles should be discarded after 28 days.

Inhalation – This means that medication if inhaled into the lung by use of an aerosol. This can be applied via a nebuliser or inhaler. Carers may be asked to help with the application of these, although this will more likely be help with inhalers. Inhalers require more of an instruction for carers to explain to the client that they have to press the trigger whilst inhaling the aerosol into their lung, which should be held for approximately 10 seconds.
If assistance with a nebuliser is required, the carer will need additional training from a health care professional as this piece of equipment is quite technical.

Per rectum – This is to give a medication direction into the rectum. This medication will come in the form of enemas or suppositories which are usually a method to encourage defecation or sometimes a method of pain control.
It may be quite rare for a carer to insert suppositories or enemas and training will be required by a health care professional if this route is prescribed.

Injectable routes of administration – This is an invasive route of administration whereby the skin is punctured with a needle to give medication either into sub-cutaneous tissue, muscles or directly into veins.

Injection – This is to use a needle to puncture the skin to give medication just underneath the skin or deeper into the muscle. In certain circumstances, some carers may be asked to assist someone with their insulin.
It is unlikely that carers will assist with this type of medication although they may become involved in helping with insulin pens. If they do assist with these, training will be required.

Infusion – This is to give medication via a drip (infusion) or pump (syringe driver).
There may be the possibility of caring for someone at home who is having food or medication by one of these routes and if this is the case, the carer will need to be aware of the need to look after the site of the infusion. This will include preventing it from being knocked or dislodged and keeping it clean and free form the risk of infection. Specific training will need to be undertaken and the carer will need to be signed off as competent.

Any medication that is to be given via an invasive route i.e. instillation, inhalation, per rectum and injection will need specialist training and competency testing before being able to assist with medication in these forms.

Antibiotics
These are used to fight an infection in the body. They are all POMs (prescription only medications) and they can be administered in different ways i.e. oral, injection, topical, instillation i.e. drops for eyes and ears.

There are many different types of antibiotics and some fight infection in specific places within the body i.e. Trimethoprim (Trimopan®) is used to treat urinary tract infections and some antibiotics are more general i.e. Amoxicillin (Amoxil®).
Common side effects can include nausea, vomiting, diarrhoea and sometimes rashes.

Analgesics
These are used to treat pain. Some can be bought 'over the counter' i.e. Paracetamol (Panadol®) and Ibuprofen (Nurofen®) and some are only available via prescription i.e. Naproxen (Arthroxen®), Mefenamic Acid (Ponstan®) and Morphine Sulphate (MST Continus®), which is a controlled drug.
They can be given in a number of ways i.e. oral, injection.
Common side effects to Paracetamol can include rashes; to Ibuprofen can be gastro-intestinal disturbance; and morphine sulphate can cause nausea and vomiting, constipation and a dry mouth.

Anti-histamines
These are used to relieve allergy symptoms such as hay fever. Some can be bought 'over the counter' i.e. Chlorpheniramine (Piriton®) and some are only available via prescription i.e. Hydroxyzine Hydrochloride (Atarax®). They can be given in a number of ways i.e. oral, injection.
Common side effects can include drowsiness and headache.

Antacids
These are used to relieve indigestion or heartburn. Most of these are available 'over the counter' e.g. Gaviscon®. They are given orally.
Common side effects can include diarrhoea and belching.

Anti-coagulants
These are used to prevent blood clotting e.g. following heart attack or thrombosis and sometimes during some surgical procedures. All are prescription only.
They can be given in a number of ways, oral i.e. Warfarin or injection i.e. Heparin

Psychotropic medicine
This is used to treat depression or psychosis. All are prescription only and can be given orally, by injection or rectally. Examples of these drugs are Risperidone (Risperdal Consta®) and Chlorpromazine Hydrochloride (Largactil®).
Common side effects can include confusion leading to falls, and constipation.

Diuretics
These are used to get rid of excess fluids in the body. These are all POM and are taken orally, although they can be given as an injection too. Examples include: Bendroflumethiazide, Furosemide (Lasix®) and Amiloride Hydrochloride.
Side effects can include minor gastro-intestinal disturbance.

Laxatives
These are used to alleviate constipation. Many laxatives are available 'over the counter' and can be taken orally in liquid or tablet form or rectally via a suppository. Examples include Bisacodyl, Senna (Senokot®) and Lactulose.
Side effects can include abdominal cramp, nausea and vomiting.

Hormones
These replace hormones that may be missing from the body e.g. insulin and thyroxine. These are only available as POM. They can be given by injection or tablet. Examples include Insulin (Actrapid®) injections and Levothyroxine, which are thyroxine replacement tablets.
Side effects from insulin can include hypoglycaemia (low blood sugar) and oedema (water retention).
Side effects from thyroxine can include diarrhoea and vomiting.

Cytotoxic medicines
These drugs are used to treat some forms of cancer and can be very toxic. These are best handled by those specifically trained to do so. These are all POM and are given either in oral form or via injection or infusion. Examples include Vincristine Sulphate (Oncovin®).
The common side effects of cytotoxic medication are alopecia (hair loss), nausea and vomiting.

Some other types of medication include:

Anti-emetics – to reduce nausea and vomiting i.e. Prochlorperazine (Stemetil®)
Anti-hypertensives – to reduce blood pressure i.e. Nifedipine (Adalat®)
Anti-inflammatory – to reduce inflammation i.e. Ibuprofen (Nurofen®) and various steroids
Antipyretics – to reduce fever e.g. Paracetamol (Panadol®)
Antispasmodics – to reduce muscle spasms i.e. Hyoscine Butylbromide (Buscopan®)

Covert Medication
The 'covert' administration of medication, i.e. disguising medication in food and drink, should only ever be used as a last resort in situations where it has been assessed that the client lacks 'capacity to consent to treatment' and that the medication is essential to their health and well-being. A 'best interests'

meeting should be held which should involve those who know and understand the client to agree whether covert administration is in the client's best interests. This meeting should involve relevant health care professionals - the prescriber and pharmacist, care workers, family member and a person who is able to communicate the views and interests of the client (this could be a family member or a friend or an Independent Mental Capacity Advocate IMCA). The 'best interests' meeting should be minuted and this will then form the basis for the support planning process. The plan should include clear documentation of the decision of the 'best interests' meeting, how best to administer the medication covertly and a plan to review the need for continued covert administration of medication on a regular basis.

In an urgent situation it would be acceptable for a less formal discussion to take place between the prescriber, care workers and family member or advocate to make an urgent decision. This should be documented and a formal meeting should then be arranged as soon as possible.

Administration of covert medication should be in accordance with the Mental Capacity Act 2005 and occurrences of administering covert medication should be, by nature, very rare.

Crushing Medication

The Medicines Act 1968 stipulates that medicines intended for use by humans are subject to a product licence. The act also requires that prescription medications be given only in accordance with the directions of a pharmacist. Crushing the tablets or opening capsules contrary to the pharmacist would be in breach of the Medicines Act 1968. Consequently manufacturers do not assume any liability for any harm that befalls a patient or any person administrating medications in this way. The administrating carer must accept a percentage of liability for any harm caused to a client, by giving a medication in an unlicensed manner. Therefore carers should not crush any medication or open capsules.

An alternative form of medication must be sought from the pharmacist in the above circumstances and a letter given to the GP for the alternative medication to be prescribed.

If a tablet needs to be cut in half this should be done with a proper tablet cutter to ensure an accurate half tablet.

What if there is an error or incident?

Errors can occur in the prescribing, dispensing and prompting or assisting with, or administering of medicines. Most medication errors do not harm the individual although some can have serious consequences. Carers must report errors in the prompting or assisting with, or administering of medication and related tasks to their Carer Support Team, this may result in appropriate further training and competence testing. It is important that errors are recorded and the cause investigated to learn from the incident and prevent a similar error happening in the future.

Failure to follow these guidelines could result in a safeguarding alert being raised. Examples of administration errors are:

- Wrong dose is given, too much, too little
- Medication is not given
- Medication is given to the wrong person (a criminal act if deliberately done)

If the carer is aware of having made an error in prompting or assisting with, or administering medicines or notices that an error has been made, the following action must be taken:

- Seek advice from the GP or appropriate health professional or A&E. Some errors may appear trivial, e.g. omitting a dose or paracetamol or antibiotics. However, since it is not appropriate for a carer to gauge the seriousness, it is advisable to seek advice, from a professional. No medication errors must be treated as trivial, and must all be reported.
- Enter the details of the error on the MAR sheet including a note of any changes or deterioration in the client's health or behaviour.

- Notify your client or/and their family
- Report to your carer support team
- If the client becomes ill, telephone the emergency services. Do not try to make the client be sick.

If a dose is missed, do not give a double dose next time. Document this on the MAR sheet and report it to your support team straight away and seek advice from the prescriber.
If serious negligence or an attempt to cover up an error is discovered, this could be treated as a negligence and the Police may be informed. This may result in legal action against the carer.

Returning From Hospital Stays

All clients discharged from hospital should have complete documentation listing all their current medication at the time of discharge. This may have changed considerably from the medicines that were taken into hospital. The hospital will inform the client's GP. The person responsible for administering the client's medicines should:

- Let the supplying pharmacy know the changes as soon as possible
- Prepare a new MAR
- Dispose of any unwanted or discontinued drugs by returning to the pharmacy
- Request a new prescription as soon as possible

If an MDS (Monitored Dosage System)/compliance aid is normally used, or newly assessed by the hospital pharmacist as necessary, the hospital pharmacist should arrange for the hospital pharmacy to dispense a new supply in the appropriate system at the time of discharge, and liaise with the community pharmacist.

Travel and Transporting Medication

When a client leaves their home, such as to go on holiday, to attend day care or college, it is essential that the client's medication is taken with them. It may be necessary to arrange alternative packaging of medicines in which case a separate prescription to cover this period will be needed. Quantities of medication taken outside the home should be recorded on leaving and return. The day service should make their own record of administration. Attendance of day care should be entered on the MAR sheet to indicate the reason why the medication was not administered by the carer.

Invasive Procedures

Usually the need to administer medications or treatments by an invasive procedure is because it is the most effective way for a person to be treated. This is because the absorption of the medication or treatment is impaired or absent by other routes and the doctor and client have agreed this method of treatment.

In exceptional circumstances the district nurse may delegate certain invasive tasks or procedures and train the carer who will be able to deliver the care in a more timely way to meet individual requirements on a day to day basis.

Under no circumstances must the carer carry out any of these procedures unless trained by the district nurse and signed off as competent in this procedure.

Under no circumstances must the carer cascade train other carers in these procedures even if signed off as competent to carry out these procedures, training is also client specific.
For delegation of an invasive task or procedure the following must give their written informed consent to what is proposed:-
The client or if lacking mental capacity the responsible person (e.g. power of attorney)
The district nurse who agrees that the individual carer has been trained

The carer who is willing and feels confident and competent to undertake the specified procedure.

Below are listed invasive procedures which are **must never** be undertaken by a carer:-

Medications
By intra muscular injection
Intravenous injections

Care of the Bowel and Bladder
Any rectal examination
Manual evacuation of bowel
Bladder washes
Initiation of Stoma care
Any vaginal examination
Removal of any catheters or tubes from the bladder
Reduction of any new prolapsed or resistant prolapsed bowel
Insertion of pessaries or rings
Internal application of vaginal and rectal creams
Application of vaginal pessaries

Feeding
Naso-gastric tube feeds
Intravenous infusions

Other
Care of tracheotomy
Suction pumps

We recommend that if you are asked by your client to undertake any of the procedures listed above that you advise your Carer Support Team, we can then advise your client that these should not be undertaken by you and also to advise that both the client and yourself would not be covered by our Liability Insurance should an accident occur.

Non-invasive procedures, **which may be** undertaken by a carer after receiving the appropriate training from the District Nurse and deemed competent:

Care of skin
- Application of prostheses
- Continued wound care after first aid for accidental damage
- Complex and non-complex dressings
- Dressings for deep wound or pressure ulcers when the skin is broken (up to and inclusive of grade 2 pressure ulcers)

IMPORTANT information regarding Oxygen

If your client requires oxygen you will have received specific training for this, the following notes are to act as a reminder of the do's and don'ts and not a substitution for training.

- DO NOT change the flow of oxygen unless you have been advised otherwise by the clinician or the prescriber of the oxygen. Turning the flow up or down could put the client in danger.
- If the clinician or the prescriber change the flow of oxygen prescribed you should advise Christies Care immediately.
- Paraffin based creams such as Vaseline should not be used as these are flammable and can be a hazard – be aware of face cream, lipstick that the client chooses to put on. Also be aware of hand creams that you or the client uses. Safe products to use are KY Jelly or other water based products.
- If using alcohol gel for the hands, ensure that it is rubbed in well and thoroughly dry prior to going near the oxygen
- Oxygen should be at least 3 metres away from any source of heat

- Oxygen should be at least 1.5 metres away from electrical sources, this includes electric toothbrushes, electric razors and hairdryers
- Do not use flammable products such as aerosols in the vicinity of the oxygen
- A minimum of 20 minutes completely away from the oxygen should be left prior to going OUTSIDE to light a cigarette, if you/visitor/client has been in direct contact with oxygen the hair and clothing become oxygen enriched. NEVER smoke or let anyone else smoke within proximity of oxygen
- The same applies to 'Electronic Cigarettes' as above
- If you or the client (or anyone in contact with oxygen) is going to use a naked flame i.e. lighting the gas cooker, then again you should be at least 20 minutes away from the oxygen prior to lighting the cooker
- Ensure that the oxygen company are contacted when you start the 2nd from last cylinder, this will ensure that further oxygen supplies reach the client in plenty of time. Do not leave it until the last cylinder is in use to do this
- Ensure cylinders are stored appropriately – away from heat and electrical sources, not blocking exits/entrances. Keep spare cylinders laying down, ensure that the cylinders are stored in a way so they won't get damaged – cylinders are pressurised containers and have the potential to explode if they are not treated with the highest regard
- Do not use the oxygen when the indicator has moved into the red section as there may be contaminates at the bottom of the oxygen cylinder
- If oxygen is being used in the client's home they should have informed the broker who is providing their house insurance
- If oxygen is being transported in your or the client's vehicle the car insurance company should be informed of this. An oxygen sticker for the car should be displayed in case you are in an accident. The cylinders should be transported laying down securely
- Do not light candles, lanterns, fires and cookers within the vicinity of oxygen
- It would be advisable for a fire extinguisher to be in the client's home
- Check the tubing from the cylinder/concentrator on a regular basis – ensuring the tubing is not twisted or squashed, or the tubing is not brittle/broken. Replace if necessary
- Oxygen concentrators should be left in the position where the engineer has installed/fitted the equipment.

Death of a Service User

Ensure service users medicines are retained for a period of 7 days in case there is a coroner's inquest.

FINANCIAL MANAGEMENT OF CLIENT'S MONEY (As per point 9 in the Code of Conduct for Carers)

When a client wishes to use Christies Care to provide care or an existing client becomes unable to deal with their own finances, a risk assessment is undertaken by our local area advisor and the action which needs to be taken will be recorded to reduce any risks.

To safeguard both the client and the carer, we recommend the following procedures are followed. The client should be encouraged to maintain as much independence as possible concerning their finances and the carer should take a supporting role where possible to achieve positive outcomes for the client.

Risk Assessment will include:-

- Assessing the source of funding and what access the carer has to the client's finances.
- Assessing the risk to the client of financial abuse
- Agreement with the client the amount of support required
- Assessing the risk the carer is to accusations and allegations
- What controls if required, can be put in place

Gifts, Bequests, Loans and Selling to the Client

We recommend that you do not accept gifts, cash or loans from clients.

We recommend you do not have any involvement in the making or benefiting from client's wills or soliciting any other form of bequest or legacy or acting as an executor or being involved in any way with any other legal document.

We recommend you do not borrow from or lend money to the client.

We recommend that you do not get involved with selling of goods belonging to the client. If the client requests that items are taken to charity shops or to the waste disposal, that you record this in the daily record book and signed as correct by the client, if there is one kept at the house. If not, get a receipt from wherever you have taken the goods and ask the client to sign to say that they have authorised this disposal.

We recommend that you do not involve the client in gambling syndicates (e.g. National Lottery, football pools). Unless this has been agreed in the Guide to Clients Wishes that it is a client's daily activity or pastime.

We recommend that you do not retain keys, benefit books, loyalty cards, credit cards, cash or cheque books beyond the duration of their period of care for the client.

Allegations of Financial Irregularities

Should there be any allegation of financial irregularities from the client, the client's families or relevant others, if the client wishes us to deal with the allegations, these will be reported on to Christies Care's quality department and dealt with as per our complaints policy.
The company will investigate appropriately and if necessary inform the police, social services and any other relevant body, as appropriate, of the allegation and ensure all information is made available.

Financial Risk Management Procedure

Cash

If you are responsible for the client's cash, we recommend that all transactions are recorded in the Financial Record Book if there is one at the home and support by receipts.

Where there is no receipt we recommend you enter the reason why and have the entry countersigned by the client.

Cards and PIN numbers

Although we strongly advise clients not to supply you with their PIN numbers, there are extreme circumstances where this is not possible; in these instances we strongly recommend that you record all transactions as much as possible.

We have an alternative account and PIN managed by Christies Care and this will always be suggested to the client as an alternative solution.

Handovers

Part of the handover check list includes the signature of both the incoming and outgoing carers showing that the records and money were correct at time of the handover.

COMPLAINTS (As per point D in the Code of Conduct for Carers)

Christies Care will ensure that its complaints procedure is well publicised and fairly applied and that complaints are dealt with promptly, efficiently and properly in all cases.

Christies aim is to provide a high quality service and our aim is to maintain our standards as consistently as we can and to rarely have complaints. However, we accept it is the fundamental right of clients, their families or friends or representatives, to complain about the services they are receiving if they feel unhappy with them. We accept that complaints do happen from time to time and that it is an important part in the running of any service to listen to feedback from clients, to investigate and admit when things do go wrong and to learn from mistakes so that they are not made again.

We believe that it is far better to deal with a complaint early, openly and honestly, for everyone's benefit.

We understand that having an effective system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by clients, or persons acting on their behalf, is a key element in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the essential standards of quality and safety with which the organisation must comply to satisfy the registration requirements of the Care Quality Commission.

The company ensures that:

- Every complaint will be welcomed and taken seriously
- We encourage and support a culture of openness that ensures any comment or complaint is listened to and acted on.
- A full record of each complaint is logged and recorded in line with our internal procedures.
- All complaints are treated entirely confidentially.
- A complaint can be made by telephone, in person, in writing or by email to complaints@christiescare.com
- A complaint must be made no later than 12 months after the date the event occurred, of if later, the date the event came to the notice of the complainant.
- The time limit will not apply if Christies Care Ltd is satisfied that the complainant can give a good reason for not making the complaint within that limit, and despite the delay, it is still possible to investigate the complaint effectively and fairly.
- All staff will be trained to accept complaints and to deal with them according to this policy.
- All clients will be made aware of the company's complaints policy and the information will be available :-
    - On our website – www.christiescare.com
    - Displayed in our offices at Saxmundham
    - Sent out with our contract letters
    - Summarised in brochure
    - Included in each Client Guide
- Making a complaint will not cause a client to be discriminated against or have any negative effect on their care, treatment or support.

In the case of verbal complaints:

- A verbal complaint can be made to any member of staff.
- Front-line staff who receive a verbal complaint should always welcome the complaint and seek to resolve the problem immediately.
- If staff cannot resolve the problem immediately, they should pass the complaint to the Quality Team who will then decide if they can resolve it, if not or if it constitutes a Safeguarding alert then an investigation will commence.

In the case of a written complaint:

- A written complaint will be acknowledged in writing within two working days.

- Written complaints will be dealt with initially by pre-quality, or if the complaint relates to a Head of Dept - by HR and the Registered Manager. If the complaint relates to the Registered Manager, then by the Managing Director.
  Every written complaint will be thoroughly investigated and a written response given within 28 days (Where a complaint is likely to take more than 28 days, in a particularly serious matter where legal advice is taken, for instance, the complainant will be notified of the delay and the reason for it).
- All written complaints will be treated entirely confidentially and with tact and sensitivity. Details of a complaints investigation will however be recorded by the quality and safeguarding and given a unique number for inspection purposes.
- Any decision made by the organisation will be fully explained. If a complaint is upheld then Christies will apologise and suggest a plan by which the complaint can be resolved. Where appropriate compensation for out of pocket expenses will be paid.

In cases where the complaint remains unresolved:

- If the complaint remains unresolved or the client is not satisfied with the outcome, it can be referred to the Local Government Ombudsman (LGO). The LGO provides a free, independent service. The LGO can be contacted for information and advice. To register the complaint go to the website and complete the on-line complaint form.

  Tel: 0300 061 0614
  Website: www.lgo.org.uk

  The LGO will not usually investigate a complaint until the provider has an opportunity to respond and resolve matters.

  Our service is registered with and regulated by the Care Quality Commission (CQC). The CQC cannot get involved in individual complaint about providers, but is happy to receive information about our services at any time. You can contact the CQC at:

  Care Quality Commission National Correspondence
  Citygate
  Gallowgate
  Newcastle upon Tyne
  NE1 4PA Tel: 0300 061 6161 Website: www.cqc.org.uk/contactus.cfm

Monitoring

- A complaints log will be kept to record the following:-
  1. Each complaint received
  2. The subject matter and outcome of each complaint
  3. Details of the reasons for delay where an investigation took longer than the agreed response period, and the date the report of the outcome of the investigation was sent to the complainant.
- An annual report will be prepared ending 31st March, which will:

  1. Specify the number of complaints received
  2. Specify the number of complaints that the provider decided were well-founded, partly or fully
  3. Specify the number of complaints that the provider has been informed have been referred to other bodies
  4. Give the subject matter of complaints received
  5. Summarise any matters of importance in those complaints themselves or in the way that the complaints were handled, and summarise any matters where action has been or is to be taken to improve services as a consequence of those complaints.

This report will be available to anyone on request.

Duty of Candour

Christies Care is fully compliant with the duty of candour and embraces a culture of openness and truthfulness in all of its dealings with clients, their carers and their families.

Christies expect their staff and all self-employed workers to strive to provide the highest standards of care at all times. It believes that, in the event of these standards not being met, it should apologise sincerely to the client concerned and provide a full explanation as to what went wrong and why.

CARER TRAINING

Christies Care has ensured that you have received comprehensive induction that took account of recognised standards within the provision of live-in care.

Annual Update (As per point 7 in the Code of Conduct for Carers)

All carers who wish to remain on our agency list must complete a two day annual update course at our Head Office in Saxmundham, which includes: Moving and Handling, Medication, Food Hygiene, Adult Safeguarding, Infection Control, Behaviours That Challenge, Diabetes and Insulin Administration, and GDPR. Christies Care will make a contribution towards your travelling expenses to attend this update.

Should you decline this update training we will not be able to introduce you to other clients through our agency.

Should you not have completed at least 12 weeks' worth for Christies Care in any one year there will be a charge for the annual update training. Please speak to your support team for the current charge.

There is also an opportunity to have tea and cakes with a director to discuss improvements/issues with the company.

Specialist Training

Christies Care has many care related training courses via eLearning which you will be advised of. Carers are also encouraged to attend any training course being run in their area by local authorities, which are usually free of charge.

CARERS RIGHTS TO PRIVACY

It is company policy to seek the right of privacy for carers in their own bedroom.

Procedure

If you believe that a client or a client's relative is knowingly invading your privacy by going into your bedroom without permission, we recommend that you advise your Carer Support Team.

Carer Support Team and the Booking Co-ordinator will try to liaise with the client to establish why this privacy is being invaded.

If the client has not agreed to privacy for the carer, this will be recorded at head office so that carers are advised before they accept the booking to the client.

Exceptions:

If there is suspicion that you may have unauthorised items in your bedroom e.g. alcohol, drugs, dangerous weapons, a room search may be undertaken if the client requests us to do so. This search will always be undertaken with you present, and usually by the local area advisor.

UNANNOUNCED VISITS (UVs)

Part of our service to our clients is to carry out regular face-to-face reviews of our clients and their care (with their permission).

Where we have a real or theoretical concern we will also carry out unannounced visits to clients and their carers e.g. client has no family support and carer has been booked for a long assignment.

Or a real concern will be, for example, where we have information relating to the conduct of a carer that needs an unannounced visit.

The purpose of the unannounced visit is to check, among other things –

- whether the state of the house and contents indicates that the carer continues to work at an appropriately high standard;
- whether the demeanour of the carer indicates that the carer remains fresh, even after a period of what might be seen as a long period of continuous duty, and not stale and tired;
- whether the demeanour of the client indicates that the client is being well treated; and
- whether it is the client's genuine choice to continue with the carer.

These UVs will nearly always be carried out by the Local Area Advisor, and can be at the request of the client, social worker or family member.

"NO REPLY"

In practice, there are very few times when you cannot get into your client's home.

This is because it is in the nature of live-in care that a client has a carer in attendance almost all the time.

A replacement carer will have an agreed 'handover' arrangement, in the client's home.

An existing carer will normally carry a house key with her, if she has left the house for an agreed break, to go shopping etc.

However, if this does happen we cover below what we recommend a carer should do.

In all situations where access cannot be made to a client's home, carers will consider there to be a possible emergency situation requiring immediate action to establish the well-being and safety of the client, or to alert the emergency services, where appropriate.

New Clients

At all times, the carer should consider their own safety, and should not attempt any of the following actions if they have reason to be concerned.

A replacement carer finds the client's house locked when she arrives for handover.

- ring carer who should still be with client
- if no reply, ring client's house
- if no reply, ring office (they will know if client has suddenly been admitted to hospital, etc.)

A new carer finds the new client's house locked when she arrives.

- ring house
- ring office for instructions
- if office say no reason that client isn't in house, then you cannot just leave matters – shout through letter box etc. (don't break anything)
- if this fails, call police who will break door

The carer should look for signs which may indicate that the house is empty, or that the client's condition has changed. This may include letters or newspapers lying uncollected at the door, unopened bottles of milk which have not been collected.

The carer should attempt to establish whether the client is at home, including the possibility that they may be lying on the floor, by looking through the letterbox, or any windows at the property which can be accessed safely, and in any gardens adjoining the home. Where appropriate, the carer should attempt to attract the client's attention by calling them through the letterbox or at an open window.

The carer should look for possible signs of break-ins, such as broken windows or doors which have been forced open. If there is any possibility that the client's home has been broken into, or that someone may be in the home without the clients consent, we recommend that the carer **should not attempt to enter the home, but contact the police by calling 999.**

If the carer does not have a mobile telephone, they should use a pay-phone if there is one nearby, or consider attracting assistance from neighbours or passers-by if it is safe to do so.
If the carer can see the client, but they are not responding, or appear to be distressed, **they should contact the emergency services by dialling 999, asking for the police or ambulance services, as appropriate.**

NUTRITIONAL NEEDS (As per point 7.1 in the Code of Conduct for carers)

Access to high quality meals, snacks and drinks is a fundamental right of all people and no less those who require home care support. You should understand that a nutritious diet, which includes access to adequate drinks, is a key element in achieving a healthy lifestyle. You should understand that many clients who require home care need assistance in establishing a healthy diet and others suffer from a dietary deficiency, such as malnutrition or obesity. All clients should be assessed and helped to make a real choice to achieve a healthy and nutritious diet.

Mealtimes represent an important part of the day for many. Carers should endeavour to ensure that mealtimes are as relaxed, pleasant and enjoyable as possible.

Freedom of choice is very important in this area and that clients should be free to choose, wherever possible, what they want to eat, when they want to eat and where they want to eat. Where clients cannot make these choices they will rely on you helping them by giving them access to a wide range of varied and healthy food options that they are known to like.

Independence is a key part of living with dignity and you should try to encourage and help all clients to be as independent in feeding themselves as possible for as long as they possibly can.

All catering and nutritional services offered by you should be compliant with food safety legislation, including the requirements of the Food Safety Act 1990.

Risk Assessment at the start of care

Christies Care believes that every client has the right to a varied and nutritious diet that provides for all of their dietary needs and offers health, choice and pleasure.
Therefore, Christies will ensure that:

- All clients will have a nutrition risk assessment conducted at the start of their care which will include a simple assessment of their nutritional and dietary needs, including any help they may need with cooking, eating or drinking. The assessment will be carried out by a local area advisor with appropriate training and skills and should be recorded in the client's Guide to Clients Wishes. Actions required by the carer will be agreed with the client, their families or representatives, and will also be entered into the plan.
- Any new client with special nutritional needs identified during assessment will be, with their agreement, referred to their GP. Where a client is already under the care of a specialist, such as a dietician or speech and language therapist, Christies Care will do all it can to work together with the specialist and cooperate with all agreed plans of care.
- Examples of such specialists include:
    - Clients with swallowing difficulties may be referred to speech and language therapy services
    - Clients who may require specialist equipment such as special plates and cutlery may be referred to an occupational therapist for assessment
    - Clients with special dietary needs relating to illness or condition may be referred to a local dietician service.
- Where a client has a specialist nutritional assessment or screening, the details will be kept in their records and will contribute to their plan of care, including any assessment of hydration needs.
- During the initial risk assessment and care planning process, each client will be asked for their individual food and drink preferences as well as their cultural, religious or health needs and these will be taken into account when planning food choices and when making drinks available. Where a client is not able to state their needs all efforts will be made to discover their food preferences by discussion with relatives, representatives or friends.
- Carers should be alert to any difficulties that a client may be having with regards to their nutrition or hydration and will report any worries or concerns to the client's family. You should be aware of common problems that can lead to a person being at risk from poor nutrition or hydration which include:

    - Dental problems, such as poorly fitting or broken dentures, or mouth or tooth disease
    - Depression or other mental health difficulties
    - Swallowing problems caused by disease, such as dysphagia resulting from stroke or dementia
    - Side effects of medication
    - Concerns with drinking relating to continence.
- Where appropriate and safe to do so, carers should help clients to plan and prepare their own meals in order to support their independence.
- Each client should be offered choices about:
    - What to eat
    - When to eat
    - Where to eat
- Where the client requires carers to choose and plan their meals for them, carers should change the food choices regularly to provide choice and variety and clients should be asked which choice they would prefer at every meal. In such cases the input of clients and their families and representatives in menu planning should be welcomed. Food and drink option's should be designed to provide high quality and popular food which the client will want to eat and which will provide for all of their nutritional needs, including vitamins and minerals.
- Where necessary menu advice and support should be obtained from a registered dietician to ensure that an adequate nutritional balance is being maintained.
- Carers should try and make meal times unhurried and relaxed with clients being given plenty of time to eat and enjoy their food.
- Food should be presented in a manner that is attractive and appealing.
- Carers should make drinks available and accessible throughout mealtimes and throughout the day, where possible, especially for clients who are unable to serve themselves with a drink.
- All meals should be cooked, prepared and served according to the high standards required by food hygiene legislation.
    - Specialist menus and therapeutic diets should be supported as required and indicated in individualised plans of care. Where a soft or pureed diet is provided appropriate advice may be obtained from a speech and language therapist and all efforts should be made to ensure that the food is served in an appetising way.
- Carers serving meals should record in the daily record book if a client does not eat their meals or if their eating habits change, and advise the family.
- Eating difficulties or a need for assistance at mealtimes will be identified within each client's Guide to Clients Wishes and a plan of assistance agreed both with the client and their relatives, where necessary.
- For any client with a need for assistance with eating, arrangements should be made to help them to feed themselves with dignity. Where a client is unable to feed themselves then discrete and sensitive assistance should be provided by the carer.

Carers should:

- understand the importance of mealtimes to the people they look after
- understand the importance of proper hygiene and handwashing in food handling and serving
- assist those clients who require help with eating and drinking using appropriate skills, tact and sensitivity
- monitor the nutritional status of clients over time and report any concerns immediately to the client's family, if you are unable to do this then contact your Care Support Team who may be able to offer you advice.
- Ensure that the specific religious and cultural requirements are catered for.

Your induction training will have covered the following:-

- importance and knowledge of a balanced diet
- how to handle, store, prepare and deliver food in a way that meets the requirements of the Food Safety Act 1990
- present food in an appetizing way
- provide food in a way that respect the clients dignity, diverse needs and religious beliefs
- dietary intolerances

- for clients to remain as independent for as long as possible
- knowledge of the support equipment available
- the appropriate position that allows clients to eat and drink safely, wherever required
- knowledge of special dietary supplements
- how to recognise malnutrition and dehydration.

ALCOHOL AND DRUG ABUSE (As per point 8 in the Code of Conduct for Carers)

Alcohol

When a new client assessment is undertaken every client is asked whether they allow their carers to consume alcohol whilst working in their home. This information is held in the Guide to Client's wishes. Even if the client is willing for you to join them in having a glass of wine with your meal we would strongly recommend that you refrain from doing so, this includes when on your time off. We also strongly recommend that you do not take alcohol on the premises unless the client asks you to purchase it on their behalf. In this instance we advise you to record in the daily record book that alcohol has been purchased on the request of the client.

Drugs

We also strongly recommend against the possession, use or distribution of drugs for non-medical purposes.
If you are prescribed drugs by your doctor, which may affect your ability to perform your work, we advise that you discuss this with your Carer Support Team.
If we are advised that there is a suspicion that you have been using non-prescribed drugs or substances while at work, or your work performance or conduct has been impaired through substance abuse, we reserve the right to require you to undergo a medical examination, at your expense, to determine the cause of the problem. We also reserve the right not to offer you any further introductions to our clients through our agency.
Christies Care reserves the right to inform the police of any suspicions it may have with regards to the use of controlled drugs.
Any proof of Alcohol or Drug Abuse will result in your referral to ISA which may mean you will no longer be able to work with children or adults at risk.

Use of Drugs by Clients

Under section 23 of the Misuse of Drugs Act it is a criminal offence to have illegal drugs i.e. cannabis in a private home. If you have any suspicions that illegal activities are taking place at the client's home we strongly advise that you inform either the police or Christies Care as soon as you have any suspicion of this. If you do not report this on you could be arrested for not reporting a criminal activity. Should this be proven you could be referred to ISA which could mean curtailment of your caring career.

Driving Your client in Your Own Car or Their Car

If you are required to drive your client and you are prescribed any of the following medication we recommend you check with your GP that you are fit to drive:-

- Diazapam
- Temazepam
- Clorazepam
- Lorazepam
- Fluritrazepam
- Exazepam
- Morphine/opiate based drugs

MOBILE TELEPHONE (As per point 1 in the Code of Conduct for Carers)

We recommend that you only use your mobile telephones whilst on duty with a client:

- In the event of an emergency where the use of such equipment is necessary to call for assistance
- During your time off periods or when you are "on standby"

For you and your client's health and safety we recommend that mobile phones should not be used while working with the client e.g. hoisting or while driving unless the vehicle has been equipped with a proper, fully fitted hands free device.

Carers, who receive a telephone call on a mobile phone whilst driving, are advised to ignore them until they are able to find a safe place to pull off the road and stop.

It is a criminal offence to use a mobile telephone whilst driving, unless it is connected to a properly fitted hands- free device. The penalty is a £200.00 fixed penalty fine with six penalty points, rising to a maximum of £1000 fine if the matter goes to court.

IDENTIFICATION OF CARER (As per point 1 in the Code of Conduct for Carers)

Upon acceptance onto the register of Christies Care, each carer will be issued with an identification card. There is a £10 deposit repayable on return of ID when you no longer wish to work for Christies Care Ltd. This will show the unique carer number, photograph, and signature of the carer and expiry date. It is advised that this is available to show to every client when starting a period of work and when a third party is in attendance or when the carer is on duty outside the home of the client, for example while shopping or going visiting with her client.
All incoming carers are advised to identify themselves to the outgoing carer by their identification card. The outgoing carer will sign the handover checklist as being satisfied that the incoming carer is the person on the badge.

If the incoming carer is unable to produce their identification card then it is strongly recommended that the outgoing carer informs the office immediately.

We strongly recommend that you always carry your identity card with you and this is shown to the outgoing carer as proof that you are the carer who you say you are; this will also need to be signed on the handover checklist. If you arrive without your identity card the outgoing carer is advised to call their Carer Support Team and advise them. They will ask relevant security questions and, if there is any doubt and the client agrees, the introduction will be considered invalid and we will need to find another suitable carer for the client.
Every identity badge will be re-issued annually.

All identification badges remain the property of Christies Care and should you not wish to be introduced to any more of our clients, we will request the return of this badge.

SAFE RESTRAINTS

Certain types of behaviours that challenge can sometimes be seen in clients whereby a client may, due to mental or physical ill health, become confused and disoriented and may respond by becoming aggressive or by threatening carers or others. In very rare occasions this may require the use of physical intervention on the part of the carer and some form of restraint.

'Physical intervention' describes any method of responding to a client which involves the use of some degree of direct physical force to limit or restrict movement or mobility. Such an intervention may occasionally be required as a response to a behaviour that is challenging but any such usage of physical intervention should only ever be considered if it is in the best interests of the client concerned and as a last resort in exceptional circumstances.
'Restraint' refers to the act of holding someone or blocking their movement. Restraint can involve actual holding by another person, chemical restraint through the use of medication or environmental restraint, for example by confining someone in a room.

Carers should be aware that that all clients who lack mental capacity are fully protected by the **Mental Capacity Act 2005** and by the deprivation of liberty safeguards, introduced in April 2009 to give further protection to vulnerable adults from the inappropriate use of restraint.

We strongly recommend that you follow:-

1. The use of physical intervention or restraint may very occasionally be required as a reasonable and necessary response to aspects of a behaviour that is challenging known to be exhibited from time to time by some of our clients.
2. The use of physical intervention or restraint should always be avoided unless it is considered absolutely necessary to prevent a client from injuring themselves or others, or causing serious damage to property. Its use should therefore be an exception rather than the rule. It should be used rarely, and only as a last resort, where all other methods of reducing risk and trying to keep the client safe have failed.
3. Physical intervention or restraint should only ever be the result of conscious decision making on the part of carer and not a mere reaction, unless the physical intervention or restraint occurs as part of an emergency or in self-defence.
4. In most cases the behaviour that is challenging will be a known behaviour on the part of the client concerned and a method of intervention avoiding the use of physical intervention or restraint included in the client's Guide to Clients Wishes. Carers faced with the possible need for physical intervention or restraint should always refer to the guide first to ensure that they have exhausted all other possible methods of response, a risk assessment will also have been completed by Christies Care at new client assessment stage and at subsequent reviews.
5. All uses of physical intervention or restraint should be subject to prior risk assessment whereby the local area advisor will consider the circumstances and the risks associated with employing physical intervention. The advisor should then agree on a course of action where the scale and nature of physical intervention or restraint is entirely proportionate to the behaviour that is challenging of the client and to the nature of harm or damage they might cause.
6. If a carer is forced to intervene physically in order to prevent harm they must ensure that they use the least restrictive form of intervention possible.
7. If physical intervention or restraint is used contact should be avoided with buttocks, genitals and breasts and we advise carers never to behave in a way which could be interpreted as sexual. The intervention should employ the minimum possible amount of force and this should be applied for the shortest period of time possible. Excessive holding, pushing or pinning down should be avoided.
8. We advise carers to never employ physical interventions which could be deemed to present an unreasonable risk to the client or to themselves never use such an intervention as a form of punishment. Interventions should never inflict pain or be intended to humiliate or detract from the dignity of a client.
9. Whenever a physical intervention or restraint has been employed full details should be recorded in the relevant care record book and an incident form completed. The client should be reviewed at the earliest opportunity with relevant caring professionals and the plan of care adjusted accordingly.
10. Care should be taken after an incident to discuss with the client concerned, and with their relatives or representatives, what happened and why so that their physical and emotional well-being is addressed. Carers are also advised to report the incident to Christies Care via their support team, as soon as possible.
11. In cases where the client concerned may lack mental capacity then a full mental capacity assessment should be conducted by the local area advisor or requested by a care professional. If the care and/or treatment being provided is in the person's best interests and cannot be applied in any other way but does take away the person's freedom to do what they want to do to the extent that they are being deprived of their liberty then the **Mental Capacity Act 2005** deprivation of liberty safeguards (MCA DOLS) apply and an authorisation check should be applied for.
12. If the client has a history of abusive behaviour a risk assessment will have been carried out by Christies Care and specific instructions on how to deal with their behaviour will be noted. This risk assessment will be kept at the client's home for carers to refer to.

BATHING/SHOWERING (As per point 7.1 in the Code of Conduct for Carers)

This is a policy for our employed carers but we strongly recommend self-employed carers are aware of the contents.

High water temperatures create a scalding risk to vulnerable people who use our care services to provide personal care. Those at risk from scalding/burning include the elderly, those with reduced mental capacity, reduced mobility, and anyone with sensory impairment, or who cannot react appropriately or quick enough to prevent injury.

The duty of care relating to bathing or showering arises from the fact that many clients are vulnerable and are unable to attend to their own personal care by virtue of frailty or incapacity.
All carers should be aware that immersing people in water temperatures of 43 degrees Celsius and above can lead to scalding.

Responsibilities of all Carers
All carers who bathe or shower a client have a duty of care for ensuring the water temperature is safe at all times.
All carers that bathe or shower a client must be deemed competent and confident to undertake the task.

Risk Assessment
A risk assessment must be completed on every client in all settings that has been assessed to require assistance with their personal hygiene needs.

The risk assessment must include:

- As assessment of bathing capability
- Can they get in and out, sit up wash themselves unaided?
- Is their sensitivity to temperature impaired?
- Can they recognise that the bath is too hot?
- Are they capable of summoning assistance if needed?
- Are they liable to add hot water if unattended?
- A moving and handling risk assessment
- The need for aids and adaptions
- Any medical problems such as epilepsy
- Number of carers necessary to assist or supervise

Clients with learning difficulties, autism or those who lack capacity will have their individual needs assessed with actions required to mitigate risks associated with showering or bathing recorded in their support plan. Carers should ensure that clients who lack capacity are fully safeguarded and must seek further advice regarding mental capacity assessment.

This risk assessment should be reviewed at the same interval as the care plan or earlier if the client's capability appears to have changed.

Care Planning
The results of this risk assessment will be recorded in the care plan held at the client's home and the carers responsible for the services users care will adhere to these instructions.

Monitoring and Review
Bathing and showering of clients provides the ideal opportunity for carers to monitor the client's general and physical wellbeing. The care plan may need to be amended if any of the following problems are noted:

- Pressure ulcers – reddening of the skin or actual breaks (heels, bottom, hip, elbows or shoulders)
- Bruises/breaks in skin – many older people have bruising of the back of the hand and forearm due to skin "thinning"
- Weight loss
- Self Neglect
- Continence problems
- Changes in behaviour
- Any evidence of abuse

We would strongly recommend that you report to Christies Care any of the above.

Safe Practices
Always fill the bath or start the shower by turning on the cold water first before adding the hot. Remember to add hot water to the cold water carefully and use a bath thermometer to check the temperature of the water.
Immediately before the client gets into the bath or uses the shower test the temperature of the water with a thermometer. The maximum temperature is 43 degrees Celsius for unassisted bath fills, 46 degrees Celsius for assisted bath fills and 41 degrees Celsius for showers. Do not overfill the bath.
Clients who are identified as requiring an assisted bath fill should NEVER be left unaccompanied in the bathroom/shower.
Ensure there are no slipping tripping hazards, use non-slip mats on floors and in the bath.
Ensure the room is warm and maintains privacy.
Gather up all the equipment necessary for the procedure before the bath commences.
Explain the procedure to the client.
Always use any lifting equipment, which is available and appropriate for the client's needs as defined in the care plan.
Always follow the instructions for use provided by the manufacturer, training or both.
If the client wishes to bath/shower alone, provide adequate but discreet supervision and/or assistance as appropriate or required.
If the client has an epileptic seizure or heart attack etc. whilst in the bath do not attempt to lift them out of the bath or shower.
First pull the bath plug out and lift the client's head clear from the water. Call the emergency services.
Electricity and water do not mix; never use any electrical appliance anywhere near water due to the high risk of electric shock, severe injury or even death.
The client's dignity and choice must be preserved, therefore any individual, cultural or religious preferences must be respected at all times.

IF YOU ARE ASKED TO LEAVE YOUR CLIENT

If you have any sort of disagreement with your client and they ask you to leave, we recommend you follow the guidelines set out below:-

Under **NO** circumstances must you leave your client on their own, even if they insist on it. In the first instance, if possible, retire into your bedroom to take the heat out of the disagreement.

Whatever time of day or night you MUST ring Christies Care and tell us that you have been asked to leave and want to know what to do next. In most cases it is better to make this call in front of the client (but not always).

ALSO, you must do this to cover yourself. We do have carers who are dismissed from their clients and who follow instructions and go, only to discover the next day that the client has accused the carer of walking out.

We will want to talk to your client to confirm their instructions to us and for us to be able to explain the consequences of their actions.

If your client is confused

If your client is confused, you must allow a little time before telephoning the office, which will give your client time to calm down or maybe forget the incident altogether.

If your client is not confused

If you are asked to leave during office hours contact your Carer Support Team. Sometimes another person for the client to listen to may be enough to calm the situation down, otherwise the Carer Support Team will ask you to go over the events which have led to this situation. All our calls our recorded and this will help us make an accurate record of the situation.

If it is out of office hours (after 5pm or before 9 am) your call will automatically be transferred to 'out of hours' answering system. This line is to a mobile number and your call will still be recorded.

It is vital you ring BEFORE YOU START TO PACK. Even if you do have to go, the telephone call made will cover you, in case you are accused of “walking out”

Serious Allegations or Complaints

If we receive a serious allegation or complaint about you e.g. neglecting the client, drinking alcohol whilst on duty, missing money, we will seek your client’s permission to send another carer to replace you. We would need to inform them of the nature of the allegation e.g. financial abuse, and the fact that at this stage it is just an allegation, but would not give other details. You may not know until a short period of time before they arrive, firstly to protect the client if the allegation is true but also to protect you from further allegations. If the replacement is in the evening we will endeavour to help you find alternative accommodation nearby. In most cases we would be unable to introduce you to other clients until the investigation has been concluded.

If the allegation is not a safeguarding issue, our quality and safeguarding department will investigate the facts as quickly and thoroughly as possible, probably over the telephone, so we can make an interim judgement of the seriousness of the allegations and their likely accuracy. We may interview you over the telephone, by Skype, by Zoom or ask you to come to head office.

The local authority will decide if it reaches a Section 42 or if Police involvement is required. We will be unable to inform you of the details about any allegations.

If they decide a criminal investigation is necessary then the Police will become the lead agency. Otherwise we will deal with. Once the investigations have been completed, if they are un-substantiated, you will be advised as soon as possible and will be able to return to work.

If they are substantiated, depending on the seriousness, you may be offered training or you may not be offered any further work with Christies Care. In very serious cases e.g. proven guilty of financial abuse, you would be referred to the DBS list. The DBS will then make a decision whether you will be on the barring service.

IF YOU WISH TO LEAVE YOUR CLIENT

Sickness

If you become unwell during your assignment, we suggest that you do not try and ‘soldier on’. We advise that you inform your Carer Support Team and they will find a replacement for you as quickly as possible. If this occurs ‘out of hours’ please contact the duty pager.

Substitution

If you wish to leave your client before your assignment comes to an end, we expect you to arrange for a substitute to take over.

We recommend that you discuss this with your client and see if the two of you can arrange something. If you intend to introduce a substitute to your client, we advise that the substitute must be equally suitable to be introduced to your client. For example, your substitute should have an enhanced CRB check and adequate training to discharge your responsibility towards your client.

If you cannot find a substitute, or you need to leave due to an emergency, we will be able to find a suitable substitute for you.

It is **important that you do not leave your client** until you have a suitable substitute. Leaving a vulnerable client on their own can result in a Safeguarding alert being made which in extreme cases can lead to you being referred to the Independent Safeguarding Authority.

IF YOU WISH TO MAKE A COMPLAINT (As per point D in the Code of Conduct for Carers)

You are working for your client directly and we advise that any issues you have with your introduction are discussed with your client or the client's representative.

However, if you are particularly dissatisfied with any aspect of your introduction or with any members of staff, we suggest you raise this with your Carer Support Team in the first instance. If you feel that you cannot complain to them, please contact the Senior Carer Support Co-ordinator. If your complaint concerns them and you feel you cannot raise this with the Senior Carer Support Co-ordinator, then write to the Registered Manager of Christies Care, who will investigate your complaint.

REGISTERING FOR SELF EMPLOYMENT

When you start working for a Private Client, you are deemed to be a sole trader.

Carers taking Self-employed positions will be registered, by Christies Care on your behalf, online via the HMRC website.

Once we have registered you a unique 10-digit tax reference number (UTR) will be sent to you in the post. Please inform Christies Care as soon as you know this number, so we may keep it on record for you, should we have an inspection by the Inland Revenue.

As a self-employed carer we recommend that you keep a record of your business income and expenditure, i.e.

- Where possible open up another bank account, keep all your private money in this account and transfer your drawing across to your current account leaving enough in this account to pay your NI and TAX.
- Keep documents like travel receipts, bills, bank statements, cheque stubs, mobile phone costs plus a record of income received from clients. (Examples of two-part receipt book shown at induction.)

You will receive a tax return sometime after the 6th April for the previous tax year.
This should be completed and returned or you can log on to www.hmrc.gov.uk and complete your tax return on line before the end of October. The Inland Revenue will then calculate your tax and NI bill for you. Once you receive this bill you have up to the end of January to pay.

If you miss the October deadline, you have up to the end of January to complete, but **you will have to calculate your own tax and NI** and send in a cheque with the return. There is an automatic penalty if the tax return is not received by 31st January of £100.00, if the return is not received six months after that date there is a second penalty of £200.00.

Christies Care will provide a list of all clients you have worked for at the end of each tax year to assist you. This list will be uploaded to your portal. We are not able to give details of income received from clients (only clients name and dates worked).

Below is a list which will give you some indication of how much money you might need to meet your eventual tax and (where appropriate) Class 4 NIC bill. The correct liability, however, can only be determined once a completed Tax Return has been filed.

Estimated Weekly Fee	Approximate Amount To Set Aside
£500.00	£ 97.00
£525.00	£105.00
£550.00	£113.00
£575.00	£121.00
£600.00	£129.00
£625.00	£137.00
£650.00	£145.00
£675.00	£153.00

EMPLOYMENT INTERMEDIARY REPORT

We now have a legal requirement to complete this form to HMRC on a quarterly basis. Should we have incomplete information for you, e.g. no 10 digit tax-reference number, this may result in HMRC contacting you to ensure you are legally able to work in this country.

PAYMENT FOR YOUR WORK

We recommend that you will be paid at the end of each week (week is Wednesday to Wednesday) and is calculated on the number of nights you work. Your client is responsible for paying you your fee as per your agreement and at the recommended rate in your Contract for Services. We advise that you do not ask for your fee in cash, and always issue a receipt showing your National Insurance number, Self Employed Registration Number, fee received and any travel expenses paid to you.

NON-RESIDENT TAX PAYERS

If you are non-resident in the UK but are working here there is a centre for Non-residents (part of Inland Revenue International) which can explain in greater detail your tax liabilities whilst in the UK.

Visit: www.hmrc.gov.uk and go to the Non-resident section or ring 0300 200 3300.

Common questions relating to non-residents

In what circumstances would I become Non-UK resident if I left the UK?
Your absence from the UK covers a complete tax year (i.e. 6th April to 5th April) and you spend less than 183 days in the UK during the tax year, or your visits to the UK do not average 91 days or more a tax year over a maximum of four years.

Why am I paying tax in the UK on my income when I am no longer resident here?
Income arising in the United Kingdom will remain liable for UK income tax. However, depending on your nationality and where you live you may be eligible to:

- Make a claim for repayment of UK income tax
- Use any personal allowances to which you may be entitled to offset some or all of your tax liability

For more information go to Double Taxation Treaties on www.hmrc.gov.uk

I have a bank/building society account in the UK. Will tax still be deducted from interest if I am non-resident in the UK?
Not if you are not an ordinary resident in the UK and the bank or building society at which you have the account operates accounts paying interest without deduction of tax to individuals not ordinarily in the UK.

You will need to ask your bank or building society for form **R105** to apply for gross payment of interest.

If tax has been deducted from the interest, you may eligible to claim a refund, whole or partial, under any **Double Taxation Treaty** between the UK and your country of residence.

What do I need to do when I leave the UK?
As a self-employed carer please inform the Self-employed help line on
0300 200 3504 and give them your new address.

Alternatively write to them at:

National Insurance Contributions Office
Longbenton
Newcastle Upon Tyne
NE98 1ZZ

I have written to make a claim, when can I expect a reply?
The Inland Revenue aim to reply to 80% of letters within 15 working days of receipt and 95% of letter within 40 working days of receipt.
80% of claims will be settled within 20 working days of receipt and the balance within 40 working days of receipt.

CONTRACT FOR SERVICES

A sample Contract for Services is included in your induction pack. We strongly recommend you use it on each assignment. This will assist you if there is ever disagreement over terms. A sample is included in Section 5.

You should also retain all your signed Contracts for Services. If, for any reason, you cannot get your client to sign the Contract, we recommend that you get your client to sign the confirmation as evidence of the contract between you. IT REPRESENTS THE ACTUAL CONTRACT BETWEEN YOU AND YOUR CLIENT. WITHOUT IT, YOU HAVE NO WRITTEN CONTRACT AND THEREFORE LITTLE PROOF OF YOUR AGREED TERMS.

If your client does not have the mental capacity to agree terms, we suggest that you contact someone else who has been appointed to deal with the client's affairs, and ask them to sign and agree these letters. If you are unsure about any aspect of this, you are welcome to contact your Carer Support Team for advice.

We are able to store these on your behalf. Please contact your Carer Support Team if you wish to take advantage of this.

YOUR TAX RETURN

In order to prove that carers have complied with HM Inland Revenue regulations and have submitted a tax return for each year worked and on time, we will ask you to complete a form in January of each year and return it to your Carer Support team. Any carers who do not return this information by the 28th February of each year will not be introduced to any further clients until it is returned.

Care Payments Administration

We also operate an administration branch which administers fees to carers where the client is unable or does not want to deal with the payment to their carers directly.

These clients are still private and you will still be self-employed. However your fee will be paid directly into your bank account by Care Payments Administration (CPA) on the Friday at the end of your week's engagement. Please DO NOT ask your client for your fee. But we advise that you do still have your Contract for Services.

Essex

We also have private clients in Essex whose finances are dealt with by the above. Your fee will be paid by them on receipt of an invoice. You do not need to issue a receipt to these clients.

Note:
Your booking confirmations will give you details of your suggested weekly fee and more details about which of the above applies. We recommend you retain the booking confirmations as a record to help you complete your self-employed tax return at the end of the year, and as evidence of your self-employed status.

Claiming Your Travel Expenses

- Where fees are plus travel we recommend you claim up to £40 for the inbound journey and £20 for every week thereafter you are booked at that client, until the balance is covered. Clients may wish to see evidence of the travel costs.
- For outbound journeys you can charge up to £40 when going home. If you are going to another client then this would be covered by this new client.
- If you use your own car, fuel can be claimed at the rate of 45p per mile.

USEFUL PHONE NUMBERS

National Insurance enquiry line	0300 200 3500
Self-employed help line	0300 200 3504
Employee Taxes help line Quote our tax reference: 245/G629 & your NI number	0300 200 3311
Inland Revenue – non-residence section	0300 200 3300
NEST	03000 200090

TAX SYSTEM IN THE UK AND COMMON QUESTIONS ANSWERED

In the UK, you account for tax once a year. The tax year runs from 6th April to 5th April.

You can earn £12,500.00 in this current tax year, and pay no tax (your personal allowance). You pay 20% tax on your earnings between £12,500.00 and £50,000.00 and 40% tax on anything over £50,000.00.

Some Common Questions Asked About Tax and National Insurance

Why do I have to pay tax?
Unless you are a student, all persons are required to account for tax under the Income Tax (Employment) Regulations 1993.

Why do I have to apply for a National Insurance number?
A National Insurance number is a unique reference number, used by the Department of Work and Pensions, to identify your National Insurance contribution record. It ensures that contributions paid by you are put to the right record so that whenever a claim to benefit is made, the correct amount can be paid.

How do I apply for a National Insurance Number?
Contact the Jobcentre Plus closest to you and ask to arrange a meeting to apply for an NI number.

At this meeting you will be asked questions about your background to help them build up a picture of your circumstances.
This information and any official documents you bring with you will help prove your identity. You may also have to complete a form to apply for a National Insurance number.

When you are given a date for the meeting, they will tell you what information or evidence to bring with you. Listed below are examples of the evidence they need. Please note that they will not accept photocopies: -

- Passport
- National Identity Card
- Birth Certificate
- Marriage Certificate
- Work Permit
- Letter from Christies Care (given by recruitment at induction training)

If your application is successful you will receive your NI number in writing as soon as possible after the interview.

In the meantime we will allocate you with a temporary one made up for your date of birth e.g. TN010648F.
(Temporary Number, 1st June 1948 Female)

I worked in the UK in the past but do not know what my National Insurance number is, do I re-apply?

- Go to your nearest HMRC Office and take two forms of identification and they will search for it and give it to you over the counter.
  OR
- Call the National Insurance number trace line: **0300 200 3502**

Can I get treatment on the National Health Service if I do not have a National Insurance number?

- If you have been a resident in this country for six months or more you can obtain treatment on the NHS.
- Less than six months – you will be classed as a NHS patient, but you may have to pay for medication.
- If you have no NI number you will be classed as a private patient and will be liable for all costs.

Do I have to pay National Insurance once I reach 'state pension age'?
No you don't pay NI once you reach state pensions age. To calculate your pension age you will need to visit:
www.gov.uk/calculate-state-pension **OR** Ring their enquiry line on **0300 200 3500**

YOUR CLIENT AND YOUR CLIENT'S HOME

You will be meeting a wide variety of clients. Some you will provide companionship to, help to bed, and do their shopping. Convalescence care to a client who has recently returned home from hospital, or caring for someone who has been discharged from hospital who wants to die at home rather than a hospice. Your clients may be young or old or have learning disabilities or a mental health problem. Your skills and knowledge will be required across a wide range of situations so we advise you keep in mind principles **which apply to everyone** as well as individual differences. Your clients may have problems, such as:-

Pain – can make people bad-tempered or cause them to withdraw into themselves in order to cope with it.

Frustration – can also make people angry, irritable, impatient, ill-mannered and uncooperative.

Drug treatment – may affect people in a variety of ways, making some depressed, lethargic or tearful and others over-active or subject to wide mood swings.

Stress – has a wide variety of symptoms, amongst them, headache, depression, nervousness, tension, lack of energy, sleeplessness and abuse of alcohol and drugs.

Loneliness – can make people withdraw, cause them to be depressed, to lose energy, and be hostile or suspicious towards any sort of help or anything that does not comply with a long established habit.

Sadness or grief – can make people angry, depressed, uncommunicative, self-absorbed, tearful and apparently unable to respond to anything that is done to bring comfort or cheer.

Depression – can make people very unresponsive, fault-finding, tearful and careless of appearance, loss of appetite and general cleanliness.

Abuse, family problems and misunderstandings – can make clients suspicious, uncooperative, unfriendly and fearful.

Fear – at any age, is often subconscious, and may make itself felt in unexpected ways e.g. irrational demands, obsessive activities, bad temper or negative attitudes.

Clients may also, just like the rest of us, feel sorry for themselves, tell lies or embroider the truth to get our sympathy, harbour old resentments, manipulate their carers, or be selfish or demanding. They may be more concerned for others than themselves, be good humoured, courageous, loving and an inspiration to all who meet them. As a carer you will become familiar with all sorts of human behaviours. You will also become more aware of your own characteristics and manner and learn to adapt them to do your job in the many different ways required by your clients.

Communication – Good communication is at the heart of good care. There is, however, a danger of perceiving that it is someone else who has the communication problem. Communication is a two-way process and each of us has the responsibility for 'getting through' to the other. We advise that communication with your clients is at a pace and in a style that suits them, especially recognising the needs of those whose first language is not English.

Confidentiality – Your client's guide is a private document containing personal details about your client which should only ever be passed on to someone who needs to know about your client e.g. incoming carer. **We strongly recommend that you should never gossip about them**.

Always keep booking confirmations secure, so that they cannot be seen or taken by anyone else.

You may yourself wish to make notes about your work if you are obtaining NVQ qualifications. If you do, we recommend that you do not put names on your records (use a code like Client A etc.).

Your Client's Home – when you go into your own home, pause for a moment and look around you. Why are things where they are? Which pictures are on the wall? How have you arranged the furniture and where do you keep your belongings? What makes it yours? Whatever your own answers are – 'I like it that way, I put it there – your clients will say the same of their homes. This means when you work in someone else's home you **must** accept another fundamental principle.

Personal beliefs and all that make up a client's identity must be respected and encouraged.

Beware of the temptation of a carer to 'take over' and do things without consulting clients.

PROFESSIONAL BOUNDARIES (As per point 9 in the Code of Conduct for Carers)

Relationships between carers and clients develop naturally in many care situations. However, as professional guidance acknowledges, carers can sometimes breach the boundaries of professional relationships, with consequences for the individuals involved.

Interactions between carers and clients must be based on assessed clinical need, not personal need, recognising that "boundaries are mutually understood, unspoken, physical and emotional limits of the relationship between the client and carer staff" (Farber et al, 1997)
So whether you are "whining" to a client about your personal life or accepting a gift, you have altered the role of caregiver to the person in care (Holland, 2013).

What are Boundaries?

Carers cross professional boundaries when they behave in any way that oversteps their professional roles with a client in their care, or with a client's family member or anyone else involved in the client's care to create a personal relationship. In professional relationships an intimacy may develop as a result of the person receiving the care sharing personal information, feelings and vulnerabilities. This should not be confused with social intimacy.

The relationship between carers and clients is one of unequal power, as carers have authority, knowledge, access to privileged information and influence. It is the responsibility of care professionals to be aware of this imbalance to maintain clear boundaries.

Reasons for power imbalances are:-

- That the person receiving care may have to disclose personal information in order for care to be provided
- Often it is the care professional who influences the level of intimacy or physical contact when care is provided
- The care professional knows what it is that constitutes appropriateness associated with professional practice, but the person receiving the care may not know what is appropriate

The appropriate use of power in a caring manner enables the carer to work with the client to meet the clients' needs. However, any misuse of that power is considered abuse. Abuse can also mean betraying the client's trust, or violating the respect or professional intimacy inherent in the relationship. Abuse may be verbal, emotional, physical, sexual and financial or take the form of neglect.

The carer-client relationship with learning disability clients can be even more difficult to negotiate boundaries or recognise when to defend themselves against boundary violations. The client may be unaware of the need for professional boundaries and therefore may at times initiate behaviour or make requests that overstep the boundaries, so it is up to carer to ensure boundaries are respected and maintained.

Grey-zones can exist because such relationships are two way. For example, a carer may disclose to a client that her car is in need of repair but she doesn't know how she is going to pay for this as her

husband is out of work. The client then begins to worry about the carer's situation, then offers to loan her money for the repair. This disclosure was inappropriate as it was meeting the needs of the carer and not those of the client. The client may have felt the carer was looking to them for financial assistance and this caused unnecessary worry for the client.

It is important for a carer to be aware when a professional relationship is slipping into the non-professional realm and to take immediate action. The table below gives some examples of boundary violations:-

Type of Boundary Crossed	Staying with Boundaries
Sharing Personal Information	
It may be tempting to talk to your client about your personal life or problems. Doing so may cause the client to see you as a friend instead of seeing you as a care professional. As a result, the client may take on your worries as well as their own.	Use caution when talking to a client about your personal life. Do not share information because you need to talk or to help you feel better. Remember that your relationship with your client must be therapeutic, not social.
Not Seeing Behaviour as Symptomatic	
Sometimes carers react emotionally to the actions of a client and forget that these actions may be symptomatic – that is, caused by a disorder or disease. Personal emotional responses can cause carers to lose sight of their role or miss important information from a client. In the worst cases, they can lead to abuse or neglect of a client.	Be aware that a client's behaviour is the result of a disease or disorder. Know the client's support plan. If you are about to respond emotionally or reflexively to the negative behaviour of a client, step back and reproach the the client later. Note that the client may think their action is the best way to solve a problem or fill a need. Ask yourself if there is a way to solve problems and help the client communicate or react differently.
Touch	
Touch is a powerful tool. It can be healing and comforting or it can be confusing, hurtful or simply unwelcome. Touch should be used sparingly and thoughtfully.	Use touch only when it will serve a good purpose for the client. Ask your clients if they are comfortable with your touch. Be aware that a client may react differently to touch from what you intended. When using touch, be sure it is serving the client's needs and not your own.
Gifts, tips and favours	
Giving or receiving gifts or doing special favours can blur the line between a professional and a personal relationship Accepting a gift from a client may be taken as fraud or theft by another person	We recommend that you say 'no' graciously to a client who offers you any gifts over the value of £20. If you do accept a gift of less than £20 we recommend you record you record this in the CRB and let your Support Team know so we can

person of family member	record the circumstances in which the gift was given. We do not recommend that you buy gifts for your clients

Over-involvement

Signs may include spending time visiting the client when you are not working with them, trading assignments to be with the client and thinking that you are the only carer who can meet the client's needs.	Focus on the needs of those in your care, rather than their personalities Do not confuse the needs of the client with your own needs. Maintain a helpful relationship, treating each client with the same quality of care and attention. Ask yourself – are you becoming overly involved in the client's personal life? If so, discuss your feelings with your Support Team.

Examples of Warning Bells for Carers

- Frequently thinking of the client when away from work
- Frequently planning other clients' care around that client's needs
- Seeking social contact with or spending free time with the client
- Sharing personal information or work concerns with the client
- Feeling strongly about the client's goals that colleagues' comments or client's or their family's wishes are disregarded
- Hiding aspects of the relationship with the client from others
- More physical touching than is appropriate or required for the situation
- Romantic or sexual thoughts about the client

Conclusion

Boundaries must be maintained to ensure safe and effective care is delivered. In the event of a complaint, it is the carer who will need to show they have not abused or exploited any professional relationship. They will need to show any boundary issues have been fully considered and that appropriate advice was sought.

PROMOTING INDEPENDENCE (As per point 7.2 in the Code of Conduct for Carers)

This aims to reduce the vulnerability of clients and reduce high dependency on their Carers, wherever possible. Carers are to support the client in their day to day living such as washing, dressing, cooking and shopping. Support in the development of their social skills and encourage the client to join in with any activities. This is especially important where clients have learning disabilities and clients who have spent a long time in hospital and have lost confidence and need help to return to living independently at home.

Personalised Guide to Client Wishes

Every client user will have an individual Guide to Client Wishes based on their identified needs, strengths and aspirations (as determined during the new client assessment and ongoing reviews).
Guide to Client Wishes will fully include a client's views, religious beliefs, cultural and lifestyle needs and will involve family, carers or other professionals as appropriate.
The Guide to Client Wishes will outline the strategies to be used by carers to enable the client to become more independent.
The Guide to Client Wishes will be reviewed regularly in order to update on progress and achievement of personal goals and to identify areas where support needs may have changed.

Self Care

Self care involves clients who are at a higher risk of ill health, in learning how to cope with their symptoms. It is recognised that where a client has a carer the carer may play a significant role in supporting self care.

Falls Prevention

Falls prevention involves interventions intended to reduce falls and fall related harm. The prevention may be primary (intended to prevent falls and fall related harm in those who have never fallen) or secondary (intended to prevent further falls and reduce harm in those who have previously fallen). Early intervention is required to restore independence. This can prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards.

Volunteering

Volunteering involves working without payment, typically towards some social, political, or cultural cause. Local volunteering also has the potential to make the life of the volunteer more meaningful and connected. In older people there is evidence that volunteering for at least two hours per week slows age-related decline especially in mental health. It also improves older people's sense of wellbeing.

Social Care Re-enablement

Re-enablement involves services for clients with poor physical or mental health that help them accommodate their illness by learning or relearning skills necessary for daily living.
Christies Care Ltd will work with clients to provide targeted support to enable relearning of skills. In particular carers will work with clients to provide positive encouragement, motivation and reassurance which will underpin the rebuilding of confidence in their own abilities.
Christies Care Ltd will also work closely with health and social care professionals to ensure that clients receive specialist input in this area (i.e. Occupational Therapists, Physiotherapists) whenever it is required.

Promoting Assistive Technologies

This can be any item, piece of equipment, product or system that is used to increase, maintain or improve the functional capabilities and independence of people with cognitive, physical or communication difficulties.

Christies Care Ltd considers that aids, adaptations and assistive technology can be crucial to enabling clients to achieve their maximum levels of independence.

Christies Care Ltd will work closely with health and social care professionals to ensure that individuals have access to the full range of resources which will enable them to continue living safely and independently in their own homes.

Positive Risk Taking

Christies Care Ltd will ensure that all carers adopt a positive approach to risk taking which will enable clients to improve their skills and confidence as well as the opportunities of personal development which are so essential to achieving improved levels of independence.

Christies Care Ltd expect carers to hold a positive view of each person's potential and to assess and manage risks based on this positive view (whilst upholding our Duty of Care).

We will work in partnership with the client, their family, and health and social care professionals to assess risk and develop risk management strategies (both proactive and reactive) which ensure the least restrictive approach, whilst avoiding exposure to unnecessary levels of risk.

We will decide together what constitutes an acceptable level of risk.

Clients will be supported to exercise choice and control over their lives. If an individual is deemed to have capacity to make their own decisions then this right will be strongly upheld by carers.

We will adopt a positive approach to risk taking which will maintain the balance between effective risk management and client's personal autonomy.

We will use individual client wishes to work with clients to set goals intended to achieve a greater level of independence.

We will establish clear and consistent boundaries and expectations for/of people.
We will whenever possible provide support, information and advice to clients which will enable them to make informed decisions (including understanding the consequences of certain actions)

We will provide training for carers in positive risk assessment/management.

GUIDE TO CLIENT WISHES

Introduction

Christies Care Ltd provides live-in care and support to vulnerable individuals who have a recognised support need. Effective support planning is about working with individuals to support them with the identification of needs and risks to support maximisation of personal outcomes and minimise risks, improving their quality of life.

Our aim is to assist vulnerable people to live full independent lives in their own homes. In order to help achieve this we will provide a high quality, effective and outcome focused Care and Support Service that strives to meet the highest standards of Care and support ensuring quality outcomes.

Implementation

In order to achieve the aim we will:

- Ensure that clients are fully aware of the principles on which our approach to support provision is based
- Ensure that the support needs of clients and any inherent risks are assessed promptly and comprehensively upon referral to our service and that this information is regularly reviewed and updated
- Ensure that an outcome focused Guide to Client Wishes is completed for every client and in the format requested, promoting choice and maximising control
- Ensure that the client is aware of the need, where appropriate, to involve other agencies in the support planning and risk assessment process. Balancing safety and risk
- Ensure that clients are fully involved in the needs and risk assessment and support planning process and that their perspective, preferences and aspirations are respected and fully taken into account

- Ensure that clients are aware that they have the right to request a review of their Guide to Client Wishes/Risk Assessment at any time, other than the regular 3 monthly reviews that are company standard
- Recognise the potential value of positive risk taking and give clients the support they need to enable them to make informed choices. We understand that new experiences and greater community involvement potentially involves people taking risks that offer opportunities for the development of independence, confidence and self-autonomy
- Ensure that all Christies Care advisors have the necessary skills and training to effectively undertake client needs and risk assessments
- Ensure we have a Safeguarding Vulnerable Adults Policy and Procedure in place and that all carers have written guidance and training on how to recognise and respond to the potential abuse of a vulnerable client. A copy of the Safeguarding policy will be kept in the Guide to Client's Wishes folder in the client's home.
- Ensure that confidentiality is maintained and any information collected is held and used in accordance with Data Protection legislation
- Ensure that if a client is refused access to the service, or the service is withdrawn, the client will be fully advised of the reasons for this
- Ensure that clients are aware of how to complain about the service if they are not satisfied and that copies of the Complaints Policy and procedure are included in the Guide To Client Wishes folder and brochure.

Guide to Client's Wishes Principles

i. Person centred and empowering – in order for the Guide To Client's Wishes to be effective, clients need a sense of ownership. This should be promoted by their active involvement in the assessment process.
ii. Outcome focused – the aspirations, goals and priorities, which the client wants to achieve, are identified to enable him/her to be supported to maintain independent living and attain an enhanced quality of life.
iii. Choice and control – support packages offer a choice of the level of service that is appropriate to individual needs. We are able to respond quickly and effectively to any changes in support needs that are identified through the needs and risk assessment review process.
iv. Partnership working – client support or social care needs that cannot be provided directly are proactively addressed by working closely with statutory, voluntary and other agencies.
v. Quality monitoring – Guide to Client's Wishes are quality monitored on a regular basis to ensure a consistently high standard.
vi. Continuous improvement – Client feedback, national best practice and the Supporting People Quality Assessment Framework Standards are used to promote Christies Care as a learning organisation with a commitment to continuous improvement.

SURVEILLANCE BY WEBCAM OR CCTV

Clients and their families are increasingly using webcams or CCTV for surveillance purposes in the home. This is a useful tool if a client is alone for long periods, or has a tendency to fall or wander. Carers should expect to encounter surveillance equipment in the course of their work, and may indeed be videoed while they are working. If you are uncomfortable with this, you should discuss this with the client's booking co-ordinator. It is illegal for clients and their families to use such equipment *without* informing the homecare organisation. However, whether you are being recorded or not, we strongly advise that you should work at all times as though your actions could be seen by somebody else.

TIME OFF

Time off can vary from client to client, it depends if they can be left alone for any part of the day or night or if there are relatives/friends nearby that can take over from you for a couple of hours. How your time

off is planned at each particular client will be covered in the guide held at the clients home. Below is the general information we give to clients when they first come to ask us seeking care.
Clients are recommended that they allow their carer's at least two hours free time each day, including a break of at least 30 minutes each morning and afternoon, and time for your own meals, a bath or shower, and a reasonable night's sleep. If the support they require is particularly strenuous or stressful we recommend they provide additional time off.
Free time means you can come and go as you please – if they insist you stay in their home, this is not free time. If this occurs we recommend you should be able to claim compensation in lieu. We recommend about £9 per hour of free time given up. However, we would always strongly recommend if free time is being given up you advise your Carer Support Team immediately so we can help you with relief. Not having your free time can lead to tiredness, stress and mistakes and should not occur on a regular basis. If you are requested to carry out extra night duties, this should be agreed with you in advance. If these nights duties are as a result of your client's condition deteriorating, contact your Carer Support Team immediately and again we will help you with relief. We suggest that you measure time spent and number of calls. We suggest that you and the client work out a way for you to get enough sleep. Maybe someone pops in in the morning and allows you to have a lie-in or maybe in the evening. This is up to you and the client to arrange though we can always give advice if that is helpful. If disturbed nights are frequent over a reasonably long time (a few days), we will suggest having a second carer who can let the main carer have proper sleep, or they use a pop in agency for a waking night carer, if space is an issue. We will work closely with our client and carers to find ways that let the carer have proper sleep. If there are night calls and there has not been a way for you to get proper sleep, we suggest that you ask your client for £9 per call if more than two calls a night or £9 per call if any call is longer than half an hour. We suggest this only when there are significant night calls. One extra call every 2 weeks does not really count.

FOOD AND HOUSEKEEPING MONEY (As per point 9 in the Code of Conduct for Carers)

Food Money

Some of our clients who are unable to eat normal or solid food provide a contribution towards their carer's food costs. This money may be given to you to purchase your own food: other clients may have family members who shop and provide food for you. This will be advised at the time that you accept a booking. If clients give you the cash to purchase your own food, we suggest you either log this in the financial record book if one is kept at the house, and, if not we suggest you give your client a receipt for the money.

Housekeeping Money

When working with some of your private clients you will receive "Housekeeping Money" to pay for the client's various expenses.

The client's guide to their wishes will explain what this money is to be used for, e.g. hairdressers, paying milk bills, taking the client out to the cinema, purchasing food for the household etc.
The housekeeping money will either be sent to you as cash or you will have to come to the office to collect the money in person (applies only to clients locally based near Saxmundham). Some clients are now using the new account we have put together with Barclays bank, so you may be given a debit card with which you can withdraw housekeeping money from the ATM.

If you go to a client where your housekeeping money is administered by Christies Care, then the client's Booking Coordinator should explain to you how you will receive the money at the time you accept the booking.

What else do you need to know about Housekeeping Money?

- There will be a receipt book at your client's home and you will be responsible for accounting for this money. When the money is less than a certain amount, you contact the Accounts Department and request that more money is sent out.
- We strongly recommend that when housekeeping, money is received from or handed over to another carer is that both carers agree that the correct amount of money has changed hands.

If there is a problem we strongly advise that you contact the client's Booking Coordinator or your Carer Support Team IMMEDIATELY to report the problem.

- If you are found to have abused the housekeeping money system in some way (e.g. taking or borrowing money for use other than your client's expenses) you will be subject to a £30 administration fee and be made to repay any shortfall.

RECORD KEEPING

Guide to Client's Wishes

This guide has been put together using the information the client and their family has given us, and should be used by the carer as a guide to the work to be undertaken by the carer. The folder also contains the relevant risk assessments which have been undertaken at the annual review with the client.

Care & Nutrition Record Book (CRB)

If the client has requested that a daily record of their care should be maintained, one of these books will have been issued for the carer to complete. This book is not intended for gossip and innuendo. It is there to be useful to the client and other legitimate readers to know about their events, as well as useful to following carers. Clients have the right to see any record about them and families and friends may have consent to see them too.

- Write facts that can be checked and shown as true
- Write descriptions of events made that you have heard from others. Make sure you record this fact clearly. State your source.
- If you are recording an opinion, make sure you state clearly that it is an opinion and not fact.

Medication Administration Record Sheet (MAR)

We strongly recommend that MAR sheets should be completed at the time of administering the medication and should **NEVER** be completed prior to administration. A new MAR sheet is set up on Tuesday for the Wednesday. The incoming carer must check the MAR sheet as part of the handover procedure. If there are 4 or less blank MAR sheets at handover, new sheets should be ordered by the incoming carer.

Examples of how to complete the MAR sheet are shown on the following pages.

MEDICATION UPDATE INFORMATION FOR CARERS

All medication is to be entered onto the Medication Administration Record Sheet. This includes all medications from the dossett box, controlled drugs and non-prescribed medications. If you need further information about the medication in the dossett box, please speak to the Pharmacist who can confirm this for you.

Anyone who is administering medication to the client, must complete their details on the front page and initial on the Medication Administration Record sheets (e.g. family, carers, DNs etc.)

When times are entered these must be via the 24hr clock, e.g. 18.00

Change in Dose – Medicine 1 – Amitriptyline 10mg
This medication is originally given 1 x 10mg, 3 times a day. (Medicine 1)

On Friday 8 February after lunch, the prescription was changed to 2 x 10mg, 3 times a day. Therefore a new record is created (Medicine 3) and is recorded in Medicine 3 for the rest of the week.

Medicine 1 AMITRIPTYLINE 10 MG	Controlled Drug Y (N)	Time:									
Dose: 1 X 10 MG; Frequency: 3 X DAY; Route: ORAL	Prescribed medication (Y) N	Breakfast	✓	LB	MC	MC					
		Time:									
		Lunch	✓	MC	MC	MC					
		Time:									
Other directions STORE AT ROOM TEMPERATURE IN LIGHT RESISTANT CONTAINER		Supper	✓	MC	MC						
		Time:									
		Bedtime									
		Time:									
Medicine 2 AMOXICILLIN 250 MG	Controlled Drug Y (N)	Time: 09:00	✓	LB	MC						
		Breakfast									
Dose: 1 X 250 MG; Frequency: 3 X DAY; Route: ORAL	Prescribed medication (Y) N	Time: 13:00	✓	MC	MC						
		Lunch									
		Time: 17:00	✓	MC	MC						
Other directions PRESCRIBED FOR 7 DAYS COURSE MUST BE COMPLETED		Supper									
		Time:									
		Bedtime									
		Time:									
Medicine 3 AMITRIPTYLINE 10 MG	Controlled Drug Y (N)	Time:									
		Breakfast	✓				MC	MC	MC	MC	
Dose: 2 X 10 MG; Frequency: 3 X DAY; Route: ORAL	Prescribed medication (Y) N	Time:									
		Lunch	✓				MC	MC	MC	MC	
		Time:									
Other directions STORE AT ROOM TEMPERATURE IN LIGHT RESISTANT CONTAINER		Supper	✓			MC	MC	MC	MC	MC	
		Time:									
		Bedtime									
		Time:									

DOSE CHANGED PLEASE SEE MEDICATION 3

MEDICATION FINISHED

PRN (as and when required) – All PRN medications need to be entered on the MAR sheet even if they are not used regularly. For PRN medication the times are added when the client actually takes the medication. Document in the care record book as to why.

Controlled Medications – will need to be stock controlled. Each time controlled medication is given the amount remaining will need to be entered in the bottom half of the box. If you do not witness the client take controlled medication you need to place the letters 'NW' in the lower half of the box and then the remaining stock in the top half of the box. See diagram below:

EXAMPLE Medicine 1 DIAZEPAM 5 MG	Controlled Drug (Y) N	Time: 08:00	✓	LB 26	MC 23	MC 20	MC 17	MC 14	MC 11	MC 8
Dose: 1 X 5 MG; Frequency: 3 X DAY; Route: ORAL	Prescribed medication (Y) N	Breakfast								
		Time: 12:00	✓	MC 25	MC 22	MC 19	MC 16	MC 13	MC 10	MC 7
		Lunch								
		Time: 16:00	✓	MC 24	MC 21	MC 18	MC 15	MC 12	MC 9	MC 6
Other directions		Supper								
		Time:								
		Bedtime								
		Time:								

Refusal or sleeping – If the client refuses the medication or is asleep at the specified time and did not take the medication within an hour an 'R' (refused) or 'S' (sleeping) must be placed in the bottom half of the box. No initials should be added in the top half of the box. If the client takes the medication one or more hours later than the time they should, another medication section on the MAR sheet would need to be completed with new times for that day. Initials would be added to the top half of the box to state the client had taken the medication. See diagram above.

Initials – only place your initials in the top half of the box if you have witnessed the client take the medication.
If you do not witness this place the letter 'NW' in the lower half of the box and do not initial the top half of the box. As diagram above, in the 'Bedtime' section.

Accounts Record Book (ARB)

Where the carer is responsible for the client's finances, we strongly recommend that an Accounts Record Book is kept. This will help provide evidence should there be any allegations of misappropriation of funds made against you.
All money received and paid out should be recorded and receipts kept. The balance of money in hand should be recorded and should agree with the actual cash held. If the client is using a Christies Care Barclays cash card the PIN number should not be written down. If the PIN number is forgotten, the Accounts Department at Christies Care can be contacted (01728 605020) and this number will be released to you following the correct answer to some security questions.
We recommend that you do not accept cash from your client on behalf of Christies Care, e.g. in payment of our invoices, but help the client in making the payment to us.

Professional Record Books (PRB)

If the client has any conditions that require specialist training we recommend that these books should be kept to record this training, e.g. PEG feeding, Buccal, Midazolam, Epi-pen, Oxygen. When the training has been completed by the care professional, e.g. District Nurse, the care professional should enter the training given in the book and sign to confirm that the carer is competent to undertake that procedure.
We recommend that the carer uses the CRB, MAR sheets and/or ARB or an appropriate other record book (such as Professional Record Book) to record the following:

- Whenever the carer has helped the client with medicines
- Whenever the carer has bought something with the client's money
- Any incident or dangerous occurrence
- Whenever physical restraint has been used
- Any damage to property
- Any sudden change in the client's condition
- Whenever a GP or ambulance is called out
- Whenever a District Nurse other care professional visit

Replacement books and MAR sheets should be ordered in good time from our special order line: 01728 605021 and they will be sent out immediately so there is no break in recording events.

IF YOUR CLIENT IS HOSPITALISED

If your client is hospitalised we recommend you inform your Carer Support Team immediately.

We strongly advise that you make sure the hospital has all the up to-date information about your client e.g. any allergies. The Medication Record Book should go with the client and also any medication that they are currently taking.

The Booking Team will notify any family members who have asked to be advised.

IF YOUR CLIENT DIES

We strongly recommend that you follow the process detailed below

Only a legally qualified doctor is allowed to state a person has died. Carers cannot do this even if there are no signs of life.

Check that your client is not breathing and has no pulse.

If the client has only very recently collapsed, or you think the client is still alive, dial 999, send for the doctor and/or ambulance as appropriate. If your client has died unexpectedly, or if the doctor does not know why your client has died, he will telephone the police and coroner's office.

It is important that you do not disturb anything that police may want to see. The police will want to take a statement from you. This is normal practice and is not something you should worry about.

Please contact your Carer Support Team as soon as you can and let them know what has happened. Usually you will be asked to stay in your client's house until a family member or someone arrives to take over from you. Upon their arrival, you will hand over to them and give them all the information they need. You may be asked to stay on at the house or you may be asked to leave. Whatever you are asked to do, please pass this on to your Carer Support Team.

If you are asked to leave and have nowhere to stay, we may be able to advise you about accommodation. If we have availability all carers are welcome to stay at our Guest House.
Write down everything that happened in the Client Record Book.

SAFEGUARDING AND HOW TO RECOGNISE ABUSE (As per point 7.2 in the Code of Conduct for Carers)

We strongly recommend that you follow these guidelines

If you believe that the client is in immediate danger, or in need of urgent medical attention, you must take action to ensure their safety and well-being. This could include calling the appropriate emergency services.

If you have reason to believe a serious crime has been committed then call the Police immediately. In cases involving physical or sexual abuse, take care to protect evidence. Ask the Police for guidance on this, when you contact them.

In these serious circumstances, you should be mindful of your own and your client's safety. Do not alert or confront the alleged abuser.

Do not discuss any information regarding this with any family members, friends, neighbours or other Carers.

However, if the client is not in immediate danger, please call Christies Care.

If you have any evidence, concerns or suspicions that a client you are caring for is being abused, it is your duty to contact your Carer Support Team immediately. If you need to report your concerns outside office hours please call Christies Care and follow the instructions to be transferred to our out of hours duty manager.
Please give the following information to your Carer Support Team or the duty manager:

Your name and the name of your client
When and where the abuse happened; include time and date if possible

What have you observed in the way of abuse, and how is it being done
Who – details of person you think is carrying out abuse
Details of any other witness to abuse

The office will then ensure that the appropriate action is taken.

DISCLOSURE & BARRING SERVICE

The DBS scheme is made up of four components.

1. There is a nationally held database of people who are considered unsuitable to work with vulnerable groups. This is called the DBS (Disclosure and barring service) barred list.
2. We have a duty to check whether a prospective carer's name is on the list before confirming an introduction to a client. It is illegal to employ in a caring role any person whose name is on the list.
3. The DBS requires us to refer carers whom we believe to be guilty of abuse to the DBS for possible inclusion on the DBS barred list.
4. It is a criminal offence for any person whose name is on the list to apply for work with vulnerable groups.

GUIDE TO ABUSE TYPES

An Adult At Risk is a person who:

- Is aged 18 years or over and
- Has or may have a care need (broadly defined) arising from mental or other disability, age or illness. Having 'a care need' means that they need someone to assist in caring for him or herself.
- Is or may be unable to protect him or herself against harm or exploitation.

Definition of Abuse:

- A single or repeated act or lack of appropriate action.
- Occurring within any relationship (professional or otherwise) where there is an expectation of trust.
- Which causes harm or distress to a vulnerable adult

Who may be at risk?

- Elderly and frail
- Mental disorder including: dementia or personality disorder
- Physical or sensory disability
- Learning Difficulties
- Severe physical illness
- Person who misuses Substances/Alcohol
- Unpaid carer
- Homeless
- A person who cannot defend themselves
- Someone attending a day centre
- Your client

Just because someone is disabled in some way or old or ill does not mean that they are unable to take care of themselves – they may be perfectly able to do so.

Generally the more dependent a person is on the help of others for activities of daily life and support; the more at risk the person is likely to be.

There are ten categories of abuse that you need to be aware of:

- Physical abuse
- Domestic violence

- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational abuse
- Neglect or acts of omission
- Self-neglect

Any or all of these types of abuse may take place as the result of:

- Deliberate intent
- Negligence
- Ignorance

EXAMPLES AND INDICATIORS OF ABUSIVE BEHAVIOUR

1. **Physical abuse –** the following are examples of physically abusive behaviour:
   - Hitting, slapping, kicking
   - Rough Handling
   - Assaulting
   - Hair pulling
   - Pushing
   - Making someone purposely uncomfortable, i.e. removing blankets
   - Restraint or inappropriate physical sanctions
   - Involuntary isolation or confinement
   - Misuse of medication
   - Forcible feeding

   The following may be indicators of physical abuse:
   - Injuries inconsistent with the account of how they happened
   - Lack of explanation as to how injuries happened
   - Injuries inconsistent with the lifestyle of the vulnerable adult
   - Multiple bruising and/or welts on face, lips, mouth, torso, arms, back, buttocks, and thighs
   - Clusters of injuries
   - Marks on the body appearing to be slap marks or finger marks
   - History of unexplained falls or minor injuries
   - Injuries at different stages of healing
   - Burns
   - Immersion burns or rope burns on arms, legs, torso
   - Injuries or physical symptoms induced, falsely claimed or exaggerated on behalf of the vulnerable adult by a “carer”, spuriously attracting treatments or services
   - Medication misuse – excessive repeat prescriptions
   - Unexplained loss of hair in clumps
   - Cuts that are not likely to be as a result of self-injury
   - Subdued behaviour in the presence of a carer
   - Being left in wet clothing
   - Late presentation for medical treatment
   - Person flinches at physical contact
   - Reluctance to undress or uncover part of the body

2. **Domestic violence** – definition of domestic abuse:
   - Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse... by someone who is or has been an intimate partner or family member regardless of gender or sexuality

- Includes: psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence; Female Genital Mutilation; forced marriage.
- Age range extended down to 16.

Domestic violence includes psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence. Honour based violence is a violent crime or incident which may have been committed to protect or defend the honour of the family or community. It is often linked to family members or acquaintances who mistakenly believe someone has brought shame to their family or community by doing something that is not in keeping with the traditional beliefs of their culture.

For example, honour based violence might be committed against people who:
- become involved with a boyfriend or girlfriend from a different culture or religion
- want to get out of an arranged marriage
- want to get out of a forced marriage
- wear clothes or take part in activities that might not be considered traditional within a particular culture

3. **Sexual abuse** – the following are examples of sexually abusive behaviour:

Non-contact sexual abuse:
- Inappropriate looking
- Indecent photography to which the adult at risk has not consented, or could not consent, or was pressurised into consenting
- Indecent exposure
- Serious teasing or innuendo
- Involvement in pornography to which the adult as risk has not consented, or could not consent, or was pressurised into consenting
- Harassment
- Enforced witnessing of sexual acts or sexual media

Contact sexual abuse:
- Inappropriate touch anywhere
- Masturbation of either or both persons
- Penetration or attempted penetration of the vagina, anus, mouth, with or by penis, fingers, other objects

The following may be indications of sexual abuse:
Physical indicators:
- Bruising and/or bleeding, pain or itching in genital area
- Foreign bodies in genital or rectal openings
- Infections or discharges in the above areas, or sexually transmitted diseases
- Pregnancy in a woman who is unable to consent to sexual intercourse
- Unusual difficulty in walking or sitting
- Torn, stained or bloody underclothing
- Bruising to thighs and upper arms
- Wetting or soiling
- 'Love' bites
- Self-inflicted injury

Behavioural indicators:
- Significant change in sexual behaviour or attitude
- Overt sexual behaviour/language
- Poor concentration
- Withdrawal
- Sleep disturbance

- Excessive fear/apprehension of, or withdrawal from, relationships
- Fear of staff or other carers offering help with dressing, bathing etc.
- Reluctance of person to be alone with an individual known to them
- Self-harming

4. **Psychological abuse** – the following are examples of psychologically abusive behaviour:
   - Prevention of an adult at risk from using services or social activities
   - Denial of access to friends
   - Denial of religious and cultural needs
   - Ignoring
   - Lack of stimulation and meaningful occupation (common with people with Dementia)
   - The use of threats, humiliation, bullying, swearing, and other verbal abuse
   - Intimidation
   - Deprivation of contact with others
   - Lack of positive reinforcement
   - Harassment

   The following may be indicators of psychological abuse:
   - Air of silence in the home when the alleged perpetrator is present
   - General lack of consideration for the needs of the adult at risk
   - The adult at risk not allowed to express an opinion
   - Privacy denied in relation to care, feelings or other aspects of life
   - Denial of access to an adult at risk, especially when the person is in need of assistance
   - Denial of freedom of movement e.g. locking a person in a room, tying them to a chair
   - Alteration in psychological state e.g. withdrawal or fear

   The following can occur in older people for a variety of social, psychological or medical reasons, but could also be an indicator of psychological abuse:
   - Insomnia
   - Low self-esteem
   - Excessive ambivalence, confusion, resignation agitation
   - Change of appetite
   - Weight loss/gain
   - Tearfulness
   - Unexplained paranoia

5. **Financial or material abuse** – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

   The following are examples of financially abusive behaviour:
   - Taking possessions
   - Misappropriating money, valuables or property
   - Forcing changes to a Will or Testament
   - Preventing access to money, property or inheritance
   - Stealing
   - Loans from the adult at risk of abuse to a member of staff or paid carer
   - Loan made to anyone if made under duress or threat, or is dishonestly extracted

   The following may be indicators of financial or material abuse:
   - Unexplained lack of money or inability to maintain lifestyle
   - Unexplained withdrawal from accounts or bank account activity
   - Power of Attorney obtained when the adult at risk of abuse is unable to comprehend and to give consent

- Failure to register an Enduring Power of Attorney after the adult at risk of abuse has ceased to have mental capacity
- Signs of financial hardship in cases where the financial affairs are being handled by an Appointee, Attorney or Receiver; or by anyone managing the adult's finances.
- Money being withheld
- Recent changes of deeds or title to property
- Unusual interest shown by family or others in the assets of the adult at risk of abuse.
- Person managing the financial affairs is evasive or uncooperative
- Lack of clear accounts held
- Misuse of personal allowance by person managing finances for an adult at risk
- Informal carers moving in a person's home, living rent free and there being no clearly set out financial arrangements

6. **Modern slavery** - includes slavery, human trafficking, forced labour and domestic servitude (work imposed as punishment). Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

How to spot the signs of modern slavery

As with other safeguarding concerns, the signs of slavery in the UK and elsewhere are often hidden, making it even harder to recognise victims around us. Whilst not exhaustive, here is a list of **some common signs** which you can be aware of:

- Physical appearance: Victims may show signs of physical or psychological abuse, look malnourished or unkempt, or appear withdrawn
- Isolation: Victims may rarely be allowed to travel on their own, seem under the control, influence of others, rarely interact or appear unfamiliar with their neighbourhood or where they work
- Poor living conditions: Victims may be living in dirty, cramped or overcrowded accommodation, and/or living and working at the same address
- Few or no personal effects: Victims may have no identification documents, have few personal possessions and always wear the same clothes day in day out. What clothes they do wear may not be suitable for their work
- Restricted freedom of movement: Victims have little opportunity to move freely and may have had their travel documents retained, e.g. passports
- Unusual travel times: They may be dropped off / collected for work on a regular basis either very early or late at night.
- Reluctant to seek help: Victims may avoid eye contact, appear frightened or hesitant to talk to strangers and fear law enforcers for many reasons, such as not knowing who to trust or where to get help, fear of deportation, fear of violence to them or their family.

7. **Discriminatory abuse** – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.

The following are examples of discriminatory abusive behaviour:

- Unequal treatment
- Verbal abuse
- Inappropriate use of language
- Derogatory remarks
- Harassment
- Deliberate exclusion

The following may be indicators of discriminatory abuse:

- Lack of respect shown to the adult at risk of abuse
- Signs of sub-standard service offered to the adult at risk of abuse

- Repeated exclusion from rights afforded to ordinary citizens, such as health, education, employment, criminal justice and civic status
- Tendency to be withdrawn and isolated
- Expressions of anger or frustration or fear and anxiety
- Denial of a person's communication needs e.g. not allowing access to a signer or lip reader

8. **Organisational abuse** – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

Types of organisational or institutional abuse

- Discouraging visits or the involvement of relatives or friends
- Abusive and disrespectful attitudes towards people using the service
- Lack of respect for dignity and privacy
- Not providing adequate food and drink, or assistance with eating
- Not offering choice or promoting independence
- Misuse of medication
- Failure to provide care with dentures, spectacles or hearing aids
- Not taking account of individuals' cultural, religious or ethnic needs
- Failure to respond to abuse appropriately
- Failure to respond to complaints

Possible Indications of Organisational Abuse

- There is a serious or persistent failure to meet the needs of adults at risk
- Carers as well as dependents show apathy, depression, withdrawal, hopelessness or suspicion
- A sequence of unexplained occurrences which have the potential to have a negative impact on people who use the services.
- Lack of choice, privacy, appropriate bedding or clothing
- A person's Health or Social Care needs are not being addressed
- Lack of supervision or action to deal with abuse
- Poor standards of care
- Public discussion of personal matters

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

The following are examples of neglecting behaviour:

- Failure to provide food, clothing, shelter, heating
- Failure to provide medical care
- Failure to provide hygiene or personal care
- Failure to administer medication
- Denial of religious or cultural needs
- Denial of educational, social and recreational needs
- Ignoring
- Lack of stimulation
- Lack of emotional warmth

The following may be indicators of neglect:

- Withholding or failure to provide care, food, clothing, or heating, which has a detrimental effect on the person's welfare
- Physical condition of the adult at risk is poor e.g. pressure areas, unwashed, ulcers
- Inadequate physical environment

- Untreated injuries or medical problems
- Failure to engage in social interaction
- Poor personal hygiene
- Malnutrition when not living alone
- Person is not afforded privacy or dignity

10. **Self-neglect** - this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. Such situations might include:
    - Portraying eccentric behaviours/lifestyles, such as hoarding or antisocial behaviour causing social isolation. This can impact on the living environment causing health and safety concerns
    - Neglecting household maintenance, and therefore creating hazards
    - Poor diet and nutrition, evidenced for example by little or no fresh food, or what there is being mouldy or unfit for consumption
    - Refusing to allow access to health and/or social care staff in relation to personal hygiene and care
    - Personal or domestic hygiene that exacerbates a medical condition that could lead to a serious health problem

Criminal Offences

Some instances of abuse may constitute a criminal offence. Examples of actions, which may constitute criminal offences, are assault (physical or psychological), sexual assault and rape, theft, fraud or other forms of financial exploitation and certain forms of discrimination, whether on racial or gender grounds.

Where a criminal offence has been committed, it may be relevant to telephone the Police before you call your support team.
(The above are examples of some types of abuse; the list is not exhaustive).

What should I do if I see or suspect abuse?

You have a duty to act if you think your client is being abused. You must gather enough evidence to be able to report in reasonable detail.

We suggest that you:

- Stay calm
- Deal with your client's immediate needs: you will learn more from your client if you don't hurry things;
- Listen to your client's story;
- Keep an open-mind don't jump to conclusions: your job is to learn the client's story;
- Let them speak without interruption, keep it going with verbal and non-verbal prompts;
- Do not ask leading questions: don't suggest conclusions to your client;
- Reassure your client that it is fine to talk about it;
- Don't promise confidentiality. You may need to explain that you have a duty to tell a member of your support team; and
- Inform your support team giving detailed information;
- Make a written or spoken record of what has happened.

What should I record?

Details of allegation/grounds for suspecting abuse.

- Date and time of incident;
- People involved;
- Observed injuries;
- Appearance and behaviour of the victim;
- Where it took place;
- What the victim has said using their words.

Action to be taken when dealing with allegations of abuse

In order to take effective action in the case of alleged abuse, you want the consent of the client, if possible. However, there will be occasions *(the client is confused or perhaps mentally incapable of giving an informed consent)* when it is not possible to obtain such consent, but nevertheless, a full and thorough investigation must be undertaken.

Initial referral or notification of suspicion of abuse may be received from a number of sources, including staff, members of the public, or other agencies.

All reports of alleged, suspected or actual abuse must be reported to your support team, as soon as you become aware of it. If injuries are present, however slight, these should be shown on a "body map" – a simple drawing of the shape of a human body on which you can mark the area where the injury is. Use a camera on your mobile phone as well, if you can.
We know that a suspicion about abuse, (particularly if it involves a fellow carer) is shocking and hard to believe. But you have a professional duty to report these suspicions. Every reported incident of suspected abuse must be taken seriously and treated with urgency.

However, take care not to make up your mind too quickly that an adult at risk of abuse is being abused or neglected.

Think about where you are. You want to listen to the client's story.
Should you go somewhere else to do it, perhaps out of the way of the possible abuser? Also, recognise when the situation is beyond your skills – call in help at an early stage.

In general, if there is immediate danger to the client, or the safety of others, of if forensic evidence needs to be gathered urgently, (e.g. sexual abuse) the Police should be involved at an early stage. Similarly in the event of major injury, the Ambulance Service may need to be called.

In all cases consult your support team for advice by the quickest means, or if unavailable the next most senior person. You should ensure that your client is accompanied on any journey to hospital (if required), and inform medical staff that the injury or injuries may have been caused by abuse, and that a report is required and may be used in any subsequent legal action.

When you are informed of suspected or actual abuse you should not confront the alleged perpetrator. As already stated you should inform your Support Team who will take the appropriate action.

We get complaints from clients, their family, even carers. A lot of these are totally unfounded with reasonable explanations.

EQUALITY DIVERSITY

As from October 2017 the 9 protected characteristics are:-

- Age
- Disability
- Gender reassignment
- Marriage & civil partnership
- Pregnancy & maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Equality – ensuring everyone has equal opportunities regardless of their abilities, their background or their lifestyle. This applies to both clients and the staff working for Christies Care Ltd.

Diversity – appreciating the differences between people and treating people's values, beliefs, cultures and lifestyle with respect.

Christies Care Ltd operates a zero tolerance approach to any behaviour that fails to treat clients or staff equally.

Christies Care Ltd also ensures that respect for equality, diversity and protected characteristics is included as a fundamental part of staff induction and training. We view staff training as of crucial importance. Training ensures that staff are up-to-date and equipped with the very latest knowledge and techniques and are, above all, safe. This ethos is supported within our induction and annual update training which all staff must attend

Discrimination training

To help meet the objectives of this policy we will provide training that:

- increases awareness of the prevalence of and harmfulness of discrimination and prejudice within the protected characteristics
- examines the nature of discrimination, both direct and indirect, and the ways in which it can occur and can be prevented;

Staff

We all have a responsibility to embrace and support this vision and must continue to challenge behaviour and attitudes that prevent us from achieving this. Using fair, objective and innovative employment practices, our aim is to ensure that:

- All employees and potential employees are treated fairly and with respect at all stages of their employment.
- All employees have the right to be free from harassment and bullying of any description, or any other form of unwanted behaviour, whether based on sex, trans-gender status, marital status, civil partnership status, pregnancy, race, disability, age, political or religious belief or sexuality.
- All employees have an equal chance to contribute and to achieve their potential, irrespective of any defining feature that may give rise to unfair discrimination.

Work/life balance

Christies Care are committed to helping its staff fulfil their potential at work whilst finding the right work/life balance by offering a Flexible Working Hours Scheme and opportunities to job share where possible.

HANDING OVER TO A NEW CARER

Changeover

Changeover day is typically on a Wednesday. We advise that the outgoing carer should contact the incoming carer at least the Monday before the forthcoming changeover. The details of the incoming carer should be contained on your client's confirmation. You are usually allowed to contact the incoming carer on your client's telephone. If there are any problems with any aspect of the changeover or your own journey, you are welcome to contact your Care Support Team for advice if you wish.

The incoming carer will generally be expected to arrive at 10am, if they are coming from an "off" week. The incoming carer will arrive as soon as possible, once they have been replaced, if they are being introduced to a client via Christies Care.
We advise that carers travel immediately to their next client once a handover has been given and that you take the quickest means of travel, which is usually the train.

We suggest that you give consideration to your fellow carers and your clients when travelling and planning your journeys. If you are delayed, the people most affected by your lateness will be the clients and carers at the end of the chain. You will find yourself in the position of being dependent on other carers travelling promptly for you to make your journey home.

Please note that carers who arrive consistently later than their clients expect are very likely to be found unsuitable to be introduced to clients.

The Handover

We recommend that a full handover is given. If your client has a handover checklist, we suggest that this is completed in full and not signed unless both incoming and outgoing carers are satisfied with everything.

We also suggest that the carer's room is left tidy and hoovered, with clean bed sheets prepared for the incoming carer.

Belongings

We suggest that you do not leave any belongings at your clients, even with consent. Once your introductions end, you may not be able to return to collect them e.g. client may be admitted to hospital, pass away or change their mind about you returning for a variety of reasons.

If collection of your belongings is required, this is likely to be done via a courier or Local Area Advisor. You will be charged for this in full and it is usually very expensive, with an additional administration fee of £30 charged for our involvement.

GUIDE TO CULTURAL BELIEFS

This information is intended as a guideline and the most important thing is to ask the client (and/or the family) what is needed and what you should be aware of. Whatever cultural or religious beliefs a client has, they will have preferences and needs which are individual and personal to them alone.

Some people have religious needs. Everyone has spiritual needs and these may basically be expressed as:

- The right to love and be loved
- The need for meaning and purpose in my life
- The need to feel worthwhile

Culture

African/Caribbean

Religion – Religion plays an important part in the lives of most African/Caribbean's. A large proportion are mainstream Christians of whom most are Protestants. Some are Catholics and there are a growing number of Muslims.

Diet – There are no specific dietary regulations. One of the common foods is rice and peas. Fish, ockra (ladies fingers), sweet potatoes and yam are also popular.

Modesty – Clients are likely to have a strong preference for a carer of the same sex.

Death – Burial preferred. Funeral and mourning customs vary depending on culture/religious belief.

Asian

This term is used to include people from Bangladesh, India and Pakistan

Religion

- Bangladeshis – majority Islam, some Hindus
- Indians – majority Hindus, some Muslims, Sikhs and also Christian
- Pakistanis – majority Islam

Diet – The diet varies considerably depending upon the client's religion. Neither Hindus nor Muslims will eat food which has come into contact with prohibited food/utensils.

Hygiene/Cleanliness – Hand washing is considered essential before and after eating. Water or washing is needed in the same room as the WC itself. If a bedpan has to be used bowls/jugs of water should also be provided. Asian clients prefer to wash in free flowing water e.g. a shower, as baths are considered unhygienic.

Modesty – Asian clients, particularly women are likely to have a strong preference for a carer of the same sex.

In some Asian cultures direct eye contact is avoided during a conversation particularly if the other person is of the opposite sex; this behaviour should not be seen as rude and does not imply disinterest.

Death – It is customary amongst some Asian cultures to express their emotions freely when a relative dies. Wherever possible they should be given privacy.

Chinese/Vietnamese

Religion – Taoism, Buddhism and Confucianism are the main religions although some Chinese are Christians.

Diet – The Chinese believe that in order to be healthy, an equilibrium between 'hot' and 'cold' needs to be maintained, whether this relates to food, herbs or medicines. Foods are classified as hot or cold (this does not refer to temperature); therefore in order to restore balance the Chinese/Vietnamese may adhere to a special diet. For example:

Hot	**Cold**
Most pulses, garlic, ginger, eggs, nuts	Cereals, rice,
wheat, fruit, potatoes	sugar, chick peas
Lamb, honey, chilli, onions, dates, tea	vegetables
milk, Green leaf and coffee.	

Rice is the staple food which is eaten with a variety of meat, fish and vegetable dishes.

Hygiene/Cleanliness – A soak in the bath is believed to be bad for the body in later life and therefore showers are preferred.

Modesty – In general women prefer same sex carers.

Death – Funeral and mourning customs vary widely depending upon culture/religious belief. Some are buried, whilst others are cremated.

Traditional Chinese Medicines – traditional remedies are sometimes used for certain conditions and it is important to consult the individual.

Religion

Baha'i

The Baha'i faith has its roots in Babuism, a Muslim denomination, it is a separate religion. It's teaching centre on the unity of mankind, the harmony of religion and science, equality of men and women and universal peace.

It has not set doctrines, no priesthood, no formal public ritual and no authoritative scriptures. However a client may want to have a visitor from the Spiritual Assembly of Baha'i.

Diet – Alcohol is not permitted – including alcohol in cooking.

Fasting – members of the Baha'i faith fast for a period from 2nd March to 21st March. The fast is from sunrise to sunset.

The elderly and the sick are exempt from fasting.

Blood Transfusions – no objection

Organ Transplants – no objection

Death – Baha'i is belief in Afterlife and therefore they treat the body with great respect after death. Routine last rites are appropriate. Cremation is not permitted.

Burial should take place within an hour's journey from the place of death.

Post Mortem – no objection

Special Considerations – NAWRUZ – New Year is celebrated on 21st March

Buddhism

Buddhist faith centres on the Buddha, who is revered, not as a god, but as an example of a way of life. Buddhists believe in reincarnation and so accept responsibility for their actions. The chief doctrine is that of 'Karma', good or evil deeds resulting in an appropriate reward or punishment either in this life, or through reincarnation along a succession of lives.

From its very beginning, Buddhism has always been culturally adaptable, and as a result a variety of forms and movements have developed within the religion, each with different traditions. Ask the client and/or family what is required.

Diet – As Buddhism encourages its followers to practise non-violence, Buddhists will mostly be vegetarian. Meals will vary considerably depending upon their country of origin.

Blood Transfusion – unlikely to be any objection

Organ Transplantation – unlikely to be any objection

Care of Dying – Buddhists believe in rebirth after death. The state of mind of a person at the moment of death is important in determining the state of rebirth. They like to have full information about their imminent death to enable them to make preparation. Some Buddhists may not wish to have sedatives or pain killing drugs administered at this time.

Peace and quiet for meditation and visits from other Buddhists will be appreciated. Some form of chanting may be used to influence the state of mind at death so that it may be peaceful.

Death – If other Buddhists are not in attendance, then a Buddhist minister should be informed of the death as soon as possible. Routine Last Rites are appropriate. Cremation is preferred.

Post Mortem – there is unlikely to by any objection
Special Considerations – WESAK – a celebration of enlightenment of Buddha – held on full moon in May.

Christian Science

Christian Science teaches a reliance on God for healing, rather than on medicine or surgery. It will be unusual, therefore, for Christian Scientists to be admitted to ordinary hospitals. They will usually seek nursing care at home or in a Christian Science Nursing home. They may, however, be admitted to hospital following accidents, and because of family or legal pressure. The Church does not attempt to control the actions of its members and the decision about whether to accept medical intervention lies with the individual.

A Christian Scientist will accept normal care if admitted to a hospital, but will normally wish to be totally free of drug treatment. They will probably wish to contact a Christian Science practitioner for treatment through prayer.

Diet – Alcohol and tobacco are not allowed. Strict Christian Scientists may not drink tea or coffee.

Blood Transfusion – It is not normally acceptable for adults.

Organ Transplantation – It is not normally acceptable for adults to donate or receive organs.

Care of the Dying – There are no rituals to be performed.

Death – Routine Last Rites are appropriate. A female body should be handled by a female. Cremation is usually preferred.

Post Mortem – Christian Scientists object to post mortems, unless required by law.

Christianity

Anglicans Roman Catholics Free Churches

Although the doctrines of Christian churches vary greatly both within and between countries, there are four features of Christianity that are nearly universal: initiation (baptism), worship, ministry and 'good works'. The sacred writings of Christian religion are in the Bible. A Christian's individual faith and religious practice will be influenced by the tradition of the church to which they belong as well as their personal relationship with God. It is important to know the clients specific denomination.

Diet – there are no general dietary requirements. Some Christians observe Friday as a day when they do not eat meat. Some Christians may wish to abstain from food (fast) before receiving Holy Communion. Some abstain from alcohol.

Blood Transfusion – No religious objections.

Organ Transplantation – No religious objections.

Death – Routine Last Rites are appropriate for all Christians.

Christmas and Easter are the most important festivals. Christians will usually wish to receive Holy Communion at these times.

Post Mortem – No religious objection.

Hinduism

Central to Hinduism is reincarnation. Hindu religious practices vary a great deal, depending on areas of origin. Hinduism is a social system as well as a religion, therefore customs and practises are closely interwoven. Please refer to the client and/or family about particular requirements.

Diet – most Hindus DO NOT eat beef. Some will not eat eggs/chicken. Dairy produce is acceptable, so long as it's free of animal fat. However, it is best to ask the client. **Some Hindus are very strict vegetarians they will not eat food which has come into contact with prohibited food/utensils.**

"Hot and Cold Foods" – this relates to perceived medicinal properties of food and has nothing to do with either temperature or spicy qualities.

Tobacco and alcohol are not generally accepted.

Fasting – This means eating only "pure" foods such as fruit or yoghurt rather than complete abstinence.

Hygiene/Cleanliness – Hand washing is considered essential before and after eating.

Modesty – Women prefer female carers

Dress/Jewellery – Jewellery usually has a religious or cultural significance e.g. a women's bangles are only removed on her husband's death.

Care of the Dying – Hindu patients very much want to die at home. This has religious significance and death in hospital can cause great distress.
Their belief in cremation and the body being returned to nature may involve a dying person asking to be placed on the floor during the final few breaths.

Blood Transfusion – generally acceptable
Organ Transplantation – No objections

Death – Distress may be caused if the body is touched by non-Hindus. The family will usually want to wash the body at home.

Post Mortems – generally disliked

Islam

The followers of the Islamic religion are called Muslims. The Holy Book for Muslims is the Holy Qur'an. There are two main denominations. Sunni and Shi'ite.

Diet – Muslims are forbidden to eat any product from pigs. Other meat can be eaten but it has to be HALAL meat, i.e. killed in a special manner stated in Islamic law. Fish and eggs are allowed but not if they are cooked near pork or non-halal food. Alcohol is prohibited.

Fasting – During the month of Ramadan a Muslim fasts between sunrise and sunset. Those who are sick are not expected to fast. If, however, a client wishes to do so, food should be made available before sunrise and after sunset. Essential drugs and medicines can be administered during Ramadan.

Hygiene/Cleanliness – Hands, feet and mouth are always washed before prayer. Hand washing is considered essential before eating.

If a bedpan has to be used, bowls/jugs of water should also be provided. Muslims prefer to wash in free flowing water, e.g. a shower, as baths are considered unhygienic.

Modesty – Women prefer to be cared for by female staff.

Dress/Jewellery – A locket containing religious writing is sometimes worn around the neck in a small leather bag. These are kept for protection and strength and therefore should never be removed.

Blood Transfusion – No religious objection.

Organ Transplantation – No specific rulings prohibiting transplantation. However, strict Muslims will not agree to organ transplants.

Care of the Dying – The dying Muslim may wish to sit or lie with his/her face towards Mecca. Moving the bed to make this possible will be appreciated. The family may recite prayers around the bed. If no family are available, any practising Muslim can help.

Death – After death the body **should not be touched** by non-Muslims. Muslims believe in the resurrection of the body after death, therefore Muslims are always buried, never cremated. The body will be ritually washed by the family and Muslim undertakers before burial. Muslim funerals take place as soon as practicable, as delay can cause distress.
Post Mortem – These are forbidden unless ordered by the Coroner.

Jehovah's Witnesses

Jehovah's Witnesses try to live their lives according to the commands of God as written in the Old and New Testaments. They regard Jesus Christ as the Son of God, but not in the sense of being equal with God or one with God.

Diet – Food containing blood or blood products are not acceptable. Jehovah's Witnesses do not smoke.

Blood Transfusions – Jehovah's Witnesses have religious views that taking blood into one's body is morally wrong and is therefore prohibited. This includes whole blood or its components, such as packed red cells, plasma, white cells and platelets.

Blood samples may be taken for pathological testing providing any unused blood is disposed of. Dialysis will usually be accepted.
Organ Transplantation – Generally not permitted. Also components where blood is not involved e.g. corneas are more likely to be acceptable.

Care of the Dying – there are no special rituals for the dying but they will usually appreciate a visit from one of the Elders of their Faith.

Death – Routine Last Rites are NOT appropriate

Special Considerations – Jehovah's Witnesses do not usually celebrate birthdays or Christmas. The only festival is the annual memorial of the death of Christ.

Judaism

In Judaism, religion and culture are entwined. It is based on the worship of one God; carrying out the Ten Commandments; and the practise of charity and tolerance towards one's fellow human beings. There are different groups within Judaism:-

Orthodox Jews – usually more traditional and observant of the religious/dietary laws.

Non-Orthodox Jews (included Conservative/Liberal/Reform) – make their religious observance fit into modern society.

Diet – Many Jews will ask for Kosher food i.e. meat that has been prepared in a special way according to Jewish law.

Shellfish, pork, rabbit and derivatives are strictly prohibited (treifu). Milk and meat products are not eaten in the same meal. This means that they do not have milk in their drinks or cream with their desserts after their meat meal and do not use butter on meat sandwiches.

Orthodox Jews may not be happy to take non-Kosher medication.

Fasting – If fasting would be a danger to their health, even Orthodox patients will accept medical advice.

Modesty – Orthodox Jewish women would prefer to have their bodies and limbs covered. They may also prefer to keep their hair covered with a head scarf. Orthodox men keep their head covered with a hat or skull cap (Kappel).

Organ Transplantation – Usually forbidden by Orthodox Jews.

Care of the Dying – Client may wish to recite or hear special psalms or prayers, especially Psalm 23 (The Lord is My Shepherd), and may appreciate being able to hold the page on which it is written.

Prayers may be said by the relatives and they may wish a Rabbi to be called to help the dying person with their formal confession and to bring comfort.

Death – In some cases the son or nearest relative, if present, may wish to close the eyes and mouth. The body should be handled as little as possible by non-Jews.
The family may wish for the body to be placed with the feet pointing towards the doorway and to light a candle. Burial usually takes place within 24 hours. Orthodox Jews are always buried but non-Orthodox Jews allow cremation.

Post Mortem – are not permitted unless legally required.

Special Considerations – The Sabbath (Shabbat) begins at sunset on Friday and lasts until sunset on Saturday. On the Sabbath 'work' is prohibited and this includes such as writing, travelling and switching on lights or electrical appliances.

Passover (on March or April) is when special foods may be required by some Jewish clients.

Day of Atonement or Yom Kippur (in September or October). This is a special day of fasting. A Jewish client will normally wish to keep that day to pray and be quiet. It is the holiest day of the Jewish calendar and is considered to set the path for the year to follow. Orthodox clients must be offered alternatives to oral medication, such as injections or suppositories, so this would have to be arranged by the district nurse.

Hanukkah or Chanukah – an annual eight daylong celebration. Its dates moves around every year but is always in the winter – December. There are prayers, menorah (candle) lighting and special fried foods to make and eat. It's to celebrate the rededication of the Holy Temple.

Mormons

The Mormon Church is also known as the Church of Jesus of Latter-Day Saints. It began in America in 1830. Mormons follow a very strict health code, known as the Word of Wisdom which advises against the use of tea, coffee, alcohol, tobacco and advocates healthy living. Family unity has great importance to Mormons.

Diet – Mormons eat sparingly and avoid products which contain a lot of blood. Tea and coffee are avoided and some Mormons will avoid all hot drinks. Milk, water and fruit juice are acceptable.

Blood Transfusion – generally acceptable.

Organ Transplantation – no objection.

Care of the Dying – There are no rituals for the dying, but spiritual contact is important. The church has "home teachers" who offer support and care by visiting church members.

Death – Routine Last Rites are appropriate. The sacred garment (if worn) must be replaced on the body following the last rites.

Church burial is preferred, although cremation is not forbidden.

Post Mortem – no religious objections.

Special Considerations – some Mormons who have been through a special temple ceremony wear a sacred undergarment. It is an **intensely private** item and is worn at all times. It is only removed for hygiene purposes. It may be removed for surgical operations but it must at all times be considered private and be treated with respect.

Rastafarianism

Rastafarians are followers of a movement which began in the 1920s in the West Indies, among the descendants of slave families who had come from Africa. The Old and New Testaments are still regarded as scriptures, but Rastafarians do not consider themselves to be Christian. Rastafarianism is a personal religion. It places emphasis on personal dignity and a deep love of God. There are no churches, services or official clergy. For some, legal marriage is unnecessary and thus extended families may be complex.

Diet – All forms of pork and shellfish are forbidden. Some Rastafarians are completely vegetarian. Some do not drink milk or coffee.

Modesty – Rastafarian women dress modestly. There is a taboo on wearing second hand clothing. If a client is admitted to hospital they may be unwilling to wear hospital garments which have been worn by others. A disposable theatre gown may be preferred.

Blood Transfusion – There will probably be anxieties about this because of concerns about contamination of the body.

Organ Transplantation – Not generally acceptable.

Care of the Dying – Amongst Rastafarians, visiting the sick is important. Visits are often made in groups.

Death – Routine Last Rites are appropriate. Burial is preferred.

Post Mortem – A post mortem will only be agreed to if ordered by the Coroner.

Special Considerations – Rastafarians will be unwilling to receive any treatment that will contaminate the body. They will prefer alternative therapies such as herbalism or acupuncture.

The distinctive hairstyles (dreadlocks or locks), are a symbol of the Rastafarian faith. Orthodox members may not permit their hair to be cut.

Sikhism

Sikhs, as an act of faith, wear the 5 signs of Sikhism, known as the 5 K's.

Kesh – uncut hair, kept under a turban
Kangha – small comb worn in the hair
Kara – steel wrist band or bangle (or ring)
Kirpan – sword/dagger
Kaccha – white shorts worn as an under garment

These symbols should not be disturbed unless it is absolutely necessary, in which case the need should be explained to the client or their family.

Diet – Many Sikhs are vegetarian. Some may not eat eggs or fish. A few Sikhs who eat meat will not eat beef. Sikhs so not smoke and alcohol is forbidden.

Blood Transfusion – No objections

Organ Transplantation – No objections

Care of the Dying – A dying Sikh may receive comfort from reciting hymns form the Guru Granth Sahab, the Sikh holy book. The family or any practising Sikh may help with this.

Death – Sikhs are happy for non-Sikhs to attend to the body. Sikhs are always cremated. This should take place as soon as possible.

Post Mortem – no objection

Special Consideration – Sikhs do not have a specific holy day: British Sikhs have adopted Sunday as the holy day, prayers are read up to five times a day.

We strongly recommend you follow:

FIRST AID (As per point 7.3 in the Code of Conduct for Carers)

This has already been dealt with in Section One chapter 3 briefly for emergency situations, but is now covered in greater depth.
First Aid is defined as the initial assistance or treatment given to someone who has been injured or who is suddenly taken ill.

It is NOT a substitute for proper professional medical treatment, and a doctor should always be consulted once a casualty has been made safe and placed out of danger.

If it is a matter of judgement as to whether a casualty should visit his or her doctor, or whether an ambulance should be called. If there is any doubt whatsoever CALL AN AMBULANCE by dialling 999/112
**When calling 999/112, the operator will need to know your name, telephone number and exact location, what has happened, how many people are involved, the extent of injury, if the casualty is alert, conscious or breathing as well as details of injuries.*

First Aid is not an exact science and you will not always have the necessary and appropriate equipment with you when you may be called upon to help someone in an emergency situation.

The Aims of First Aid are:

- To preserve life
- To prevent the worsening of any injuries
- To promote recovery

The Priorities of First Aid are:

- Assess the situation calmly & quickly
- Protect yourself and others from danger
- Assess the casualty(s)
- Deal with life threatening conditions

First aid and infection control

The following points will assist you and your client if an accident happens. We strongly advise you follow these instructions and report any incident, however small, to your Care Support Team to enable us to comply with RIDDOR Regulations, and record it in the Care Record Book.

N.B. in an emergency situation, do not give the casualty anything to eat or drink (you can, if need be, moisten their lips), as they may require an operation once they get to hospital.

Assessing a first aid situation

To help you assess the situation, you need to remember the acronym DR ABC:-

D = Danger

Check carefully before going to the assistance of a casualty that it is safe for you to do so. Remember: a few seconds doing this assessment could be enough to prevent a possible life-changing injury to yourself and/or any bystanders. Ask others to wait until you have done your initial assessment.

R = Response

If the casualty seems to be unconscious, check this by speaking directly into both of their ears, 'Can you hear me? Open your eyes'. If they do not respond, try gently rocking their shoulders.

If there *is* a response:

- Preferably leave the casualty *in the position found* and summon help if needed
- Treat any obvious condition
- Monitor the casualty either until help arrives (doctor / emergency services) or they recover

If there *is no* response:

- Shout for help
- If possible leave the casualty *in the position found,* then check and open the airway (as detailed below)

A = Airways

With a possible unconscious casualty, your first priority is to open and maintain their airway.
First, quickly check for any obstruction (e.g. false teeth, chewing gum)
Next, place one hand on the casualty's forehead and gently tilt the head back, whilst lifting the chin using two fingers only. This will move the casualty's tongue away from the back of the throat and help them to breathe more easily.

B = Breathing

You will now need to look, listen and feel (for no more than 10 seconds) to see if the casualty is breathing normally.
Look to see if the chest is rising and falling. Listen for breathing. Feel for breath against your cheek
If the casualty is breathing and you do not suspect a spinal / head injury, place them in the 'Recovery Position', ensure airway is open and re-check their breathing. If casualty is breathing move on to C = Circulation.

C = Circulation

Conditions affecting blood circulation can be life-threatening, e.g. as in severe bleeding from an injury.

- Put on disposable gloves
- Check around and under casualty for any severe bleeding
- Control and treat any bleeding
- Treat for possible shock (*see next section)*

Chest compressions and AED guidance

If casualty is not breathing;

- Call 999 / 112 for emergency help, answer their questions and follow their instructions – the operator will, if need be, stay on the phone until the ambulance arrives

Start chest compressions and rescue breaths immediately, until an AED arrives.

Pump

1. Place one hand on the centre of their chest. Place the heel of your other hand on top of the first and interlock your fingers, keeping your fingers off their ribs.
2. Lean directly over their chest and press down vertically about 5-6cm. Release the pressure, but don't remove your hands.
3. Give compressions at a rate of 100-120 per minute.
4. After giving 30 chest compressions give two rescue breaths (if confident to do so).
5. Give rescue breaths by tilting the head back, closing the nose and making a seal over the mouth.
6. Continue with the cycle of 30 chest compressions and two rescue breaths until help arrives.

Shock:

Shock occurs when the circulatory system fails, the most common cause of which is severe blood or fluid loss – this could come about through any severe injury, heart failure, serious infection, low blood sugar, burns, vomiting, drug overdose or spinal cord injury. As a result, vital organs such as the heart and brain are deprived of oxygen as the blood is no longer being pumped sufficiently around the body. The casualty will have cold, clammy skin, a rapid pulse and may feel weak, dizzy and nauseous. Your priorities are to:

- Treat any possible cause
- Help the casualty to lie down (preferably on a rug or blanket)
- Raise and support the casualty's legs ("going pale, raise the tail")

- Loosen tight clothing at the neck, chest and waist (with consent if conscious)
- Call 999 / 112, and monitor casualty's condition

Quick guide to other first aid treatments

Allergic Reactions:

Allergies may present as itching, swelling, wheezing or digestive problems, but may also progress to full-blown anaphylaxis. Your first priority is to assess the severity of the allergic reaction, remove the trigger if possible and treat any symptoms.
If the reaction starts to look more dramatic, i.e. the casualty's hands, feet and face start to swell and a red, itchy rash starts to spread quickly, they may go into anaphylactic shock so call 999 / 112 immediately. If the casualty is carrying an auto-injection of adrenaline (Epipen), pull off the safety cap and help them to administer it, placing the tip firmly against the thigh in order to release the medication (this goes straight through clothing). Keep the casualty sitting down or, if becoming pale, treat for shock by raising and supporting their legs. If there is no improvement, seek medical attention. Monitor the casualty's levels of response until help arrives.

Asthma:

The person may be wheezing, have difficulty speaking and have grey-blue colouring to the skin and lips. Reassure them, and help them to find their 'reliever' inhaler (usually this is a blue one).

Encourage the client into a comfortable position which will help them breathe more freely, often sitting leaning slightly forward helps. If the symptoms haven't improved within 5 minutes, call 999/112.

Bleeding:

For *minor cuts and grazes*, first wash and dry your hands, then put on disposable gloves. Clean the cut and pat dry. Cover the cut completely with a sterile dressing.

In the case of severe bleeding, wash and dry your hands and put on disposable gloves.
Then, putting a sterile dressing or clean cloth over the wound, apply firm pressure with your fingers/palm of your hand or you might be able to ask the client to do it themselves. If there is an object in the wound, apply pressure either side of the wound, but do not remove the object. Maintain pressure on the wound, and if appropriate raise and support the injured part above the level of their heart to help reduce blood loss. Take particular care if you suspect a fracture. The client may go into shock, so if appropriate, help the casualty to lie down keeping the injury high as well as elevating and supporting their legs. Bandage the pad or dressing firmly to control bleeding, but not so tightly that it stops the circulation – check every 10 minutes. If blood seeps through the bandage/dressing, do not remove the first dressing; apply another on top of existing dressing. Call 999/112 for emergency help.

For *nosebleeds*, ask the casualty to sit down and lean forward, to breathe through their mouth and apply pressure just above the nostrils on the fleshy part of the nose. Check after 10 minutes and, if the bleeding still persists, advise them to reapply the pressure for two more 10 minutes spans. If this continues for more than half an hour, seek medical help. Once the bleeding has stopped, advise the casualty to rest and avoid blowing their nose.

Broken Bones / Sprains:

A casualty with a fracture may have distortion, swelling and bruising at the injury site; also, twisting or shortening of a limb.
Do not try and move the injured part, but help the casualty to support it below and above the injury itself. Use towels, blankets or cushions to help support in a comfortable position.

It may be appropriate for the client to be taken by car to hospital but this will depend on the nature of their injury, how they are feeling and their pre-existing conditions. It is not appropriate call 999/112.

Remember to treat for possible shock, and monitor the casualty's levels of response and breathing until help arrives.

Burns and Scalds:

Help the casualty to sit or lie down. Flood the burnt area with cold water (immersed in a bowl of water / placed under running water). Cool for at least 10 minutes, and change the water if necessary to keep it cold. Call 999 / 112 if the burn is severe – e.g. blister the size of the palm of the hand, larger area of redness or where the skin is charred – and explain the circumstances and size / depth of burn. While cooling the burn, gently remove any jewellery or clothing, UNLESS it is sticking to the burn itself.

Do not apply lotions or creams or use adhesive dressings, and do not attempt to burst any blisters.

A sterile, non-fluffy dressing may be used, or you could cover the area with a plastic bag or kitchen film (placed lengthways).

N.B. severe burns or scalds can lead to shock, which then becomes a life-threatening emergency.

Chest Pains:

Chest pains could indicate a number of different conditions.
If a person is prone to *angina* (constriction of the chest), this will be made worse by increased demands on the body's blood supply, common with over-exertion.
They may have central chest pain, shortness of breath, sudden weakness and anxiety. Help the casualty to sit down and rest, and assist them to take their medication (spray or tablet under the tongue). If the pain persists, call 999 / 112.

A *heart attack* happens when there is sudden obstruction of the blood supply to the heart (e.g. because of a clot in a coronary artery).
Symptoms include persistent, vice-like central chest pain, discomfort high in the abdomen which is similar to severe indigestion, breathlessness (or gasping for air), ashen skin, profuse sweating and sudden faintness, dizziness or collapse.

Make the casualty as comfortable as possible, this may be the 'Lazy w' position; head and shoulders supported, slightly leaning back with their knees bent. Call 999/112 and follow their advice. The casualty may also want you to contact their GP. Try to keep yourself and the casualty as calm and relaxed as possible to avoid unnecessary stress to their heart.

Choking:

If the blockage of the airway is mild the casualty should be able to clear the obstruction by coughing so firstly, ask the casualty 'are you choking?' If they are able to speak the blockage is mild, and therefore they are able to breathe. Encouraging the casualty to cough should clear it.

If the casualty cannot speak or stops coughing, start by giving a firm blow on their back by using the heel of your hand between their shoulder blades. After each blow check to see if the item has been dislodged – it will often 'fly' out. If the item hasn't cleared repeat the process up to five times. If the item still hasn't dislodged after five back blows try abdominal thrusts.

How to carry out abdominal thrusts -
Stand behind the casualty putting both arms around their upper abdomen, put one fist between their navel and bottom of the breastbone – think 'thumb to tum' –then grasp your fist with your other hand and pull sharply inwards and upwards up to five times. Again, recheck to see if the obstruction has gone/shot out. If need be repeat the sharp blows and abdominal thrusts but, if after three cycles the obstruction has not cleared call 999/112 for emergency help. Continue the sequence until it does clear, help arrives or the casualty loses consciousness.

Hypothermia:

Hypothermia can develop when the body temperature falls below 35°C (95°F). Depending on the speed of its onset and how low the temperature eventually falls, the effects can usually be reversed. Symptoms include shivering, lethargy, disorientation and slow, shallow breathing. You can either help the casualty into bed or wrap them in a duvet. As long as they are still conscious and responding, warm drinks or high energy foods such as chocolate may help to re-warm them. Sharing your own body heat may also help. If you are unsure as to how serious the condition is, then call their doctor or the emergency services for assistance.

Poisoning:

A poisonous substance can enter the bloodstream by being 'ingested', 'absorbed', 'inhaled', 'injected' or 'instilled'. Your priorities are to find out as quickly as possible what has caused the reaction, to maintain the casualty's airway, breathing and circulation, to call 999/112 and to have ready for the ambulance crew the 'evidence' of the cause. Try and keep the casualty warm and comfortable until help arrives. DO NOT induce vomiting.

Seizures:

Seizures are due to a disturbance in the electrical activity of the brain which usually results in loss or impairment of consciousness.
The most common cause is epilepsy; other causes may be head injury, a lessening of oxygen / glucose to the brain or poisoning (e.g. alcohol). The general recognition features of a seizure are sudden unconsciousness, rigidity and arching of the back, followed by convulsive movements. Breathing may be noisy, and there may also be loss of bowel or bladder control. If possible, try to ease the casualty's fall but do not try and prevent it. Ensure any nearby dangerous objects are moved / kicked away to prevent injury.

Try and cushion the casualty's head and loosen any tight clothing around the neck. Keep talking to them and offering reassurance until the seizure subsides. Once the seizure is over, the casualty may fall into a deep sleep, so place them into the recovery position initially and then allow them to take themselves to bed. If this is the first time they have had a seizure, the seizure continues for more than five minutes or they have a subsequent seizure very soon afterwards, call 999/112.

Some people may experience a focal seizure, which may manifest as physical jerking or strange sensations in the arms or legs; the person's sense of taste, smell or hearing may also appear odd to them. In a complex focal seizure, it may look as if the person is in a trance: they may fumble at their clothes, smack their lips, swallow repeatedly or do other repetitive movements. This could lead on to a generalised, seizure, so it is best to guide the person to sit down and stay with them until they are fully recovered and aware of their surroundings.

Stroke:

A stroke (or 'brain attack') is where the blood supply to the brain has been disrupted by either a clot or ruptured blood vessel.
If you suspect a person has had a stroke, use the FAST guide to make a quick assessment:

- F – facial weakness: the casualty's mouth or eye on one side is drooping and they are unable to smile
- A – arm weakness: the casualty is only able to raise one arm
- S – speech problems: the casualty has difficulty speaking or is unable to understand the spoken word
- T – time to call phone 999/112 for emergency help if you believe the casualty has had a stroke.

Other symptoms may be a sudden severe headache, dizziness, tingling or numbness, unsteadiness or a sudden fall.
When you call for emergency help, let the ambulance control know that you have used the FAST test. Keep the casualty comfortable and regularly monitor their condition until help arrives.

A *Transient Ischaemic Attack (TIA)* is similar to a full stroke but the symptoms may only last for a very short time. It is important to seek medical advice if these symptoms start to manifest as, if overlooked, they could eventually lead to a stroke and more serious consequences.

Looking after yourself and the casualty

When dealing with an emergency incident, try and stay in control of the situation and remember to look after yourself too. It is likely you will feel nervous and may feel shocked by what has occurred, but remember to stay calm for the sake of the casualty and any other people present. Be gentle but firm with the casualty: for their own safety and best interests, you may need to insist that they do not move until help arrives.

If there are bystanders, enlist their help to make any necessary phone calls or get blankets to keep the casualty warm. If you need to make physical contact with the casualty, such as feeling for broken bones or bleeding, or loosening their clothing, explain everything you are doing, and why. Keep reassuring your casualty, even if they seem to be unconscious: remember, your hearing sense is the last sense to go and the first to return as you come back to consciousness. Do not leave your casualty until help arrives.

Involvement in any emergency situation may possibly lead to a delayed reaction, once the trauma is over.

Afterwards you may experience tearfulness or shakiness, feelings of isolation or irritability, flashbacks and repeated analysing of the incident itself, and sometimes insomnia or lack of appetite. These are all perfectly normal reactions, but it may be useful for you to take some time out for yourself to relax more fully and / or have a change of scene for a while. If the symptoms persist, do talk to your Support Team at Christies or visit your GP who may be able to refer you to a local counselling service.

We strongly recommend you follow:

SAFER PEOPLE MOVING AND HANDLING (As per point 7.3 in the Code of Conduct for Carers)

This section of the guidelines contains, (amongst other notes) a summary of some of the visual aids used when we deliver the training. It is intended to give you an understanding of the theory of moving and handling, as well as the opportunity to look at and discuss moving and handling aids.

Laws which concern moving & handling

The Health & Safety at Work Act 1974 (this law is included for your information)

The general duty imposed on all employers is to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees.

The employer has further duties that include:

- Provision and maintenace of plant and safe systems of work;
- Safety in the collection, use, storage and transport of loads and substances;
- Provision of information, instruction, training and supervision of employees;
- Maintaining a safe workplace, access to and egress;
- Maintaining a safe and healthly working environment, including providing adequate welfare facilities.

The employer also has a duty 'to prepare and revise a written statement of his general policy with respect to the health and safety at work of his employees and the organisation and arrangements for carrying out that policy, and to bring the statement and any revision of it to the notice of all his employees.

Duties of the employees

All employees must take reasonable care for the health and safety of themselves and of other persons who may be affected by what they do or fail to do at work – their acts or omissions. This duty includes taking positive steps to understand the hazards in the workplace, to comply with safety rules and procedures to ensure that anything they do or fail to do does not put themselves or others at risk.

The Management of Health & Safety at Work Regulations 1999

Every employer shall make a suitable and sufficient assessment of:-

(a) The risks to the health and safety of his employees to which they are exposed whilst they are at work; and
(b) The risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking.

All those affected should be made aware of the risks and appropriate measures in place to reduce these risks.

Specific risk assessments should be in place for young people at work (i.e. under the age of 18 years of age) and new or expectant mother (i.e. employees who are pregnant, who have given birth within the previous six months or who are breast feeding).

There is a duty to review risk assessments if there is a reason to believe it is no longer valid or there has been a significant change to which it related and where changes to the assessment are required, the employer must make them.
Employees' Duties

Every employee shall take care of their own health and safety. This includes using the equipment in accordance with any training and instructions they have received. The employee has an additional duty

to report unsafe working practices where the situation presents immediate danger or adequate protective arrangements by the employer are not in place.

Manual Handling Operations Regulations 1992

Manual handling operations means any transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or bodily force. 'Load' is anything which is moveable, i.e. inanimate object, person, or animal.

The employer's duty is to avoid Manual Handling as far as reasonably practicable if there is a possibility of injury. If this cannot be done then they must reduce the risk of injury as far as reasonably practicable. If an employee is complaining of discomfort, any changes to work to avoid or reduce manual handling must be monitored to check they are having a positive effect. However, if they are not working satisfactorily, alternatives must be considered.

The regulations set out a hierarchy of measures to reduce the risks of manual handling. These are in regulation 4(1) and as follows:-

- **Avoid** hazardous manual handling operations as far as reasonably practicable;
- **Assess** any hazardous manual handling operations that cannot be avoided;
- **Reduce** the risk of injury so far as reasonably practicable.
- **Review** any assessment if there is reason to suspect that it is no longer valid, if there has been change in the manual handling operations or an injury has occurred.

In addition, employees have duties to take reasonable care of their own health and safety and that of others who may be affected by their actions. They must communicate with their employers so that they too are able to meet their health and safety duties.

Employees have general health and safety duties to:

- Follow appropriate systems of work laid down for their safety;
- Make proper use of equipment provided for their safety;
- Co-operate with their employer on health and safety matters'
- Inform the employer if they identify hazardous handling activities;
- Take care to ensure that their activities do not put others at risk.

Lifting Operations & Lifting Equipment Regulations, 1998 (LOLER, 1998)

These regulations apply to the use of lifting equipment in all sectors of the industry and in all work activities. These regulations complement the MHOR, 1992 and PUWER, 1998).

Is it lifting equipment?
To identify equipment you need to apply the test of primary purpose or principal function. On this basis hoists and bath hoists would be lifting equipment, but electric riser-recliner chairs or height-adjustable beds would not be, on the grounds that they are primarily chairs and beds respectively.
Lifting equipment provided for use in the homes of clients would be covered by the LOLER, 1998 if it is operated by employees, but not covered if operated only by relatives, friends and so on.

Employers must ensure that equipment for lifting persons is thoroughly examined at least every six months.

Records of examination should be kept for inspection purposes and any defects must be reported.

All employees must have adequate training and instruction for use, so that they are able to ensure that the lifting equipment is safe to use, e.g. pre-use checks, checks on a day to day basis to detect wear and tear and malfunction. This overlaps with PUWER, 1998.

Provision & Use of Work Equipment Regulations, 1998 (PUWER, 1998)

These Regulations cover all equipment used at work, including manual handling equipment e.g. handling belts, slide sheets, transfer boards etc.

'Every employer shall ensure that work equipment is used only for operations for which, and under conditions for which, it is suitable'.
Suitability means: 'Suitable in any respect which it is reasonably foreseeable will affect the health or safety of any person'.

Duties are also imposed on the employer to provide information, instruction and training for people who use work equipment.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulation, 2013 (RIDDOR)

Reporting accidents, incidents and ill-health at work is a legal requirement as an employer or someone in control of work premises under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013. The information enable the HSE and local authorities to identify where and how risks arise and to investigate serious accidents. The authorities should be notified as soon as possible in the event of the following:

- Deaths
- Major injuries – fracture, other than to fingers, thumbs and toes, amputation, dislocation of the shoulder, hip, knee or spine, loss of sight (temporary or permanent), chemical or hot metal burn to the eye or any penetrating injury to the eye, injury resulting from an electric shock or electrical burn leading to unconsciousness, or requiring resuscitation or admittance to hospital for more than 24 hours, any other injury leading to hypothermia, heat-induced illness or unconsciousness, or requiring resuscitation, or requiring admittance to hospital for more than 24 hours, unconsciousness caused by asphyxia or exposure to a harmful substance or biological agent, acute illness requiring medical treatment, or loss of consciousness arising from absorption of any substance by inhalation, ingestion or through the skin, acute illness requiring medical treatment where there is reason to believe that this resulted from exposure to a biological agent or its toxins or infected material.

  It is required to report injuries that lead to an employee or self-employed person being away from work, or unable to perform their normal work duties, for more than seven consecutive days as the result of an occupational accident or injury (not counting the day of the accident but including weekends and rest days). The report must be made within 15 days of the accident.

  A record of the accident must be kept if the worker has been incapacitated for more than three consecutive days. An employer must keep an accident book under the Social Security (Claims and Payments) Regulations 1979, that record will be enough.

Disease
If a GP notifies the workplace that an employee is suffering from a reportable work-place related disease then this must be reported to the authorities. Diseases include:

- Certain poisonings
- Some skin diseases e.g. occupational dermatitis
- Some lung diseases e.g. occupational asthma, farmer's lung, asbestosis
- Infections such as tuberculosis and legionellosis
- Certain musculo-skeletal disorders, decompression illness and hard-arm vibration syndrome.

Dangerous Occurrences

If something which does not result in a reportable injury, but which clearly could have done, this too must be reported. These include a 'collapse, overturning or failure of load-bearing parts of lifts and lifting equipment'. This would include patient hoists and accessories.

Ergonomics and Biomechanics

Ergonomics is the scientific study of often complex relationships between people and their occupations. A leading article in The Lancet (1965) entitled "The Nurse's Load," began with these words:

The adult human form is an awkward burden to lift or carry. Weighing up to 100 kg, or more, it has no handles, it is not rigid, and it is liable to severe damage if mishandled or dropped. In bed a client is placed inconveniently for lifting, and the placing of a load in such a situation would be tolerated by few industrial workers.

Biomechanics is the application of mechanical principles to the human body.

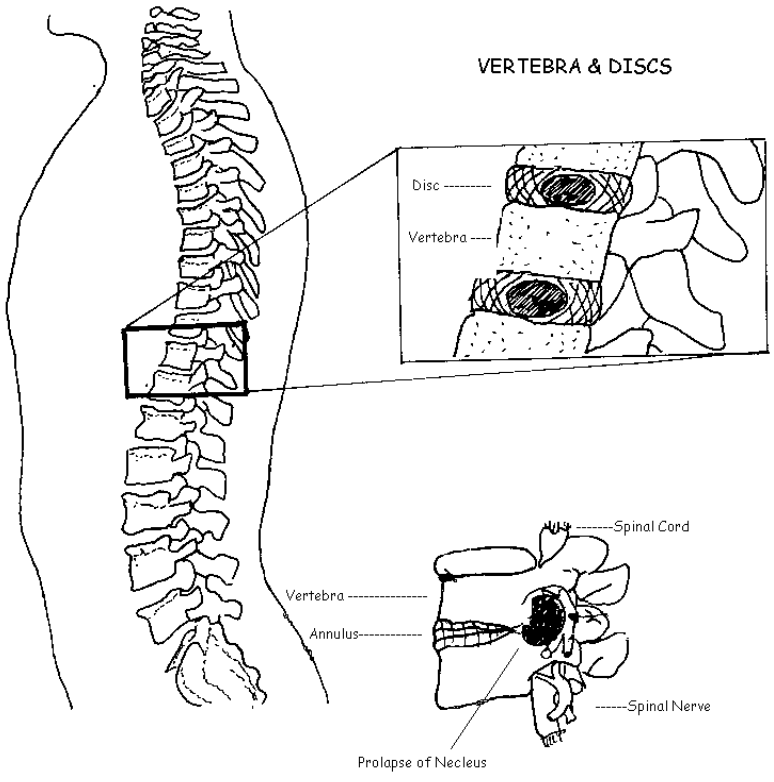
We need to develop our knowledge of body behaviour to help identify hazards, for example: heavy loads, risky positions, unsafe environments.

Biomechanics enables us to look at the relationship between the heavy loads and risky positions.

The body is put into a state of 'stress' and 'strain' when it is subjected to externally applied force(s). In mechanical engineering the terms stress and strain have precise meanings:

Stress is the internal resistance set up in a material when the shape is changed by the application of an externally applied force, e.g. a toothpaste tube being squeezed.

SIDE VIEW OF SPINE



A material is strained when the shape is changed by the application of externally applied force, e.g. trees standing in the path of the wind get blown to a new angle. In Biomechanics, there are terms for movements:

Flexion	bending or decreasing the angle between the parts of the body
Extension	straightening or increasing the angle between the parts of the body
Adduction	moving (arm/leg) towards the mid line of the body. If you squeeze your knees together, you are adducting your legs.
Abduction	moving (arm/leg) away from the mid line of the body. When you stand with your feet apart, your legs are in abduction (abducted).
Medial Rotation	turning towards the mid line of the body
Lateral Rotation	turning away from the mid line of the body
Pronation	rotating forearm so that the palm faces down
Supination	rotating forearm so that the palm faces up
Positioning Movements	involves movement of part of the body from one place to another

The Handling Environment

Prepare the workspace

Human bodies need room to manoeuvre all around in the course of handling other human bodies. Carers have to be very aware of the space in which they work. Their handling posture must be stable. They need space behind them as well as in the direction they intend to move the client.

More room is needed when using handling equipment. The space must be clear of obstructions and hazards or potential hazards.

This means taking positive action. All carers will learn to modify and manipulate the space in which they work: and this is the application of user ergonomics. The space between the chair and the commode; the height of the bed; the position of the bedside table or anything that may get in the way; even the space between beds where there is more than one bed in the room; the carer must be prepared to make the best use of these spaces. However, if the carer regularly has to move beds, etc., then this task in itself causes strain.

Responsibility then falls to the client, or to management, to find a solution: for instance, remove the spare bed, re-arrange the room permanently etc.

The question of space and access can be critical, particularly in the community. Consider, for instance, a client sick at home following discharge from hospital, lying in a double bed in the corner of a crowded room.

Before a client returns from hospital there should be ample time to plan the environment in which the carers will have to work and in which the client's rehabilitation will have to continue. This is a matter for safe discharge procedure (Department of Health) and proper communication between the Health Authority Community Nursing Service and the Local Authority, Social Services Department.

Assess the risk

Before carrying out any manoeuvre, you need to RISK ASSESS:

- The Task
- The Individual
- The Load
- The Environment
- The Equipment

TILEE: Think of building Tiles– Everything fits together

The Task

- What has to be done?
- What basic principles will I use?
- What is the risk of sudden movement of the load/person?
- What must I do before I start the task?

- How many people will be needed?

The Individual

- Are you well enough?
- Are you fit enough?
- Do you have the necessary training?
- If working in pairs, are your heights evenly matched?
- Are you dressed correctly (clothes – shoes – jewellery)?
- Are you sure what you must do and how to do it?

The Load

- How heavy is your client? Recommended maximum weight load for a woman to lift on her own – 2st 8lb/16.6kg. For a man – 3st 13lb/25kg
- Does your client need help?
- Can/will your client co-operate?
- Have you looked at the care plan?

The Environment

- Is there enough space to work?
- Is the floor slippery/uneven?
- Is it warm enough?
- Is there sufficient lighting?
- Are there any obstacles in your way (before, during and at the end of the move)?

The Equipment

- What equipment do I need?
- Is it in good working order?
- Is it suitable for the task and load/person?

Keep Your Spine in its Natural Curve

Every time you use human effort directly or indirectly to do any of the following:

- Transport
- Support
- Lift
- Put Down
- Push
- Pull
- Carry
- Move an object/person by hand or bodily force

Give the right command

It is recommended that the commands 1, 2, 3 are NOT used. It is uncertain for the client and the carer.

The recommended commands are: <u>READY, STEADY,</u> (Slide – stand – sit)

This needs to be said with conviction and both client and partner (if one is used) should be aware of the commands to be used.

NEVER TAKE CHANCES! IF IN DOUBT DON'T DO IT!

Good Moving and Handling technique

Listed below are some important points to consider, when handling anything, here we refer to handling a box:

- Stop and think: Plan the move. Where is the box to be placed? Use appropriate handling devices if possible. Do you need help to transfer? Remove obstructions. Assess the task to be performed and nature and weight of the box, perhaps it is not regularly shaped or its weight is uneven, the environment in which you are moving and your own capability. Avoid long transfers, such as floor to shoulder height - consider resting the box mid-way on a table or bench in order to change grip.
- Position your feet: Keep your feet apart, giving a balanced and stable base for moving. Leading leg as far forward as is comfortable.
- Get a firm grip: Try to keep your arms within the boundary formed by your legs.
- The best position and type of grip depends on the circumstances and individual preference, but it must be secure.
- Adopt a good posture: When transferring from a low level, bend your knees. Keep your spine in its natural curve (tucking in your chin helps). Lean forwards a little over the box if necessary to get a good grip. Keep your shoulders level and facing in the same direction as your hips.
- Put down, then adjust: If you have got to put the box down in an exact position, put it down first, then slide it to where it should go.
- When it comes to moving people, sliding devices are widely available to help handlers in moving and handling and transferring.

Moving and Handling and transferring in teams or pairs

- WORK with someone of similar build and height, if possible.
- COMMUNICATE with your partner (and client) in planning and preparing the move.
- CHOOSE one person to call the signals.
- TRANSFER using the power of your legs.
- MOVE smoothly and in unison.

Moving objects above head height and lowering

This will not apply to moving your client, but you may be asked to move objects in your client's house.

- IDENTIFY nature of the load.
- LIGHTEN the load, if possible.
- STAND on something sturdy, with one foot in front of the other, unless using a stepladder.
- GET help if the load is awkward or heavy.
- TEST the load weight by pushing up on it. Check to see if the load will shift when you move it.
- STAND as close to the load as possible.
- GRASP the object firmly, sliding it down your body.

Pushing and pulling safely

Whether using a shopping trolley or pulling a piece of furniture, the following advice should assist you to push and pull safely.

- STAY CLOSE to the object.
- GET A GOOD GRIP on it.
- KEEP YOUR SPINE IN ITS NATURAL CURVE, stomach in, knees bent.
- LEAN IN THE DIRECTION you're pushing or pulling.
- WATCH OUT for obstructions.

REMEMBER: KEEP THE STRAIN OFF YOUR BACK. LET YOUR BODY'S WEIGHT AND LEG MUSCLES DO THE WORK FOR YOU

Moving people safely

You must not try to handle a client until you have been properly instructed in the principles of safer moving and handling and shown how to transfer correctly for both your and the client's safety.
Certain clients may be provided with mechanical handling devices such as hoists, etc. You should not attempt to use them unless you have received proper instruction.

You should only use the procedures with which you are familiar. Never guess the correct procedure or improvise a technique. Do not hesitate to ask questions or seek help if you are unsure what to do.

The following advice will give you examples of appropriate techniques of moving and handling:

YOU MUST:

- Learn and apply the principles of safe moving and handling
- Check each client's condition and moving requirements beforehand.
- Do not attempt to move anyone or anything beyond your capabilities. Seek help if you need it.
- Keep yourself in shape for moving and handling and report any problems to your Care Support Team. When moving clients you must always follow these 7 points:
  1. Keep your spine in its natural curve to protect ligaments, joints and muscles.
  2. Keep your head erect and keep chin tucked in. This helps keep your spine in its natural curve.
  3. Use your thigh and buttock muscles.
  4. Keep your feet apart to give a stable base, hip width is usually comfortable.
  5. Keep your elbows close to sides. This gives greater muscle force efficiency.
  6. When working with another person, both of you must have received instruction on moving and handling.
  7. Do not attempt any moving and handling with a full bladder.

Total Transfers should only be performed when a detailed Moving and Handling Risk Assessment has been carried out which has indicated that:

1. There are no alternative means of moving the client e.g. sliding, rolling.
2. The client's weight is within recommended safety limits for handlers.
3. The handlers are trained in moving and handling techniques.
4. The handlers are fit.

Mechanical handling devices

Mechanical handling devices must be used according to the manufacturer's instructions and in situations for which they were specifically designed. You will be trained how to use mechanical devices correctly and will be supervised until you are proficient and confident in their use.

- Before you move your client, evaluate the situation.
- Before moving and handling, decide how you are going to do it and who will lead the moving procedure and will signal when starting the operation (if working alongside another carer).
- Move any items of furniture e.g. chair, bed, tables and stools to give you a clear uncluttered area for moving your client.

Process of handling

- ASSESS: Ensure you are aware of the client's ability, weight and unpredictability before moving and handling and if the client is too heavy or awkward do not attempt to move the client. Arrange for assistance.
- PLAN: Always agree on a signal so that handlers and client move together.
- PREPARE: Clear the area in which you are working and ensure adequate space.
- MOVE: Move the client smoothly at their own pace.
- EVALUATE: After completion, make sure the client is comfortable. Replace any articles moved and leave area tidy.

You could be injured when moving and handling due to:

- Not maintaining a correct posture and not keeping your spine in its natural curve.
- Using inappropriate techniques.
- Attempting to move too heavy a weight.
- Sudden movement, which causes strain on muscles - prepare for moving and avoid tension (expect the unexpected).

- Turning and twisting the body at the same time when lifting. During the move, keep the body poised with good muscle balance. Adjustment of balance between the upward move and the turn must take place independently.
- Working with a person whose capabilities and height are unequal thus putting additional strain on one carer.
- Slipping whilst moving - The floor should be very dry and have a non-slip surface. If there is a loose rug, move it to one side; if there are polished tiles, wear crepe or rubber soles. Footwear should be suitable to ensure good firm balance.
- Unpredictable or uncooperative clients.
- Existing health problems and injuries.

Appropriate clothing

You should make sure your uniform/clothing allows you to adopt a wide base stance and that you do not have to adjust your clothing or compromise your dignity whilst handling clients. Shoes should be flat, closed in and supportive. Do not wear jewellery as this can 'nick' the skin of older people. Ensure your nails are well trimmed. Do not wear "dangling" earrings, large ornate rings or necklaces. Long hair should be tied back.

Manoeuvres demonstrated and practised

In this section, we are assuming that the client's weaker side is their RIGHT. If it isn't, apply the instructions as being from the other side. The manoeuvres that were demonstrated and practised during the training session were:

- Tell your client what you are going to do.
- If the client is in a wheelchair, put the brakes on.
- Assist the client to the front of the seat using the appropriate method, as below.
- Ensure that the client's feet are placed flat on the floor, one foot slightly in front of the other.

To enable the client to move to the edge of the seat

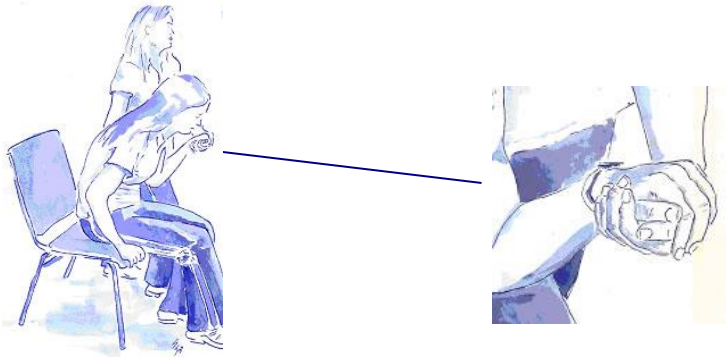
- Client to do an independent shuffle
- Client to cross over leg, one after the other – 'can can'
- Carer to perform the assisted shuffle – client to lean to one side of chair with both hands on the chair arm. Carer to slide opposite buttock forward from the hips, with slight pressure to side of knee to ease legs forward. Same on the opposite side.
- A handling sling placed around the client's hips could assist them forward.

Assisting a client to stand from a sitting position when the client can weight bear and transfer to another seat

Palm to palm move

1. Carer to stand one side of the client, generally on the weaker side. If the client's right side is the weaker, then assist from the right side – carer facing forward, feet slightly apart with one foot in front of the other, knees bent, back upright keeping the spine in its natural curve. Carer to place left hand across to the far hip on the clients back, if using a handling belt use the correct hold. Carer's right hand to hold the client's right hand using the correct handhold (fist or palmar hold).
2. Client to have head over toes and use stronger arm to help push up from the chair.
3. Use commands that both client and partner (if using one) are aware of. *Ready, Steady Stand* is the recommended command.

4. Client and carer take one movement forward together in unison.



Sideways step move – Palmar hold

Face the side of the client, stand in the dynamic stable base. Palmer hold or fist hold the client's hand nearest to you, place your other arm across the client's back to other hip or middle of their back, if you are using a handling belt hold it appropriately. On command step forward with lead leg in direction of travel, mirror with back leg. Start stable, finish stable. Step towards client if necessary to stabilise them.

Sideways step move – Variation Palmar hold

Face the side of the client, stand in the dynamic stable base. Palmer hold the clients shoulder nearest to you, place your other arm across the clients back to other hip or middle of their back. On command step sideways with lead leg in direction of travel, mirror with back leg. Start stable, finish stable. Step towards client if necessary to stabilise them.

Handling Belt

A handling belt is to give a client guidance, support and confidence. It should NOT be used to lift a client or take their weight. Hold the loops on the handling belt with the fingers and thumb (in a fist hold) with the knuckles facing away from the belt.

Reverse Palmar Hold on the shoulder

A client can also be assisted to sit down using the 'Palmar Hold'. Stand facing the opposite direction of the client. Your hand (nearest the client's body) place towards the client's far hip across their tummy, your other hand toward their shoulder blade nearest to you, take a lunge step forwards toward the back of the chair.

To Assist To Back of Chair

To assist a client back into a chair you can use a pillow to protect the kness and push back whilst they are lifting their bottom slightly off the seat of the chair OR kneeling down at the side of the client, the client can then place their foot on your knee and then push themselves back into the chair independently.

Assist client to put feet to the floor from the bed

Client sits on flexidisc or sliding sheet on the bed, (sliding sheet under feet) to enable the client to move round so feet are able to be placed to the floor, supporting both ankles, or use the handling sling. Remember to keep yourself ergonomically correct and not to twist.

Assist client to sit up in bed

Profiling bed, rope ladder or bridge could be used to assist the client to sit up in bed.

Assist Client To Stand From The Edge Of The Bed

Palmer hold – carer sits next to the client on the bed.

Assisting Client Up and Down Stairs

Going Up The Stairs

Stand to their side facing the same way as the client, one foot on the same step, and your other foot on the lower step to the client. Your arm nearest to the client should be holding the handrail (your arm across their back), your other arm supporting the client on the front of their shoulder with the palmar hold.

Coming Down The Stairs

Stand to their side facing the opposite way to the client (client facing bottom of stairs, you facing the top of the stairs), one foot on the same stair and the other on the step below. Your nearest hand to the client holding the handrail (your arm across their stomach), your other hand supporting the client's shoulder (near should blade) using the palmar hold.

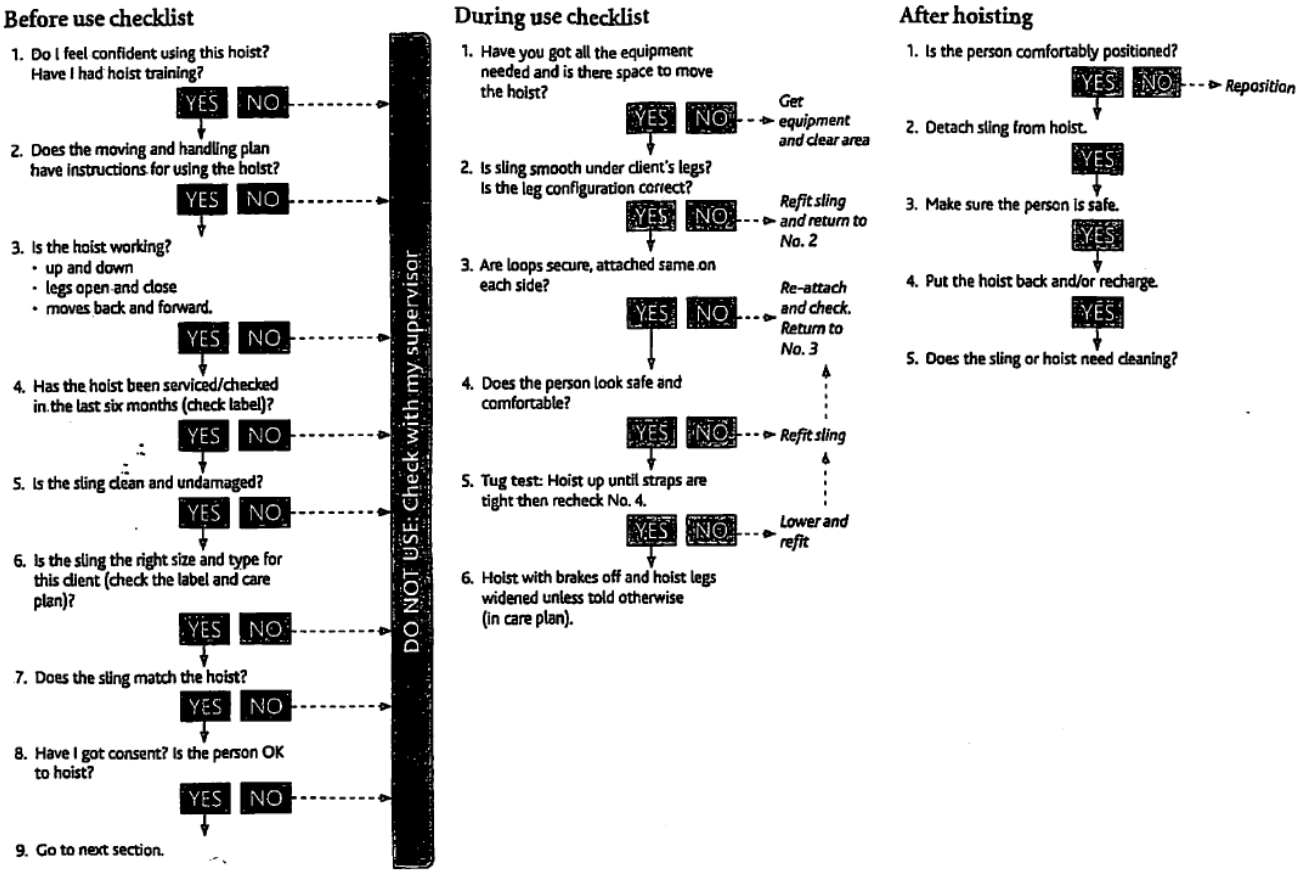
Hoist Client From Bed To The Chair

Using the hydraulic hoist, to hoist client from the bed using the appropriate sling. Place the sling under the client by using the 'log roll'. Hoist the client from the bed, supporting head and neck if necessary, with the sliding sheet under their feet move the hoist slightly from the bed. Gently slide their feet off the bed using a pillow over their knees/shins move them round to face the mast. Wheel the hoist to the chair and lower them into a good seated position. Remove the sling from underneath the client.

Sling – Read the clients moving and handling risk asssesment for guidance on which straps to use on the sling as it is specific to each person.

Assisting the client up from the floor

When the client is weight bearing - assist the client by the means of two chairs, client should be able to do this on her own with moral support and guidance from the carer. If the client can get on all fours (hands and knees), chairs can be placed with the seated area facing each other.



When the client is non weight bearing - suitable hoist, chair with seat and back of chair on the floor, client sat on the floor with knees slightly up, their back to be against the back of the chair. Sling to be put correctly in place. One hoist leg to go through V of chair, the other hoist leg to go under the client's legs, spreader bar of the hoist to be across the chest of the client.

Sling to be attached to the spreader bar. Client then hoisted. If necessary the client can also be hoisted from a flat position.

Turntables and transfer boards

Turntables for clients are placed under the feet in a seated position, NOT for client to be stood on free standing. Transfer/sliding boards – for bridging the gap from one area to another e.g. a wheelchair into car.

Flexi-disc

Placed under the client's bottom to assist them to turn easier.

Unsafe Practice

The Original Four

The Drag Lift
The Orthodox Lift
Lifting with the client's arms around the carer's neck
The use of poles and canvas

The Drag Lift (or any version of it)

This lift has been condemned since 1981 but is still commonly used. The reason it is commonly used is because the under arm (axilla) offers an ideal 'handle' to get hold of to drag people up from a chair/wheelchair to stand or transfer or move further up in bed. The Drag Lift is dangerous for the carer as it can cause injuries to the spine, shoulders, wrists and knees. It can also cause hernias. It is dangerous for the client as it causes friction and shearing that contribute to the development of pressure ulcers. It can also cause dislocated shoulders.

The Orthodox Lift

This lift has been condemned since1987 and has been the second most common cause of injuries to carers. It is as dangerous as the Drag Lift. A Carer is not able to position herself in a safe position (twisting her back whilst in a stooping position). The heels of the client may drag on the bed causing sores.

The Use of Poles and Canvas

The use of poles and canvas is no longer acceptable as it involves a total body lift usually at waist height, meaning that the lift has to be done with arms and shoulders. The legs are usually already straight so they cannot help with the lift. It is usually also necessary to lean over the bed or twist or reach onto the bed.

The previous techniques have been criticised for some years, but carers are still being injured by performing manoeuvres that have not been previously condemned.

The Australian or Shoulder Lift/Slide

The use of this lift has been the leading cause of injury to carers. The full weight of a client was transferred by the means of the client placing their arms over the back of the carers, a carer each side of the client joining their arms underneath the client's thighs and then lifted. This means that the carers twist their backs while stooping forward holding the full weight of the client.

Not only does this lift cause injury to the carer, it also causes injury to the client such as: the force of the carer's shoulder can cause breathing difficulties for the client, the bend of the body is not suitable for clients with abdominal or chest wounds, clients with arthritis and similar conditions in their shoulders, arms or hips are hurt by getting into the posture for the shoulder lift and it can cause further damage to the shoulder or hips.

Standing In Front of a Client

Pivot Transfer

The client held the carer around their neck and if the client lost balance they would drag the carer causing injury to the carer's neck and also to themselves.

Elbow Hold

Similar to the Pivot Transfer but has one difference – the client is 'bundled' Up with their head under the carer's arm. All the dangers of the Pivot Transfer apply to this lift but there are also other dangers; the client must not try to stand up as they will lift the carer and be unbalanced. This will cause the carer and client to fall together. If this manoeuvre is used against a wall the client may feel that their head is going to be banged against the wall and they then try to pull back when the lift is done. Again this causes the carer and client to be unbalanced.

Bear Hug

The dangers are similar to the Pivot Transfer but again there are added dangers.

Holding the client up whilst the carer and client shuffle round has a risk that they may stumble and fall.

The client cannot see their own feet so finds it difficult to move them or becomes confused and trips over their own feet. Therefore inappropriate for clients who have had strokes or for clients who have problems coordinating or controlling their bodies. Also when the client falls the whole of their weight is put onto the carer's body.

Arm and Leg Lug

Carers hold the client under each arm (axilla) and one hand under the client's thigh. Half the load is applied under the arm. The carers take the full weight while in flexion and uses twisting motions. The disadvantages have already been identified in the Drag Lift

Drag Lift with a Walking Frame

The carer carries out the Drag Lift whilst the client holds onto the walking frame. The walking frame is unstable and needs to be stopped from toppling over. The only way that this can be done is for the carer to place her foot on the frame to hold it still.

This makes the carer's stance even worse than the Drag Lift and there is also the potential for the walking frame to break and dig into the carer's leg. The injuries incurred to the client are as with the Drag Lift.

Pulling the client up from a chair

The method of standing in front of the client and holding on to their hands and pulling them to a standing position is dangerous for both carer and client. An approach from the front causes there to be no stability and can cause a reflex pull in the opposite direction. The carer may be trapped in a sideways fall and it can also cause the client to have shoulder injuries.

Moving the client across the bed

The Flip Turn

The carer stood at the side of the bed and placed her arms under the client, then pulled the client toward her and simultaneously lifted and rolled the client away from her. For the carer this has a risk of lower back and/or shoulder injuries. The risk for the client is the generation of bedsores through friction and also of rolling the client out of bed.

Poor Posture

Using Flexion

By having the knees straight and the back bent puts extra stress on the spine, by twisting while flexing increases the risk of injury to the carer. Examples are repositioning a client's feet, putting socks or shoes on for a client, assisting with feeding and talking to the client.

Other Unsafe Techniques

Cross Arm Lift

Two carers hold the client under the arms and then a handling sling is placed under the client's bottom. The carers are twisting whilst taking the full weight of the client.

Taking all or most of the weight of the client

Excess weight

Never <u>catch</u> a falling client; this can cause injury to you as well as client. If you are in a good position a <u>controlled</u> fall could be carried out.

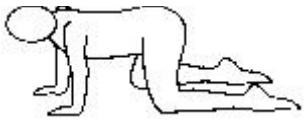
Using linen sheets to lift or drag

Sheets would rip and tear. The carer is also taking full body weight.

Exercise for a better back

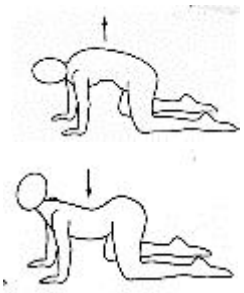
Spinal Mobility Exercises - perform daily

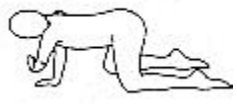
These exercises should be carried out slowly and deliberately. If you have pain when you perform any of them, limit the particular exercise movement so that you are comfortable. If you feel pain when you start any movement, then it should not be carried out.



Starting position for all exercises is on all fours. Hands should be placed shoulder width apart, arms and thighs vertical. Use an exercise mat if you have one.

Arch the back, at the same time, look down at the floor. Then lower the stomach towards the floor, hollowing the back and at the same time look up to the ceiling. (If you are pregnant you should not do the second part of this exercise hollowing your back, instead keep your back straight)
Repeat 10 times.





Slowly walk the hands around to the right, back to the starting position then around to the left.
Repeat 5 - 10 times.

Raise one hand off the floor, reach underneath your body as far as you can.
On the return, swing the arm out to the side as far as you can then return to the starting position.
Follow the moving hand with the eyes. Repeat with the other arm.
Repeat 5 - 10 times.

Draw alternate knees to the opposite elbow.
10 times

Repeat 

Stretch one arm forward in front, at the same time stretching the opposite leg out behind.
Repeat 10 times

Swing the seat from side to side in a controlled manner.
Repeat 10 times.

Sit back on your haunches. Lower the body forward and down so that the nose goes as close to the ground as comfortably possible. Move forward, running your nose along the ground as far as you can go before coming upright and repeating.
Repeat 10 times.

ASSISTING WITH PERSONAL HYGIENE AND APPEARANCE (As per point 7.3 in the Code of Conduct for Carers)

Helping with appearance

In principle, we advise that you should encourage your client to be clean and tidy, to be dressed smartly and turned out well. But, we recommend you check first, does your client want to look smart and well dressed? Does he like being unshaven? We suggest that you follow your client's wishes. You are there to offer your client a care service – NOT to impose your standards on him/her! You have got lots of time and we suggest you encourage the use of make up or jewellery if appropriate. Your client may be shy about wanting to bother with either or both.

Even if your client is totally casual about the clothes he or she wears, we suggest you must aim at a certain minimum standard. We advise that you should try to change socks and underwear every day, shirts, blouses, etc. two or three times a week. Encourage washing and teeth cleaning every day, and hair washing and bathing at least once a week. However, we suggest that you must remember that your client will make his/her own decision even if that may not be in accordance with your advice. If you have any concerns about a client's personal hygiene contact the support team for advice.

Washing hair

There are many hairdressers who operate an at-home service. We suggest you discuss the possible use of these services with your client. We advise that you discuss hair washing with your client and follow his or her wishes.

We recommend:

- Make sure that all equipment needed is near to hand.
- Use the hair products your client likes best.
- Ask your client to test the temperature of water to be used if possible. If this is not possible, test using your own elbow, or a water thermometer.
- Find the most comfortable position for your client, at the same time ensuring their safety.
- Protect the furniture and the clothing of your client from water.
- Massage the scalp gently, do not rub, ensuring that shampoo is worked into the hair and rinsed out thoroughly afterwards.
- Dry hair thoroughly but gently using a clean, dry towel. Finish drying with a hair dryer if available.
- Brush or comb from the roots to the ends of the hair. If necessary put gentle pressure on so that untangling does not pull at the roots of the hair.
- Do not assume that a client with little hair does not wish it to be combed or brushed. The scalp will be healthier for some stimulation.
- When using pins and grips, take care not to scratch the scalp or pull the hair.
- Should a lotion have to be rubbed into the head, do it with the tips of the fingers – gently. Take care that you do not get hair spray in your client's eyes.

Cutting nails

- We advise that you should NOT cut or clip toenails.
- The reason for this is that, should nail cutting result in a skin cut, infection can set in which could lead to gangrene. This applies especially to the toenails of clients suffering from diabetes, heart disease or circulatory problems. If in doubt, you may contact us for advice, if you wish.
- If attention to toe nails and feet is needed, this should be noted and reported so that a chiropodist can be called. Carers are advised to not cut toenails.
- Use only sharp nail scissors or clippers to cut fingernails. Kitchen scissors or dressing scissors are not suitable.
- Use emery boards to smooth any rough edges of the nails after cutting.

Dressing and undressing recommendations

How much do you help?
The general rule is to help as much as needed and wanted, but no more. Most people prefer to dress and undress without help, then, perhaps, a little help with some clothes. Similarly, most clients like to choose their own clothes. The good carer follows her client's wishes, helps the client choose the clothes they like and which suit their physical needs, taking into account such things as mobility, continence etc.
Have you got the right clothes?
As people become less able to look after themselves so they should consider special clothes, which help reduce the effect of their disability, whatever it is. However, you must be careful here.

Think of your client's vanity (wanting their favourite skirt although now she has grown too big) and their dignity (most people hate getting older and will be reluctant to accept aids offered, especially as they may not look as nice). We list some of these aids in the papers which follow. Your client's occupational therapist may also be able to give you advice.

Potential Difficulties

Do not, however, infringe your clients' right to make their own decision just because you think something should be changed. Sometimes, your client will be reluctant to change clothes, but they are dirty. Try removing them at night and putting out fresh clothes for the morning. Do not rush your client. Your job is to follow their view, where possible, and to allow them to do as much for themselves as they like. Offer help as needed. Maintain their dignity and modesty at all times.
There are many different ways to help dress or undress your client. Below are a few ways of how it may be done.

Clothes on

Socks and Stockings

Open up the sock wide and carefully placing over foot and up and over the ankle, or by rolling down the sock to the toe, placing on the toes and rolling over the foot, over the heel and up the leg. Both ways may be done whilst the client is sitting or lying down.
Elastic-topped self-supporting stockings may be easier than tights. If she uses suspenders, check your client isn't sitting on them in discomfort.

Look out for socks or stocking that are tight, which may inhibit circulation. Watch for skin swelling over the tops of socks and stockings. If this happens, you could encourage your client to try longer socks or stockings. Swelling of the legs and ankles can be a sign that medical attention may be required. Call a doctor if necessary.

Underwear

If the client is sitting down, then place the underwear over the feet and pull up to the knees. If the client is lying down, again pull over the feet and over the knees.

Trousers

Whether the client is sitting or lying down, put leg of trousers over one foot and then other leg of trousers over the other foot and pull up to the knee.

If the client is lying down then roll the client onto one side pulling up underwear and trousers, then roll them on the other side pulling up underwear and trousers. If the client is in a seated position put their shoes on at this stage. Then, if needed, assist the client to stand and pull up underwear and trousers so they are comfortable.

A Vest
Try putting it over your client's head first, then if they have a stiff arm place it through its arm hole first, then the good arm through the other arm hole. Or your client may prefer to put both arms in first and then have the vest pulled over their head.

A Shirt
With a shirt, generally the client will put a stiff or rigid arm into the sleeve first and then the shirt will be pulled around their back and then they push their good arm into the other sleeve. Or it maybe that the client puts both arms into the sleeves of the shirt and then it is pulled over their head, or it maybe that the client prefers to have their head put through the shirt first and then push their arm into the sleeves.

A Dress
If the client wears a dress it maybe easier to take it over her head first, then place her arms into the dress and then pull down, or it maybe easier for the dress to be put on from the legs and pulled up to the waist and then putting her arms into the dress and then fastening up.

When the client wears a pullover, do as above.

Skirts
These may be put over the client's feet first and then pulled up, or put the skirt over the client's head and pull downwards to the waist.

Skirts with elastic waists, clip-on ties, cravats and scarves, and Velcro (touch-and-close) fastenings may be useful.

Shoes
Place the client's shoes on by opening up the shoe wide then sliding their feet into the shoes carefully and comfortably, making sure that sock/stockings do not crinkle up and cause discomfort or pressure. Encourage your client to wear proper shoes; bedroom slippers do not support feet as shoes do. People tend to shuffle in them and may be in danger of tripping.

Clothes on and off at night

Nightdress or pyjamas
Sometimes the back of the nightdress is cut to allow easier dressing/undressing – arms through first and then over the client's head. Or put one arm through and then the other. With a pyjama top, it could be put on the same way as a shirt and with pyjama bottoms the same as trousers.

When undressing your client, fold or hang clothing neatly as it is removed, or place it in the laundry as necessary.

When helping clients who have suffered a stroke insert the weakest arm/leg into the clothing first and remove it from clothing last.

Whilst dressing/undressing the client you must also take into consideration things such as catheters, conveens and incontinence pads, making sure the client is comfortable and nothing is causing discomfort.

If catheters or conveens are worn then it is important to make sure that if you have to roll the client to dress them, then the leg/urine bag should be on the side that you are going to roll them to so it doesn't pull on the catheter or the conveen. If a client wears an incontinence pad you need to make sure that they are kept smooth with no bumps/creases in them.
Also, make sure that if the client wears elasticated net knickers to keep the pad in place, ensure that they are over the pad and not cutting into the skin anywhere.

Mouth care and oral hygiene

You must do your best to maintain a high standard of oral hygiene with your client. If you constantly meet with refusal by your client you should ring the office and we will try to get help from another source.

- Encourage your client to brush their own teeth but, if this is not possible, brush teeth from the gum line to the end of the tooth.
  Rinse the mouth thoroughly after brushing. You may find that an electric or battery operated tooth brush is easier to use than an ordinary one.
- Ensure that any items, e.g., toothbrush, false teeth, belong to your client and not to another member of the household.
- Use the products your client prefers.
- Where dentures are worn, follow the instructions of the manufacturer about denture cleaning products.
- Ensure that dentures are rinsed for at least 30 seconds under a cold tap. Generally speaking dentures should be removed at night.
- Clean all toothbrushes, etc., after use and store in their correct place.

Dentures

Remove the bottom denture - hold the middle of the bottom teeth between your thumb and middle finger, and gently rock the denture back and forth. Be patient and go slowly so as not to irritate the gums. Once the denture has become loose, you can remove it by pulling it up and out.

The top denture may be a little more difficult to remove because of the larger plate that it sits on. You can follow the same rocking motion as you did with the bottom teeth, but be careful not to scrape the top of the gums. Concentrate on pushing up and out toward the nose.
Soak the dentures. Fill a glass with water, and add the denture cleanser. Let the dentures soak for five to 10 minutes. Make sure you read the packaging for the brand of denture cleanser for more detailed instructions on how to prepare the soak.

While the dentures are soaking, you can work on removing the denture adhesive (if used) residue in the client's mouth.

To remove the sticky denture glue from the roof of their mouth and gums, swish mouth with warm water and follow that with a mouthwash rinse. Brush the mouth, gums and the roof of their mouth with a soft-bristled toothbrush and toothpaste.

Once the dentures have soaked for about 10 minutes, the adhesive (if used adhesive) should have effectively loosened. Remove them from the denture soak, and brush them with a denture/tooth brush, toothpaste and warm water. You should brush for at least two minutes to properly clean and disinfect the dentures.

Shaving

Follow your client's wishes, whether he wants shaving twice a day or twice a month. There is no health risk in being unshaven, but consideration should be given to trimming beards etc., where this is appropriate. Only use electric or safety razors. NEVER use cutthroat razors.
Ensure that a wet razor has a fresh, sharp blade fitted and that a battery/electric shaver is safe to use. If disposable razors are used they should be replaced as often as necessary, even if necessary after each shave.

- Use any shaving foam/gel, etc., preferred by your client and that after-shave/moisturiser, if used, is applied after shaving.
- Clean all shaving equipment thoroughly after use and store in its correct place. Shaving equipment should not be shared amongst members of the household.
- Shave in the direction of hair growth and stretch out creases in the skin to ensure no areas are missed.
- If your client should request any other parts of their body shaved:- we recommend that carers only shave the client's underarms, lower leg, below the knee only, and no area below their waist

If a client wishes to have a bikini line shaved or this area shaved for health reasons, this must be undertaken by a professional e.g. a beautician.

You may only shave your client's face, neck, armpits and legs (below the knee). Any shaving must be with the consent of the client. If clients request any other areas of their body to be shaved this must be undertaken by a professional e.g. beautician.
You may be requested to undertake this due to religious reasons, but this procedure can be seen as an invasive procedure. If you are in any doubt, ring your Carer Support Team **BEFORE** you undertake any procedure you are unsure of.

Washing, bathing, showering and bed bathing

Before you start, make sure that you are ready yourself: wash your hands, tie your hair back, and ensure that you are not wearing jewellery that will pose a hazard to your client – e.g. rings with large stones etc. Put on any protective clothing, e.g. aprons, gloves:

- Make sure that the room is warm and your client is comfortable and safe. If necessary, remove any loose rugs and position a chair beforehand. Check that the floor is dry and there are no slippery surfaces.
- Before starting personal cleansing, check that all equipment, e.g. soap, flannels, towels, clean clothes, etc., are in easy reach.
- Fit any bath/shower aids securely so they cannot move when in use unless designed to do so. If a bath mat is used, see that it cannot slip in the bath.

Never assume that the water is at the correct temperature. Ask your client to test it if possible. If your client cannot, test it with your own elbow or use a water thermoneter. When running a bath, always run the cold water first and then add hot water. While assisting your client with bathing Do Not place your client in a big bath unless it is safe. This is to protect both your client and you from possible injury.
If in doubt, contact us for advice. You should NOT attempt to lift your client in or out of the bath unaided. Use hoists or bath seats if they are available. If manual handling aids are required but not available – DO NOT attempt to use the bath for your client.

- Maintain your client's dignity and independence: allow your client time to wash the parts of the body that they can reach. Offer help for the parts they cannot. This may take longer than doing it yourself, but that doesn't matter; you must take as long as your client wants.
- Use the toiletries your client likes. Rinse all soap away: - soap, left to dry on the skin will cause soreness.
- Always use two flannels and two towels, saving one for intimate areas.
- Maintain the water temperature as you work. Top up with hot water as necessary, taking care that the hot water does not pour directly onto any body part of your client.
- It is extremely important to wash the skin of a client suffering from incontinence but is a very delicate subject.
- Look out for broken or extra tender skin. Note any new area of broken skin. Tell the district nurse and whosoever usually helps you deal with areas of broken skin.
- When you have finished, always clean up after yourself. Leave the room neat and tidy. Hang flannels and towels up to dry or place in laundry as appropriate.
- Dispose of gloves and apron before you leave the bathroom.

If your client has a dressing on their arm or leg that must not get wet, use an arm or leg protector. If none is available a large plastic bag may suffice. Use with caution.

INFECTION CONTROL ADVICE (As per point 7.3 in the Code of Conduct for Carers)

INFECTION

a) Affects any organ or system of the body
b) Can pass from person to person
c) Generally causes unpleasant signs and symptoms
d) Ranges from being mild to serious and can even be fatal
e) Most infections are treatable.

Infection is an attack on the body by micro-organisms that cause disease. They enter the body, grow and multiply and make the person ill. The most common way infections are spread is by cross infection from one person to another.

CAUSES OF INFECTION

There are various types of micro-organisms with varying modes of action.

Types of organism are:

BACTERIA VIRUS FUNGI PARASITES

Bacteria are found everywhere in the environment. Most bacteria need warmth, moisture and nutrients to thrive and multiply. Some bacteria cause diseases, these are call pathogens.

We all have bacteria on our skin and inside our bodies. Most of these bacteria are helpful to us and do not do any harm, they are called non-pathogens and they form part of the body's natural defence mechanism. However, if they get into a part of the body where they do not normally live they can cause disease. For example – E.Coli bacteria are commonly present in faeces. These will cause illness if introduced to another part of the body e.g. the urinary tract during toileting.

We all carry bacteria on our body. If a large amount of bacteria are found in one place on the body this is known as a colony. The most common places for a colony of harmful bacteria are: the nose, the throat, the groin, the naval and the armpit, also leg ulcers, pressure ulcers, and long term skin rashes. Indwelling devices, such as catheters and PEG sites, are also high risk.

Bacterial infections are treated with antibiotics. However there are some bacteria that have evolved to be resistant to common antibiotics, making them difficult to destroy.

A **Virus** is a smaller disease-causing organism (pathogen), which can only be seen with the electronic microscope.

Viral particles can only multiply within the cells of an animal or plant (the host); it takes just one or two particles to cause infection. Viruses cannot survive for long outside the host body.

The best defence against viruses is through immunisation. There are some anti-viral medicines, but a viral infection cannot be treated with antibiotics.

A viral infection will destroy the normal body defences and can lay dormant and re-occur at a much later date.
Fungi are mould like organisms that can affect the whole body or be localised to a specific area.

Some fungi affect just the surface of the skin eg. in the mouth and other moist body surfaces, including skin conditions like ringworm and candida.
Other fungi can invade the body system.

Not all fungi are harmful. Penicillin, the first antibiotic, comes from a blue/ green mould.

Fungal infections are treated with anti-fungal medicine.

Parasites are organisms that live in or on a host body e.g. scabes on humans or tape-worms in a dog. The parasite survives by feeding off the body it is living in or on. Parasites are destroyed using anti-parasitic medicines.

HOW MICRO-ORGANISMS ARE TRANSMITTED

Micro-organisms can be transmitted by either direct or non-direct contact.

Direct contact – from person to person in close proximity.

This includes touching skin to skin, talking and breathing close together, kissing mouth to mouth, all sexual activity. Also contact with any rash or wound. The more intimate the contact between people the greater the likelihood of passing an infection.

Indirect contact - from a contaminated person to an object or substance and from a contaminated object or substance to a person.

This can include **anything** that can carry an infection. E.g. door handles, cups, bedpans, clothing etc. etc. Also food and drink, swimming pools, the sea and the air we breathe.

If a person sneezes into their hand, then opens a door, that door handle is then carrying the germs from the sneeze.

Sharp objects should be handled with care as a break in the skin can be a route for infection to enter the body.

THE BODY'S NATURAL DEFENCE SYSTEM

a) T-cells, which are mainly white blood cells, protect the body from infection.
b) The skin is an effective barrier against disease. The acid content of the skin secretions may kill or prevent growth of certain disease organisms.
c) Lining of the mouth and nose - these carry away bacteria.

In ill health the body defence mechanism breaks down and infection sets in.

FACTORS THAT CAN MAKE INDIVIDUALS MORE LIABLE TO INFECTION

a) Age: babies, children and the elderly are more susceptible to infection.
b) Poor diet and malnutrition
c) Low body temperature - reduces the blood supply to tissues and suppresses the production of antibodies
d) Ill health and disease reduces the immune system and increases the risk of infection
e) Drugs - some depress the production of antibodies, e.g. steroids
f) Radiation - reduces the body's ability to produce antibodies and white blood cells.

SIGNS OF INFECTION

These are the result of a battle between the body's defences and micro-organisms. Usual signs can be: headaches, aches and pains, rise in temperature and pulse, swelling, redness, discharge and loss of control of body function, change in behaviour, irritability and loss of appetite.

MANAGEMENT AND CONTROL OF INFECTION

Environment

Help control infection by keeping the surrounding areas clean and tidy – social cleanliness is very important in preventing cross infection. Dust represents a hazard as it is largely made up of skin scales, which are constantly being shed into the environment, each one of which may be covered in thousands of micro-organisms. The removal of dust is therefore an important control measure.

Routine cleaning schedules should be maintained.

It is recommended that the house is kept well ventilated, free from odour and warm.

Personal Protective Equipment

Disposable gloves and aprons should be used

- when dealing with any personal care
- when handling used linen
- when disposing of soiled hygiene or healthcare waste
- These gloves and aprons are for single use.
- for cleaning, especially toilets and rubbish bins
- for handling and disposal of household waste

Methods of cleaning
First – clean using hot water and detergent, rinse area and leave to air dry or use paper towels.

Second – after initial cleaning use disinfectant in high risk areas such as toilets and rubbish bins, and anti- bacterial sprays on kitchen surfaces where food is to be prepared.

Always clear up spills quickly and clean the area appropriately.

It is important to use cleaning agents and disinfectants correctly. Always follow care instructions on the label.

Handling linen

a) Hold the linen away from you to prevent the transfer of micro-organisms
b) Avoid shaking linen and keep it off the floor
c) Wear disposable gloves and aprons when handling linen
d) Wash hands thoroughly afterwards

Disposal of waste

- All waste should be disposed of quickly and safely.
- Bins need to be cleaned out with disinfectant regularly, and lids kept closed. Do not overfill waste bins.
- Rubbish bags should be sound with no tears, and should also not be overfilled
- Any offensive/hygiene waste – e.g. continence pads, sanitary items etc., should be double-bagged and placed in bins outside.
- Healthcare waste – e.g. dressings, catheter bags, sharps etc. – There will be special bags and bins for this type of waste and instructions for disposal will be included in the care plan.
- The sharps container must not be overfilled.
- Always wash your hands thoroughly after handling any waste, bins or bags.

Hand washing is the most important element of Infection Control

Hands should be washed frequently, with particular regard to the following.

a) Before eating or drinking
b) Before dealing with grazes, scratches or cuts
c) After giving personal care to your client
d) After household tasks, e.g. bed making, handling the washing, dusting etc.
e) After using the toilet
f) After sneezing, coughing and blowing your nose
g) After handling bedpans, urinals or dealing with your client's continence needs
h) After touching any animals
i) The first thing you do when entering the kitchen, even if you have just washed your hands elsewhere.
j) After removing protective gloves

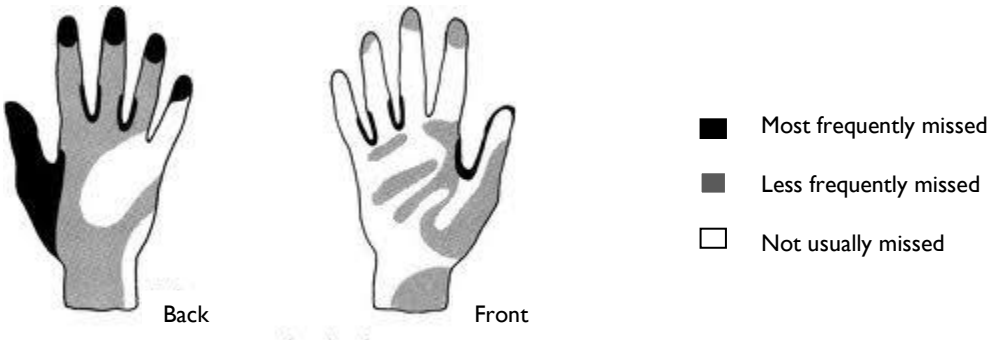
It is the flow of water and rubbing with soap that removes germs. Water should not be too hot, otherwise you will not be able to take the time to wash properly.

Nail biting encourages infection because it involves putting your hands in your mouth, with possible dirt under the nails. Also the delicate skin around the nails can tear and pathogens will enter the skin.

Good Handwashing Procedure

a) Remove jewellery
b) Ensure nails are cut short, with no nail polish, and are not harbouring dirt
c) Roll sleeves up to expose wrists and forearms
d) Use running water at a warm temperature that is comfortable
e) Use anti-microbial or household soap. Liquid soap is preferable to solid as it is less likely to harbour micro-organisms
f) Rub hands and fingers together vigorously for about 10 to 20 seconds, with particular care in the areas that are frequently missed (see pictures below)
g) Rinse under running water
h) If at all possible use disposable towels to dry hands, otherwise make sure towels are kept clean
i) If you can use hand cream, this will help keep your skin in good condition
j) Any cuts or grazes should be covered with waterproof plasters.

Pay particular attention to these areas which are frequently missed

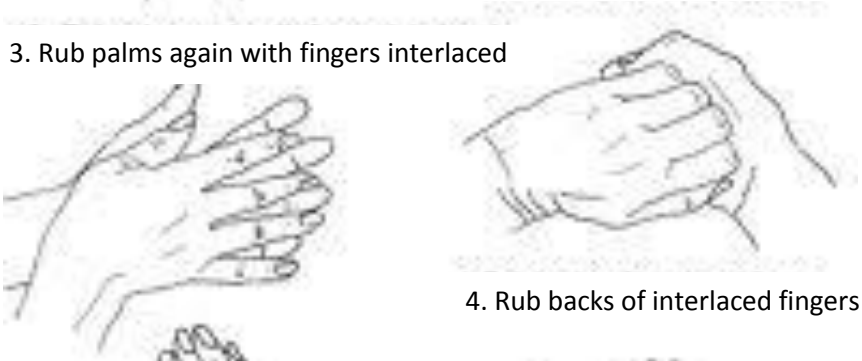


How to wash hands correctly to reduce the risk of infection

1. Rub palm to palm

2. Rub the back of both hands

3. Rub palms again with fingers interlaced



4. Rub backs of interlaced fingers

5. Remember to wash back of thumbs

6. Rub both palms with fingertips

7. Wash hands under running water using soap, rinse and dry thoroughly

Diarrhoea and vomiting are caused by one of a number of pathogens, most of which come from food poisoning.

Illness is usually caused by eating infected food or drinking infected water. It can sometimes spread directly from person to person, especially if hygiene is poor such as with small children. It can be spread if someone who is ill prepares food for others.

The incubation period varies from a few hours to a few days, depending on the type of micro-organism and how much infected food was eaten.

The main symptoms include diarrhoea, vomiting, nausea, abdominal pain and fever. Different micro-organisms cause different symptoms, but the same micro-organism can cause different symptoms in different people.

Most people will get better with no treatment. For some infections antibiotics may even increase the length of illness. One or two of the less common illnesses may require specific treatment.

Caring for a person with diarrhoea and/or vomiting

At first, the infected person should drink plenty of clear fluids. Water, re-hydration solutions, non-fizzy drinks or tea without milk are good. The symptoms will usually clear up in 24 hours. If the symptoms last for over 24 hours, or there is blood in the diarrhoea, the GP should be contacted.

Personal hygiene should be very strict. Everyone should always wash their hands with warm, soapy water after going to the toilet and before handling food. The person who is ill should not prepare food for others.

The toilet should be kept clean. Make sure that the seat and handle are cleaned frequently with disinfectant or anti-bacterial cleaning fluids.
Linen or clothing soiled with faeces or vomit should be handled as infected linen.

In general people should stay away from work until they have been free of symptoms for 48 hours and feel well. Those who handle food as part of their work should check with their employers and GP before returning.

CLOSTRIDIUM DIFFICILE

If a person with diarrhoea has recently been in hospital or had a course of antibiotics it is possible that they have contracted Clostridium Difficile (C. Diff). The most common symptom of this is explosive diarrhoea, but abdominal pain and fever can also occur. This is a particular type of infection which can result in serious illness and even death. The illness is mild in the majority of patients and full recovery is usual. Elderly patients may become seriously ill with dehydration as a consequence of the diarrhoea.

C. Diff is infectious and the bacterium can form spores which can survive unseen for long periods in the environment such as on floors and around toilets.
However, there is very little risk to people who have not recently had a course of antibiotics.

If you suspect your client may have this illness you need to call a doctor out immediately.

METICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

Staphylococcus aureus is a type of bacteria carried in the nose of 20-40% of normal healthy people and is also commonly found on people's skin, usually without causing harm.

However, in certain circumstances, particularly when the skin is broken, this germ can cause boils, wounds and other infections. These may improve without treatment, or may require a course of antibiotics.

Hospital patients, however, are more vulnerable to infection with S. aureus because they are unwell or may have surgical wounds.

MRSA behaves in the same way as ordinary S. aureus and does not cause different or more serious infections. However, infections with MRSA can be more difficult to treat as there are fewer antibiotics with which to treat them and sometimes suitable antibiotics cannot be swallowed and must be given by injection.

The only way of knowing if anyone has MRSA would be through examination of a specimen by the laboratory, e.g. a wound or skin swab or urine sample. **Outside hospitals many people carry MRSA on their skin or in their noses without it causing harm to themselves or others.** They are said to be carriers or to be colonised with MRSA.

If basic good hygiene precautions are followed, MRSA carriers are not a hazard to others including their family, babies, children and pregnant women.

All strains of MRSA are sensitive to at least one antibiotic and most are sensitive to three or more so that treatment is always available should an infection occur.

Treatment for colonisation without symptoms of infection is not usually necessary, but it is sometimes treated with special antibiotic ointments to the nose and/or washing with special antibacterial preparations.

If good basic hygiene precautions are maintained within the home, clients with MRSA are not a risk to their carer, visitors or members of their family.

Good hygiene will prevent the spread of many infections, not just MRSA.

THE MAJOR SOURCE OF TRANSMISSION OF MRSA IS VIA THE HANDS!

Clients with MRSA should not be isolated within their home; their normal everyday activities must not be restricted.

The following advice should be taken:

a) They can receive visitors and leave their home as required.
b) Carers with open wounds should ensure they are covered before commencing any procedure with the client.
c) Carers with eczema or psoriasis involving open lesions should not perform intimate care to clients with MRSA; the reason being that open lesions provide opportunity for bacteria to invade the tissue which may result in subsequent colonisation of the carer.

The necessary precautions that carers should take are all the basic Infection Control precautions that we have already looked at, especially the following:
Scrupulous hand washing. This is the single most effective measure that can be taken by us all. Hands should be washed well with soap and water and dried thoroughly, preferably with a disposable paper towel if at all possible. See notes on hand washing on the previous pages of this section.

Strict personal hygiene

- Keep yourself and your clothes clean
- Do not touch or squeeze spots or pimples with your fingers
- Keep any cuts covered with a dressing or plaster.
- It is imperative that care workers make themselves aware of their workplace policy and procedures on infection control.

LEGISLATION

You need to be aware of the following Laws:

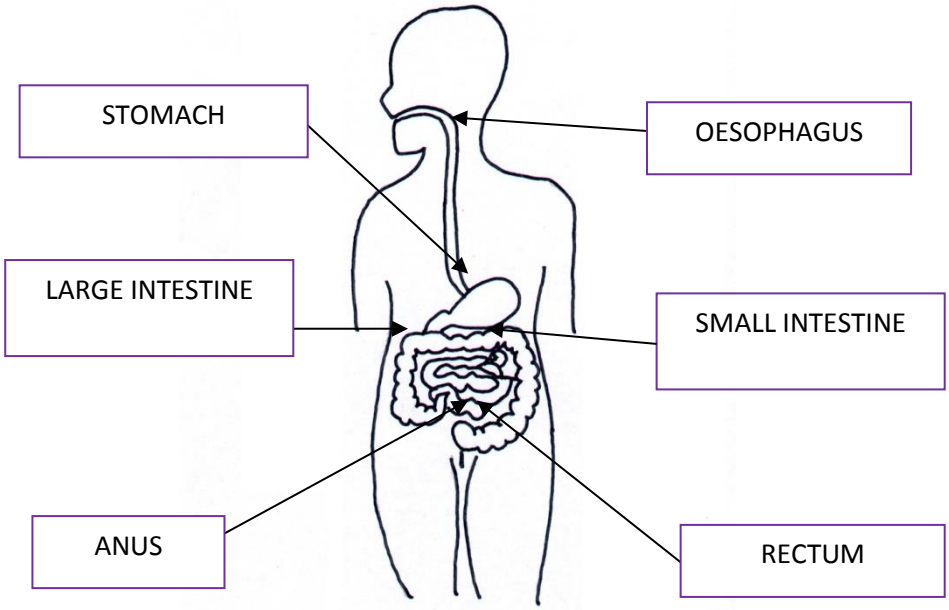
- The Health & Safety at Work Act 1974
- The Management of Health & Safety at Work Regulations 1999
- The Public Health (Control of Diseases) Act 1984
- Food Safety Act 1990
- The Health Act 2006: Code of Practice to Help Reduce Health-Care Associated Infections.

FURTHER INFORMATION

The National Institute of Clinical Excellence has published a booklet called 'Preventing infections in people having treatment or care at home or in the community'. Copies of these guidelines can be obtained free of charge from the NICE website (www.nice.org.uk) or from the NHS Response line (tel. 087015555455) and quote reference number CG139. Further specific advice can be sought from a GP or Local Area Health Authority.

Carers need to report to Head Office so an Infection Control Risk Assessment can be undertaken for any infectious disease.

Our Digestive System:



Digestion

Our digestive system consists of a long continuous muscular tube, beginning at the mouth, running through the body and ending at the anus. It is divided into the mouth, oesophagus, stomach, and the bowel. The 'bowel' comprises of the small intestine, the large intestine or colon and the rectum. The job of the digestive system is to digest food into simple components so that the body is provided with a continual supply of nutrients, electrolytes and water. To do this, it performs the function of digestion, absorption of food and fluids, and elimination of residue and waste products.

In the mouth, chewing food helps to break it up and to mix it with saliva, which helps moisten it and to break down starch. Once swallowed, food stays in the stomach for anything between 3-5 hours. In the stomach, chemicals in the gastric juices and the rhythmic movement of the stomach itself continue the digestive process.

Most of our digestion and absorption of nutrients in food occurs in the small intestine. Food moves slowly through its 18-20 foot length, firstly being mixed with bile from the gall bladder and secretions from the pancreas, and is then broken up by contractions which bring it into contact with its surface so that as many of the nutrients as possible can be absorbed.

The large intestine has no role in digestion itself. Its main job is to absorb water and salt from the digested food and drink as it moves through the large intestine. About 500mls (approximately 1 pint) enters the bowel per day but 80% of it is re-absorbed. It is this recycling system, which stops us from becoming dehydrated.

What is left behind is indigestible and un-absorbable food residue e.g. fibre, mucus and left over secretions such as bile.

It is this matter that forms faeces and which is expelled from the rectum.

How our digestive and bowel movements normally work:

Our bowel is part of the digestive system, and its job is to break down what we eat and drink so that our bodies can use it as energy. After a meal is progressively digested, the left over waste products move from the stomach to the small intestine and from there into the large intestine (colon). Here water is absorbed gradually to form faeces (stools) that will eventually be expelled from the rectum (bowel movement).

Stool consistency varies from very hard lumps to very loose or mushy stools, depending on how long they have been in the colon and on how much water has been absorbed. Stools will also vary according to the person and what they have eaten.

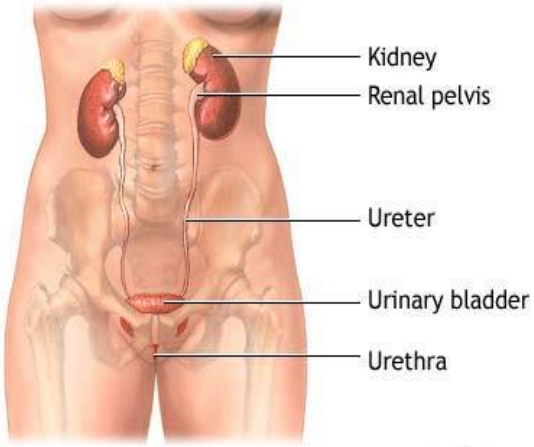
As the large intestine fills, it will stretch and this triggers messages to the bowel muscles to move the faeces down to the end of the large intestine into the rectum. Normally the rectum is relatively empty. It fills up, not all the time, but as a result of mass movements, which happen from time to time during the day. A hot drink or a meal entering the stomach can also trigger these mass movements, which is why we will often feel the need to empty our bowels after a hot cup of tea or coffee in the mornings.

Another message going up to the brain indicates when it is time to open the anus and evacuate the contents of the rectum.
This is often called a bowel movement. Normally it is possible to control our abdominal and pelvic muscles to allow us to empty the rectum at the right time.
Our colon is controlled mainly by nerves that leave the spinal cord at level T6 – T12 (lower thoracic vertebrae) and these nerves control movement in our abdominal muscles.

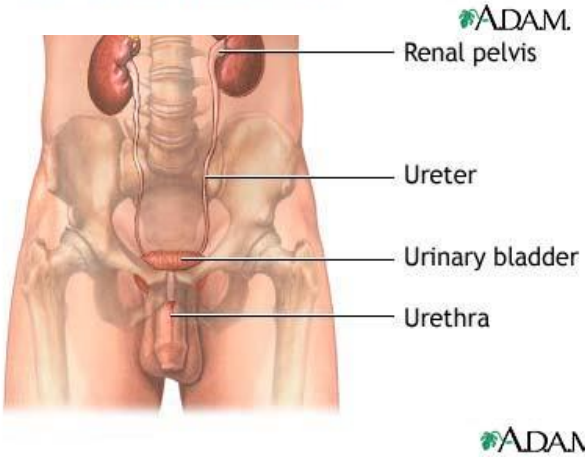
The lower end of the colon is controlled by nerves that leave the spinal cord lower down at level S3 – S5 (sacral vertebrae). There is also some automatic (also called autonomic) control from within the bowel itself. This is the part that brings on the urge to empty the bowel when somebody becomes stressed or is frightened.

Our Urinary System

Female:



Male:



How we normally pass urine:

Normal bladder control means that you know when you need to go to the toilet to pass urine and that you are able to “hold on” until you reach a toilet.

The bladder is a hollow sac with flexible muscular walls, which stores urine. The empty bladder lies in the cavity of the pelvis. The shape and size of the bladder is roughly the same in men and women.

The empty bladder is flattened downwards by the pressure of the overlying bowel. When the bladder fills with urine it distends above the border of the pubic bones. The kidneys filtering the blood for waste and impurities produce urine, which drains down into the bladder via two tubes – the ureters.

Most of the bladder wall thickness is made up of muscle arranged in spirals and whorls – the detrusor muscle – and it is the contraction of this muscle that empties the bladder.

The kidneys, in a healthy person, produce approximately two pints of urine a day. In adults, once about a half a pint of urine has been collected in the bladder, signals are sent from the bladder to the brain to alert us that the bladder needs emptying. We are able to “hold on” until it is convenient to use a toilet. This hold on process is quite complicated and involves controlling a muscular sphincter which opens and closes like a purse string to release or hold the urine. A sheet of muscles that line the floor of the pelvis helps it to control the sphincter. The sphincter acts like a tap – when closed it prevents the urine passing out and when relaxed it allows the urine to drain away.

When do our clients need help?

There are many reasons why someone’s bladder and/or bowels may not work normally, so they need the help of their carer.

We have clients who need help for one or more of the reasons set out below:

- Illness, such as: Multiple Sclerosis, Muscular Dystrophy, CVA (Stroke)
- Accident, such as: Spinal Injury, Acquired Brain Injury
- Incontinence: in old age or through illness
- Mental Dysfunction, such as Dementia

Medication – many medicines will interfere with normal bladder / bowel function and may cause incontinence.

The extent that your client needs help will depend on their condition and the extent of any injury that they may have. The type of help they need, will normally be written in the care plan and they themselves will often be able to give you directions.

Some will need just a hand with clothing or perhaps with hygiene while others will be totally dependent on you for complete bowel/bladder care.

Whatever level of help and assistance is required it is essential that, at all times, you consider your client’s dignity and work in such a way as to ensure that you maintain their dignity and minimise any embarrassment that they may feel.

Each client will have their own set routine for bladder/bowel management and this may involve just your assistance or may also involve others such as a District Nurse or a relative.

You should at all times work according to their plan and not try to change things to suit you.

If at any time you are in any doubt about what you are doing, or have any questions please discuss these with your client and also consult Christies Care if appropriate. We will do our best to advise you and answer any questions.

Some clients will need help just getting to the commode or toilet, and be able to manage once they are there. Some will need you to undo buttons and zips and to remove their clothes. Some will need you to wipe them after they have opened their bowels etc.

If they use a commode it should be emptied and cleaned with disinfectant immediately. Always wear protective clothing (gloves and aprons) when helping your client in the toilet. If your client objects you should explain that it for their protection as well as yours and is part of good care practice.

Stress and urge incontinence and mixed incontinence (a mix of the two):

The bladder fills in the normal way. The incontinence takes place when the signal, "I need to go" is sent to the brain and your client cannot make it to the toilet on time.

With stress incontinence, it happens with an increase in intra-abdominal pressure, perhaps caused by a cough or sneeze. This sets off the signal and your client cannot make it to the toilet.

With urge incontinence, it is even simpler. There is no need for a bit of 'stress' to set off the signal. The normal filling of the bladder sets it off and then it is too late.
With mixed incontinence, it is a mixture of stress and urge.

Overflow Incontinence:
This occurs when the bladder does not empty properly. As a result, over time, large quantities of urine are stored in the bladder causing it to overflow. This type of incontinence is more common in men as the result of an enlarged prostate gland blocking the bladder opening.

Transient or Occasional Incontinence:
This is fairly common in the elderly and may be caused by mental confusion, infections, medication, constipation, depression, immobility and other such conditions.

Whatever the type of urinary incontinence, your client should consult a doctor so that the cause can be properly investigated and diagnosed. Most people will respond to treatment and there are many aids for those who will remain incontinent.

Medicine:
Some drugs can relieve and control the symptoms and can also be used to treat infections.

Exercise:
Sometimes the answer can be as simple as doing special exercises to strengthen the pelvic floor muscles, or training the bladder to hold on for longer.

Surgery:
There are some simple straightforward surgical procedures that can help many people overcome their urinary incontinence. These include operations to strengthen or repair weakened muscles or to remove a blockage from the bladder.

Pads and Special Clothing:
There is a whole range of special incontinence aids available. These include pads, special pants to hold the pads, bed sheets, bed pads, and many of these may be available through a local health authority. It is always worthwhile asking a doctor or community nurse for a referral to a Continence Advisor – people specially trained in the management of continence.

Urine Bottles:
For a male client who finds it hard to get around or to get in and out of bed at night, a urine bottle is invaluable. It can be carried around easily and discreetly, and a bottle with a stopper can be used on journeys and outings, especially if there is any doubt about the availability of toilets.

Keeping Your Client Clean:
For many clients, continence management means keeping clean and dry after going to the toilet, and not smelling. Always act in a way that shows empathy with your client and do your best to decrease their embarrassment.

Dignity:
Using the toilet is a very personal and private thing. Many people get very upset and embarrassed about needing help and don't like to do it with someone else present. One of your main tasks as a carer is to enhance the dignity of your client and do your best to lessen any embarrassment that they may feel. After you have helped someone onto the toilet and made sure they are safe, leave them alone for a while, closing the door behind you. You can, if necessary, stay within earshot so that they can call if they want more help and to let you know when they are finished.

Never let your client see you wrinkle your nose if there are unpleasant smells. Do not expose more of their body than is absolutely necessary. Imagine how they must be feeling and think how you would like to be treated if you were the client.

Wiping:
If you need to help with wiping, you should always wipe from front to back, particularly with female clients. This is to prevent transferring bacteria from the bowel to the genital area where it could enter the bladder and cause an infection. Always use clean paper for each wipe.

Washing:
You may have to wash your client after they have used the toilet. Again consider their dignity. Do it in such a way that their embarrassment is kept to a minimum, use the bathroom or toilet to wash them; any soiled clothing should be washed immediately.

Urinary Tract Infection:
We provide our carers with test strips, because you may need to test for a range of concerns including glucose levels, leukocytes and ketones. You will then be able to pass the information on to medical professionals for further investigation or treatment. Please read the instructions within the packaging.

Cleaning intimate areas of the body:
Remember to talk to and reassure your client as you work. Tell them what you are about to do and what you are doing.

It helps your client to relax and avoids any sudden shocks for them.

- Always wear gloves and a disposable apron when cleaning your client's anus, vagina or penis. Explain to your client that wearing gloves is part of the universal precautions applied to all clients and is for the protection of both the carer and client from cross infection. Explain that it protects them against risk of infection from a carer as well as the other way round.
- The foreskin of male clients (unless they have been circumcised) should be retracted gently and washed carefully with warm water and mild soap before being gently replaced. Failure to replace the foreskin may lead to a condition called Para phimosis. This is a condition where the foreskin is trapped behind the glands, which then becomes swollen and can lead to a medical emergency.
- If a catheter is present, wash carefully around the catheter, using mild soap, and dry the skin thoroughly. Be careful not to pull the catheter tube. Do not use talcum powder if a catheter is in place.
- Any sanitary items used should be double wrapped and disposed of safely and in accordance with procedure.
- Always use mild, non-irritant soap for intimate areas and soft flannels or cloths. Use separate flannels/cloths and always wash from front to back. With male clients, always wash the penis before the anal area and with female clients wash the vagina before the anal area. This avoids the risk of infection.

Indwelling Catheter:

If a doctor decides, after investigation, that your client is unlikely to regain control of their bladder, the solution may be to have a permanent indwelling catheter. This is a tube that is inserted into the bladder via the urethra and is connected to a leg bag.

The illustrations on the following pages show an 'indwelling' catheter; it is also possible to have the tube pass through a hole made in the abdomen wall, just above the pubic bone, into the dome of the bladder. This is called a supra-pubic catheter and its advantages are discussed below.

The tube allows urine to drain freely from the bladder into the leg bag, which needs to be emptied regularly throughout the day.

At night it is usual to connect a larger "night bag" to the ordinary leg bag so that there is no need to empty the bag during the night.

Always make sure that your client is not lying on the tubing once in bed. Many clients will have a small metal stand beside the bed to hook the night bag onto.

The insertion of an indwelling catheter is an invasive procedure that should only be carried out by a qualified nurse or a doctor. Either client or carer can easily empty the leg bag/night bag as necessary and keep the external bits of the tube clean.
There is a slight risk of infection and the catheter itself may block. The District Nurse/doctor should always be informed when such problems arise.

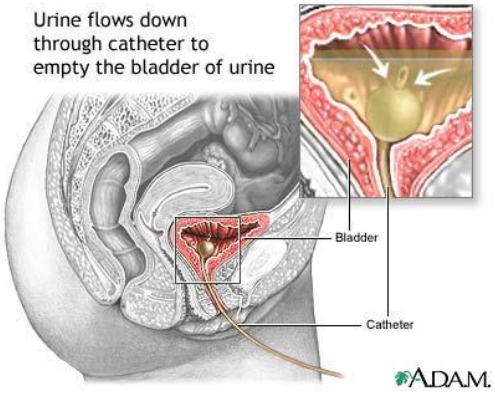
Although more invasive and less reversible, supra-pubic catheters do not damage urethral tissue, they are often more comfortable, especially for chair-bound clients, they do not interfere with sexual activity and they can be blocked off with a valve easily, to allow a trial without a catheter.

Care of indwelling urinary catheters

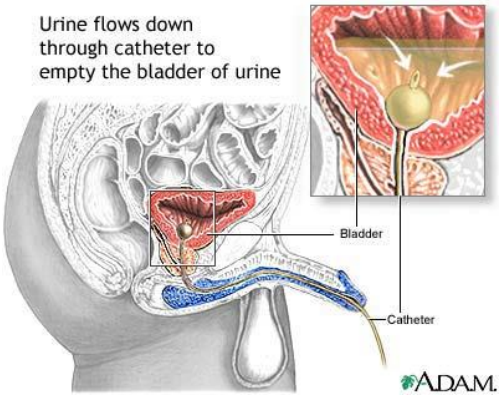
- For your own and your client's protection, always wear gloves and a disposable apron when dealing with urinary catheters.
- Always ensure that the tubing is free from any kinks, that the client is not sat on it and that it is freely draining.
- The drainage bag must always be positioned below the level of the bladder.
- During the day, leg bags should be fastened to your client's leg usually just above the knee using the elasticated straps provided. Make sure the elastic straps are not too tight or they may cause sores, and that they are not so loose as to cause the bag to drag and pull on the tube.
- At night, attach the night bag to the tap of the leg bag and then open the leg bag tap. The leg bag should not be removed. This prevents the introduction of infection. The night bag should be attached to a bag stand beside the bed.
- After use, remove the night bag from the leg bag and empty it, or dispose of it depending on the type of bag. Ensure that the leg bag tap is in the closed position prior to removing the night bag.
- Night bags may be of single use disposable design, or they may be re-used. Check the wrapping for detailed instructions.
- Leg bags should be emptied at least once every 4 hours, more often if necessary. Never allow the bag to over-fill.
  If they are allowed to over fill the weight of them may dislodge the catheter itself and cause extreme discomfort and possibly serious injury to your client. These bags can be emptied either directly into the toilet or into a container specifically reserved for that purpose and then emptied into the toilet.
- Take great care not to pull on the catheter as this, apart from being very painful for your client, could lead to it becoming dislodged.
- Check your client for any sign of infection, such as bladder discomfort and rise in temperature.

- If infection is present there may be blood and or pus in the drainage bag and the urine will be dark in colour and may smell very offensively.
- Encourage your client to drink plenty of fluids, the District Nurse or doctor should be contacted.
- Check the urine regularly for discoloration, reduction in output, or blood and/or pus in the urine
- Pus, blood clots and other debris can sometimes block catheters. In the event of such a blockage you should contact the clients District Nurse or doctor. You will recognise a blockage because urine will seep from around the catheter tube and not go into the drainage bag. Clients with longstanding indwelling catheters will recognise the symptoms and alert you that some action is required.
- If you have any doubt, contact us for advice.
- Some clients while not having an indwelling (always in place) catheter will need to be catheterised on a regular basis. Some will do it themselves while others may have it done by a relative or nurse. This is not a job for a carer to undertake.

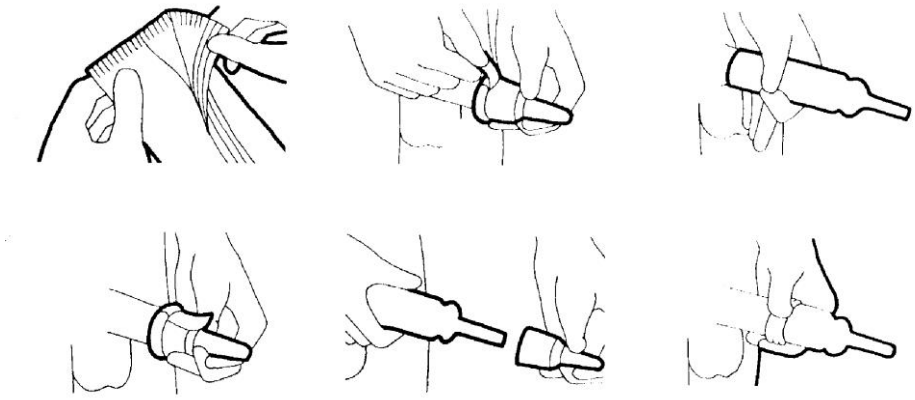
Female:



Male:



Incontinence Sheaths for men:
Incontinence sheaths are very similar to condoms in that they are sheaths that roll onto the penis. The end is attached to a tube and leg bag so that they collect urine very much like an indwelling catheter. They may be held in place by a piece of special surgical adhesive tape. You or your client can fit these. You should make sure that your client does not have any allergic reaction to the adhesive tape or sheath.



What can you do to help yourself if you are incontinent?

- Watch your weight – being overweight makes incontinence more likely.
- Practice pelvic floor exercises.
- Eat plenty of fresh fruit and vegetables to help avoid constipation, this can cause pressure on your urethra which will cause an obstruction.
- Stop smoking – a chronic cough can cause incontinence.
- Don't drink excessive amounts of tea, coffee or alcohol – these will increase the amount of urine you need to pass (Do not however, cut down on liquids – ideally you should drink at least 8 large cups of fluid every day).
- Bladder Drill – When you feel the urge to pass urine, tighten your pelvic floor muscles and hold on for five seconds before emptying; increase the hanging on time gradually.
- Toilet Regime – Over a period of a week or so record when you go or were incontinent. You may notice a pattern. From this record make up a routine of using the toilet that best suits your needs (for example visiting the toilet every two hours).

Helping your client in bowel management & faecal incontinence:

Diarrhoea; Constipation; A lack of muscle control

A major problem with bowels is that of constipation. It is suffered at some stage by everyone and is normally cured with the occasional use of a laxative. It is commonly caused by poor diet and sometimes by medication, especially pain control drugs. No matter what the cause, if it persists for more than a few days a doctor should always be consulted.

Other problems with the bowels can be caused by accident, especially spinal cord injury and, as a carer; you may need to help your client with their bowel care.

Sometimes, when someone is constipated it can at first seem as though they do in fact have diarrhoea. This is known as constipation with overflow and happens when there is a large hard stool in the bowel, but fluid is leaking around the stool and being passed instead of the stool.

Some people with neither constipation nor diarrhoea will need help because they have lost control of the muscles that control the bowels or/and bladder. It may help in these situations to establish a regular toilet regime – such as to help your client to use the toilet every two hours, whether or not they feel the need to go.

Laxatives:

Laxatives are used to help relieve constipation. But, before giving a laxative, you need to be sure your client really is constipated. Normal bowel movements vary from person to person. Some people usually go at least once a day, while for others once every two or three days is normal.

A good guide to whether a client is really constipated is that their stools have become hard and they are passing them less often than usual - or having difficulty passing them. It is important to remember that over-use of laxatives can cause the bowels to become 'lazy' and not work properly. If a client is in reasonably good health, there should be no need to take laxatives regularly. A balanced diet that includes fibre, such as fruit, vegetables and whole grain cereals, and drinking enough (2½ litres a day) should keep bowel movements regular. If your client is constipated, it's worth trying to increase fibre intake and drink more water before taking laxatives.

In general, laxatives should be reserved for people who are at risk of an illness, such as angina, being made worse by straining to pass stools, or for people who have piles (haemorrhoids). Laxatives can also be helpful for people with constipation caused by prescription drugs (e.g. codeine) or by illness; in older people who are constipated because of reduced mobility; and to help get rid of worms. They are also prescribed to clear the digestive tract before surgery or certain medical tests. It is particularly important not to give laxatives to children unless a doctor has prescribed them.

Which Laxatives?

Bulk-forming laxatives are particularly helpful for people with small hard stools who can't increase the amount of natural fibre they eat. This includes people with colostomy or ileostomy bags, piles, irritable bowel syndrome, and anal fissures (small cracks around the anus).

Stimulant laxatives are helpful if the bowel if full and a bulk-forming laxative is inappropriate. Some osmatic laxatives are best used when urgent emptying of the bowels is needed.

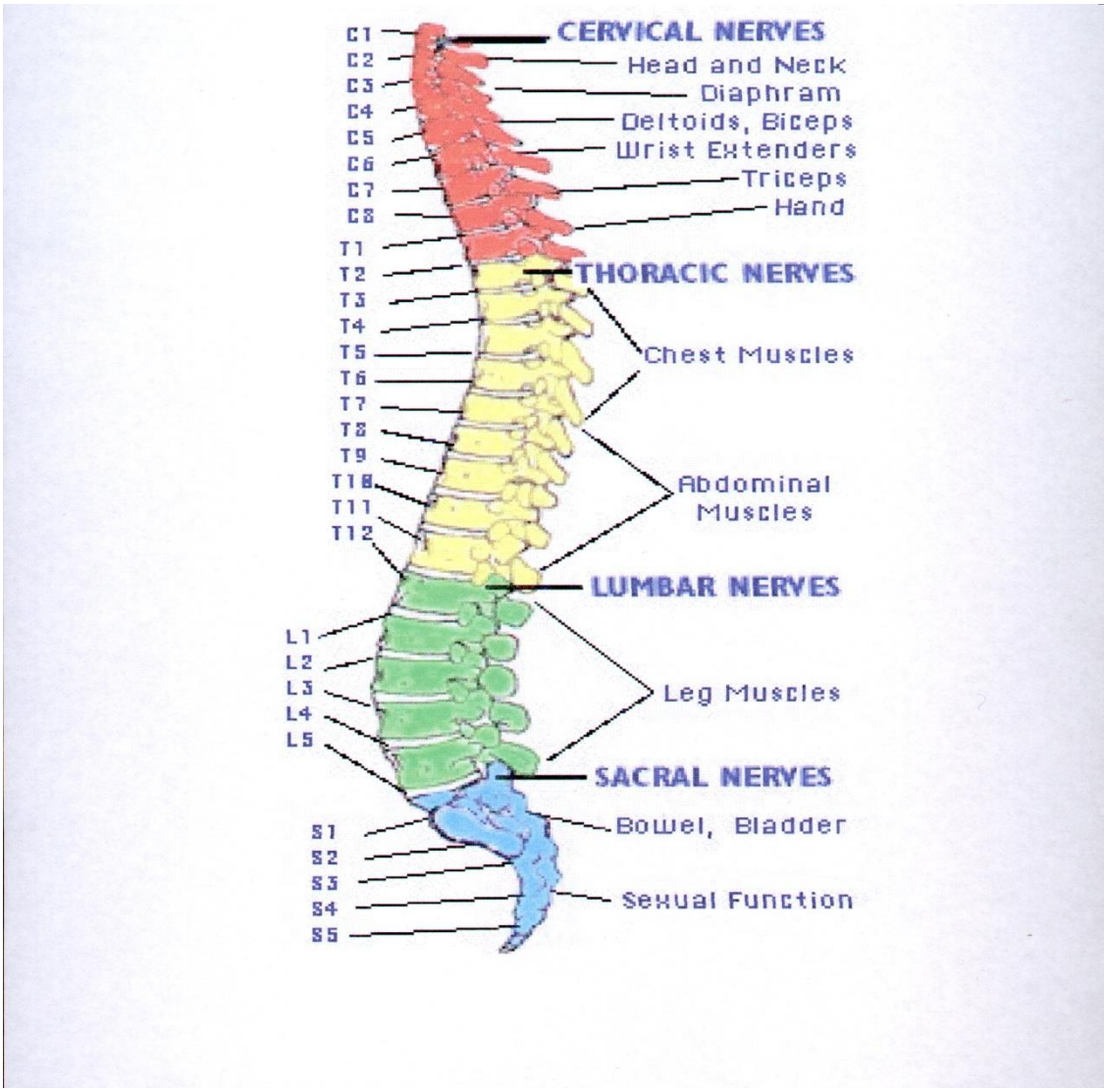
How do laxatives work?

There are three main types of laxatives: bulk forming, stimulant and osmotic.
By swelling up within the intestines, bulk-forming laxatives soften and increase the volume of stools. This then encourages the bowels to move and push the stools out. The full effect of this type of laxative can take a few days to occur.

Osmotic laxatives work by reducing the amount of water absorbed from the bowel and so increasing the amount of water in your stools. This makes them softer and easier to pass.

The clients GP should always be contacted if you feel the client is in need of laxatives.

The Spinal Column



Autonomic Dysreflexia:

Manual evacuation and finger stimulation may trigger Autonomic Dysreflexia, (AD). An erection, sexual intercourse, period pains, pregnancy and labour pains are other causes. This is a *MEDICAL EMERGENCY* that is potentially life threatening and can develop quite suddenly. If it is not treated promptly it can lead to seizures, strokes and even death. *If you suspect that your client is having an AD attack call an ambulance immediately.*

Autonomic Dysreflexia, also known as hyperreflexia or dysautonomia, is a condition or state that is unique to people who have a spinal injury at or above T6. Those with spinal cord injuries at T5 are very susceptible, those with injuries at T6 to T10 may be susceptible and those with T10 and below are not usually susceptible. The older the injury the less likely the person will experience Autonomic Dysreflexia.

Autonomic Dysreflexia means an over activity of the sympathetic nervous system. It is characterised by a rapid rise in blood pressure. Anything that would have been painful, uncomfortable or physically irritating to the person before their injury may cause Autonomic Dysreflexia.

The most common cause of AD seems to be the bladder. It could be due to a blockage in a urinary drainage system, bladder infection – cystitis, bladder spasms etc. Other causes include stimulus to the rectum such as finger stimulation or manual evacuation. The symptoms of AD are:

- Restlessness and shortening of breath
- Severe pounding headaches (caused by rise in blood pressure)
- Blurred vision and dizziness
- Goose pimples above the level of paralysis
- Profuse sweating particularly above the level of injury
- Flushing or blotching of the skin
- Stuffiness in the nose (congestion)
- Slow pulse

The stimulus sends nerve impulses to the spinal cord where they travel upward until they reach the lesion at the level of the injury. Since the impulses cannot reach the brain, a reflex is activated that increases the activity of the sympathetic portion of the autonomic nervous system. This triggers various mechanisms within the body that cannot be properly regulated because of the spinal injury and the end result is AD.

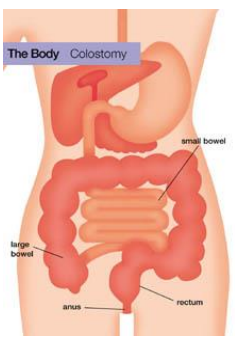
Treatment must be begun as quickly as possible to prevent complications, while awaiting medical assistance the following will help:

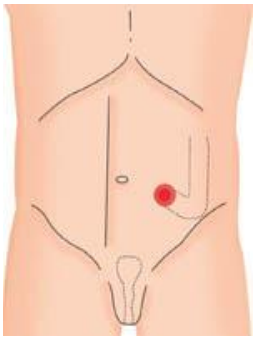
- Sit your client up or do pressure relief immediately – transfer to bed but ensure the head stays elevated.
- Check urinary drainage systems – since a full bladder is a frequent cause.
- Check for skin irritations, burns, scalds, wounds, pressure ulcers, convene too tight, other unusual conditions.

Prevention of Autonomic Dysreflexia:

- Take special care of indwelling catheters and other urine drainage devices. Urinary tract infections (which can be caused by poor hygiene) are common causes.
- Maintain a regular bowel programme (your client should keep a bowel diary).
- Avoid constipation. (Increased bowel emptying may be required during constipation).
- Maintain a comfortable position during bowel care.

Colostomy and Ileostomy





Simply put, both colostomies and ileostomies are the surgical creation of artificial openings in the abdomen for the disposal of faecal waste matter. They can be permanent or temporary.

During a colostomy operation, the end of the shortened colon is brought to the surface of the abdomen to form the stoma, usually on the left hand side. This is where the faeces will now pass from the body. The stoma is moist, pinky red in colour, and protrudes slightly from the abdomen. With an ileostomy, it

is the end of the ileum, the lowest part of the small intestine which is used to form the stoma. What's the practical difference? The ileum is earlier in the digestive process than the colon. Less water has been extracted. The material to be collected is more liquid and has to be collected and disposed of more regularly. and your client has to drink more!

Despite being red, there is very little sensation in the stoma and it is not painful. Unlike the anus, there is no sphincter muscle around the stoma, therefore your client will have no control over the material coming out and will need to wear a bag to collect the faeces. The bags are disposable are designed to be unobtrusive and easy to manage.

What are the risks?

As a carer you may be called upon by your client to undertake certain invasive procedures e.g. suppositories, manual bowel evacuation. Certain procedures can be undertaken by you if you have been trained by the district nurse and signed off as competent. If the Guide to Clients Wishes at your client's house advises that this is the case then only undertake these procedures if you have been signed off by the district nurse.

In the majority of cases the district or other health professional would normally carry out many of the procedures. If your client asks you to undertake a procedure that is not stated in the care plan please discuss this with your support team first. If out of office hours, contact the pager duty person.

It is your duty to ensure you do not undertake any procedure that you are not trained or qualified for.

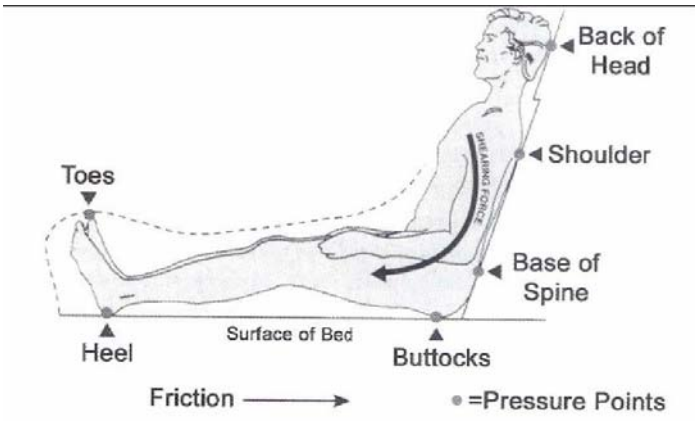
PRESSURE ULCERS, RISK AND CARE

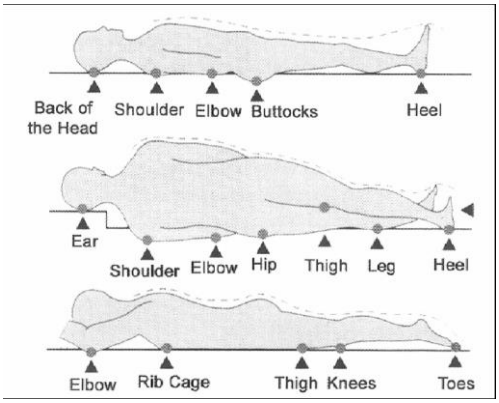
Pressure ulcers are areas of damage to the skin and underlying tissue. If care is not taken, pressure ulcers can become serious. They can damage not just the skin but also the fatty tissue beneath the skin. Pressure ulcers may cause pain, or lead to a longer stay in hospital. They can become infected, sometimes causing blood poisoning or bone infections. In severe cases, the underlying muscle or bone may be destroyed. In extreme cases pressure ulcers can be life threatening.

Pressure ulcers represent a major burden of sickness and reduced quality of life for clients. They are thought to be caused by a combination of pressure, shear and friction and are defined as “skin ulceration as a result of pressure in combination with the effects of other variables”.

The Risk Factors – reduced mobility or immobility; sensory impairment; acute illness; extremes of age; vascular disease; severe chronic or terminal illness; previous history of pressure damage; malnutrition and dehydration. The potential to develop pressure ulcers may be exacerbated (made worse) by medication and moisture to the skin.

Skin inspection should occur regularly and the frequency determined in response to changes in the client’s condition in relation to either deterioration or recovery. Skin inspection should be based on the individual’s assessment of the most vulnerable areas of risk and may include different or more areas which require inspection than those identified here: heels; sacrum (five fused vertebrae at base of spine), ischial tuberosity (weight bearing point in the sitting position); parts of the body affected by anti-embolic stockings (stockings made with firm elastic that give graduated compression to the leg); parts of the body where pressure, friction and shear (pulling, twisting, stretching of skin) is exerted in the course of an individual’s daily living activities; parts of the body where there are external forces exerted by equipment and clothing; elbows; temporal region of the skull; shoulders; back of head and toes.



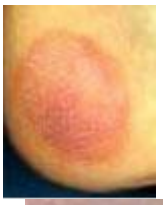


Carers should be vigilant to the following signs which may indicate pressure ulcer development: purplish/bluish patches on dark-skinned people; red patches on light-skinned people; swelling; blisters;

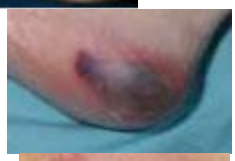
shiny areas; dry patches; cracks, calluses, wrinkles; non-blanching hyperaemia (when there is no skin colour change when light finger pressure is applied); discolouration.

Dressings for deep wound or pressure ulcers when the skin is broken (up to and inclusive of grade 2 pressure ulcers) may be undertaken by a carer after receiving the appropriate training from the District Nurse.

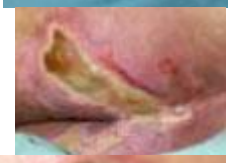
The signs to feel for are: abnormal hard areas; warm areas which, if skin becomes damaged is replaced by coolness; swollen skin over bony points. Do not rub the affected area as this may cause further skin damage.



GRADE 1: Non Blanching Erythema - Discolouration of intact skin not affected by light finger pressure. This may be difficult to identify in darkly pigmented skin.



GRADE 2: Partial-thickness skin loss or damage involving epidermis and/or dermis. The pressure ulcer is superficial and presents clinically as an abrasion, blister or shallow crater.



GRADE 3: Full thickness skin loss involving damage of subcutaneous tissue but not extending to the underlying fascia. The pressure ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

GRADE 4: Full thickness skin loss with extensive destruction and necrosis (death of living cells) extending to underlying tissue.

The following should NOT be used as pressure relieving aids:

1) Water-filled gloves – these placed under the heels are not effective because the small surface area of the heels means it is not possible to redistribute pressure by this localised method.
2) Genuine and synthetic sheepskins – these do provide comfort to some individuals, but they are not pressure relieving or redistributing aids. If sheepskins are used for comfort rather than perceived pressure relief, care is needed with regard to cross infection and the correct laundering process.
3) Doughnut-type devices – these are believed to adversely affect lymphatic drainage and circulation, so are likely to cause rather than prevent pressure ulcers.

Poor diet, incontinence and poor hygiene are said to increase the risk of developing pressure ulcers, therefore it is important for the client to have a good cleansing skin care routine as well as a good balanced diet.

If the carer or the client notices possible or actual signs of damage, it should be reported immediately to the GP or District Nurse and it must also be documented. The support team should also be notified. **ALWAYS REPORT AND DOCUMENT.**

DOMESTIC MANAGEMENT

Most of us take our domestic 'chores' for granted. However, they have great significance on our social lives for it is often through them that we meet our neighbours and stay in the know about styles and fashions. Shopping keeps us up to date with prices and provides the basis of many a conversation. We also think about our image …. 'What shall I wear tomorrow – Oh! It needs a wash'. Much as we might dislike housework, most of us do like to present a tidy home to a visitor. So chores are important parts of our social selves and relevant to self-esteem. It is the same with your clients and it is up to you to ensure that your clients get good value from domestic activities.

Finance, pensions, gifts

Money – if you are responsible for your client's money is it vital you record all transactions in the financial record book and keep all receipts. Your responsibilities regarding finance will be clearly written in the care plan.

Pensions – if you are asked to collect your client's pension from the post office, the client has to sign the pension book giving you permission to do so. Enter the amount collected in the financial record book and make sure you return the pension book to its correct place.

Gifts – The giving and receiving of gifts is discouraged.

Shopping

The Guide to clients Wishes should detail who and when the shopping is done. However, where possible, encourage your client to make their own list.
You will have a good idea of the quantities of goods required, but always check what size of packet is wanted. If a pack lasts for months, the taste might deteriorate.

You may think your client can afford the best quality, but your client may want the cheapest on offer, or the most expensive. Always ask which shop they would prefer (if this is not already covered in the Guide to Clients Wishes). People who cannot shop for themselves are working on yesterday's prices. When you are shopping for someone else, particularly someone who is much older than yourself, an important part of your job is to try and keep your client in touch with price changes.

Once you have returned with the shopping, put things away **where your client wishes** and where your client can reach them.

Domestic cleaning

Cleaning Materials – many household products, while in common use, can be quite dangerous. Particular care should be taken when storing these if your clients are non-sighted or partially sighted (see Health & Safety at Work section).
Waste Bins – these should be emptied regularly, whatever they contain, and waste thrown away in sealed bags. Soiled pads can be placed in a plastic bag, securely tied and deposited in the dustbin. Should medical waste need disposal, special bags that are left by the district nurse should be used.

Sinks, basins, baths – after use, these should always be cleaned. Hair must be removed from the runaway pipe. Taps should also be wiped and soap dishes cleaned.

Floors – bathroom and toilet floors should be mopped dry after cleaning. Carpeted floors should be dried if wet, and regularly vacuumed. Mats or carpets should, if possible, be secured to prevent them slipping.

Surfaces – furniture surfaces should be clear of dust. If a client is at all asthmatic, surfaces should be wiped with a damp cloth. Picture frames and mirrors which collect dust along the top edges should also be damp dusted.

Armchairs – the cushions should be shaken up and a check made for articles that may have fallen down the sides of them.
Washing Clients Clothes – let your client tell you how he or she likes her washing to be done. Make sure you do not put clothes that should be hand washed into the washing machine, in most cases woollen or cashmere jumpers should be hand washed – always read the labels in cloths if you are unsure. Some of the more common symbols on clothes are:-

- Triangle – bleach 
- Plain circle – dry clean only 
- Square with a circle inside – can be tumble dried  (one dot low heat, two dots normal heat)
- Square with temp inside – recommended  washing temp
- Do not tumble dry 

Ironing – let your client tell you how he or she likes the ironing done. When you have finished, ensure the iron is unplugged and left in a safe place to cool down. Ironed clothes should be aired before being put away.

Food handling recommendations

Food Hygiene Awareness is covered in greater detail in the next chapter.

Food Storage

Refrigerator

- Check sell-by dates
- Store uncooked meats on a plate and on a lower shelf than cooked meat so that fluid from one food cannot drip to another
- Store cheese in airtight containers
- Store salad and vegetables in a salad box
- Cover fluids with a lid or cling film to prevent absorption of odours from other foods
- Cover food to prevent drying
- Should anything become mouldy, remove it immediately
- Regularly wipe over the inside of the refrigerator

Store Cupboards

- Where possible, put heavier jars and tins on the lowest shelves
- Check cupboards for any dampness when storing dry food
- Keep ventilation openings clear
- Store similar foods together
- Do not keep tins that are rusty or that bulge or are misshapen

FOOD HYGIENE AWARENESS

FOOD HYGIENE – Definition

Food hygiene is the action taken to ensure that food is handled, stored, prepared and served in such a way, and under such conditions, as to prevent or reduce contamination.
Food hygiene means keeping premises and equipment clean and handling and storing food safely. Food should be prepared as safely as possible to reduce the risk of illness. Good practices should always be followed.

THERE ARE THREE TYPES OF HAZARD TO FOOD

Biological Physical Chemical

BIOLOGICAL HAZARDS

BACTERIA

Bacteria are microscopic organisms, (germs) – living things so small that you can only see them under a powerful microscope.
They multiply by splitting into two. Two then become four and so on. Within 9 hours one bacterium can become 100 million bacteria. 100 million would only be the size of a pinhead!

Certain types of bacteria are capable of forming protective coverings called **Spores.** This protection enables bacteria to remain alive, but inactive, in situations that normally would kill them.

Later, if conditions become suitable, the spores change into the usual form of bacteria that then multiply rapidly. Spores can withstand high cooking temperatures and are able to survive situations where nutrients or moisture are not immediately available.

High enough numbers of harmful bacteria will cause food poisoning.

Bacteria need all **four** of the following conditions to multiply:

FOOD, WARMTH, MOISTURE, TIME

There are three types of Bacteria.

Helpful Bacteria can make food such as yoghurt and cheese. Some make vitamins to help us digest our food and grow crops. Others are used to treat sewage, create medicines, laundry and cleaning products.

Most bacteria will not harm us and are called **non-pathogens**. They form part of the body's defence mechanism. They **do** cause disease if they get into a part of the body where they do not normally live. Then they are called **pathogens** or **pathogenic bacteria.** For example bacteria that normally live in the bowel may cause disease if you eat them.
Harmful Bacteria

Pathogenic bacteria are the main cause of food poisoning and food-borne illnesses.

There are many sources of pathogenic contamination.

Raw Food – vegetables and animal products.

Unwashed vegetables may be contaminated by harmful bacteria in the soil. Bacteria live in the intestines of animals, so meat products may be contaminated in the slaughter house, e.g. minced meat for burgers etc. Fish, poultry, seafood and eggs are all likely sources of harmful bacteria and should be cooked thoroughly.

Water – all untreated or incorrectly treated water, e.g. rivers, lakes etc. can carry harmful bacteria and should not be drunk or used in food preparation.

Pets and pests – **all** animals, such as flies, cockroaches, rats, dogs, cats etc. carry harmful micro-organisms in and on their bodies.

People – Pathogenic bacteria are found on human skin, particularly in the ears, nose, throat and hair. Also in cuts pimples and boils.

Air and dust – There is always dust in the air, which carries particles of food waste, dead skin etc. These particles are covered in harmful bacteria which can settle of food if it is left uncovered.

Food spoilage bacteria, cause food to rot. The contamination sources are the same as above. These bacteria do not usually cause food poisoning although, if there are enough of them, they can make us

ill. However, the signs of food spoilage can indicate that there are harmful bacteria present, so we do not recommend eating food that has 'gone off' in any way.

On average it is estimated that most food poisoning starts between 1-36 hours and is caused by unsafe practices by people.

VIRUSES

These are even smaller micro-organisms that can cause food poisoning. They do not need food or water for survival. Viruses are mainly found in sewage and polluted water and food poisoning from these is usually associated with water, shellfish and raw food such as salad and raw vegetables. They can also be passed from person to person, e.g. from hand to hand etc.

You cannot see bacteria or viruses with the naked eye or detect them by taste or smell.

PARASITES

Parasites live on other organisms, e.g. fleas on dogs or cats. The parasites that cause illness related to food are:

- Roundworm, flatworms, and flukes, these are all from animal products such as pork, beef and fish

Microscopic types or parasite that can be found in water.
Thorough cooking must be carried out to destroy these parasites.

NATURALLY POISONOUS FOODS

There are foods which are naturally poisonous to people which you should be aware of, these include:

- Raw red kidney beans need to be boiled for the correct time (canned beans are already processed)
- Rhubarb leaves must not be eaten
- Castor beans are also poisonous
- Some fish products need to be processed correctly e.g. canned tuna, mackerel and herring
- Some fungi e.g. certain mushrooms and toadstools are very poisonous.

PHYSICAL HAZARDS

A Physical hazard is anything that can drop into food at any time during storage or preparation. This could happen during the processing of the food by the farmer or manufacturer, or during cooking by the consumer.
Examples of physical hazard in food would be finger nails, hair, plaster, and pieces of metal, glass, wood or plastic. There are of course many other things that could end up in food which could cause illness and injury and care should be taken at all times.

CHEMICAL HAZARDS

- Chemical cleaning products used in the kitchen
- Pesticides sprayed on fruit and vegetables
- Once open, metal cans can react with the food inside and produce toxic chemicals.

ALLERGENS

Some people are allergic to certain foods and for them eating these products can be very dangerous.

The most common foods linked to allergic reactions are:

- Nuts
- Seeds

- Shellfish and fish
- Milk and dairy products
- Food colorants and flavour enhancers
- Chocolate
- Fruit
- Flour

If your client has an allergy of this kind it will be included in the Nutritional Risk Assessment and/or the Care Plan. You should make yourself aware of the details and check ingredients of any products used as sometimes it may not be obvious that the allergen is present.

HIGH/LOW RISK FOODS

High-risk foods are usually moist and high in protein and include:

- All cooked meat and poultry
- Cooked meat products: stews, gravy, meat pies, cook-chill meals and stock
- Milk, cream, artificial cream, custards and dairy produce, especially un-pasteurised milk and products from un-pasteurised milk, ripened soft and moulded cheeses
- Fish or meat pâtés and spreads
- Cooked eggs and egg products, especially those made with raw eggs (mayonnaise, mousse, and homemade ice cream)
- Shellfish, seafood (raw oysters, mussels and cooked prawns)
- Cooked rice, which should never be reheated more than once
- Prepared salads and vegetables.

Remember - FOOD, WARMTH, MOISTURE, TIME

Food - Bacteria need nutrients which they get from our food. Even if the food is thoroughly cooked, any bacteria landing on it after cooking can quickly multiply if the conditions are right.

Warmth – The danger zone, when bacteria and fungi and can multiply is from 5°C - 63°C. Ambient room temperatures usually fall into the danger zone. Human body temperature is 37°C, which is the temperature that is the ideal temperature for bacteria multiplication.

Moisture – Food poisoning bacteria cannot multiply in dry food and need moisture to stay alive. As soon as moisture is added to food it provides the ideal conditions for bacteria. Salt and sugar in food absorbs moisture, making it difficult for bacteria to multiply.

Time – Bacteria on food in the right conditions can very quickly multiply to a level that causes illness

Low risk foods are:

- Preserved foods (sterilized milk or canned food, whilst unopened). As long as blown or damaged cans are not used. Once opened, food from a can should be transferred to suitable container if it not to be eaten immediately
- Dried foods (flour, bread, and biscuits)
- Acid foods such as fruit, vinegar or products stored in vinegar
- Fermented products such as salami or pepperoni
- Foods with high sugar/fat/salt content such as jam or chocolate.

Bacteria cannot easily multiply in these foods.

How food is contaminated

The best way to stop food getting contaminated is to know how bacteria or unwanted objects get into it. This can happen at any time during food production, preparation and serving. Contamination is usually accidental, although it can sometimes be deliberate. Bacteria are static and cannot travel on their own. They rely on other things to transfer them to food. These things are known as vehicles and the main ones are: hands, clothes and equipment, hand-contact surfaces, food-contact surfaces.

Food poisoning occurs because food can be contaminated by:

Air - contains bacteria, and some can settle on food if it is left uncovered.

People – bacteria are often passed from people to food. Ears, noses and throats often contain food poisoning bacteria. You can pass them on if you touch your ear, nose or mouth before you handle food. Coughing, sneezing and spitting near food also contaminate the food. Hands (especially under your nails) can carry bacteria, which will be passed on when you touch food.

Raw Food – has some bacteria on it when it comes into food premises. There may be bacteria in the animal's gut and this contamination would be spread when the animal was killed. Juices from meat may also contain bacteria. Most poultry is likely to be contaminated. Unwashed fruit, salad and vegetables also have bacteria on them. Shellfish are caught in shallow water, which may be near a sewage outlet and may contain harmful bacteria.

Animals – all animals carry dust, dirt and microbes. Household pets should not be allowed near food. Mice and rats can pass bacteria on to the food.

Flies and insects – carry bacteria on their bodies.

Rubbish – especially kitchen rubbish. Open bins will attract flies and other pests, which then carry the bacteria to food.

Dust and dirt – is made up from soil, dead skin, fluff and other small particles, which are easily blown onto food.

Water – if you use water that has not come from a mains tap, other than commercially bottle water, it could contain harmful bacteria.

Physical contamination – this could be glass, small pieces of machinery, jewellery, plasters etc.

Chemical – pesticides, which are sprayed on fruit and vegetables. Bleach and cleaning fluids. Once opened, metal cans can react with the food inside and cause poisoning.

FOOD POISONING AND FOOD-BORNE DISEASES

PEOPLE MOST AT RISK from food poisoning and food-borne diseases are:

- the very young
- the elderly
- pregnant women and their unborn babies
- people who are ill, convalescing or have weakened immune systems.

The onset of symptoms is usually sudden and may start within 1 hour of taking food but there may be an interval of several days. The illness typically lasts 1 to 7 days but can sometimes continue for longer.

The main symptoms are:

- abdominal pain
- nausea (feeling sick)
- vomiting
- diarrhoea
- may also include a fever and headache.

Once diarrhoea and vomiting begins 'at risk' groups can become dehydrated extremely quickly. This is a condition in which the body is deprived of water. The condition is accompanied by a serious loss of weight. The person may have furring of the tongue, the skin loses elasticity, the face appears pinched and drawn and eyes are sunken in the sockets. If the condition is not treated, the person may have kidney failure leading to unconsciousness and death.

Care of person with food poisoning - Ensure that fresh water is readily available for the person to drink. Always offer to pour a drink for the person whenever you enter his or her room because they may not feel able to do so for themselves, encourage your client to keep drinking water, and maintain a fluid balance chart.
If the symptoms last longer than 24 hours or there is blood in the diarrhoea telephone the GP.
Main reasons for Food Poisoning

- Food handlers pass on infections when handling the food
- Food is prepared too far in advance and stored at a warm temperature (in the danger zone 5°-63°C)
- Food is cooled too slowly before being refrigerated
- Food is not re-heated to a high enough temperature to kill the bacteria in it, i.e. above 70°C
- Food is undercooked, i.e. core temperature below 70°C
- Poultry is not thawed completely before being cooked
- Hot food is kept warm at a temperature of less than 64°C
- Contaminated canned food
- Raw food consumed
- Use of leftovers
- Too large quantities prepared
- Cooked food is contaminated by raw food.

KEEP FOOD CLEAN, COOL AND COVERED

How can we help to prevent Food Poisoning and Food Contamination?

To prevent bacteria from getting onto food:

- Always wash hands before and after handling food
- Always wash hands after using the toilet
- Keep food covered
- Handle food as little as possible
- Keep preparation and serving areas clean
- Wear clean clothing
- When entering the kitchen area or serving food put on a clean tabard or apron
- Keep animals away from the food areas
- Clean and disinfect equipment and work surfaces after every use
- Wash all fruit and vegetables
- Check all food before you use it to make sure it is in good condition
- Throw away any food that is past the 'use by' date
- Do not use food from rusted or dented cans or damaged packages
- Thaw frozen meat and poultry completely, keep separate from other food
- Store raw meat at the bottom of the fridge in a covered container
- Keep washed and unwashed food separate
- Keep cooked and raw food separate
- Work with separate utensils and, if possible, use separate chopping boards for different types of food
- Clean and disinfect your utensils and boards when you work with different types of food
- Store food correctly
- Keep your fingers out of food
- Use tongs and other suitable utensils

- Keep your hands away from your face, body and any other source of contamination while you are dealing with food

Never smoke in food-handling areas

To prevent bacteria multiplying:

- Store ready-to-eat high-risk foods below 5°C
- If keeping food hot this should be at 64°C or above
- Bacteria that cause food poisoning will grow at temperatures between 5°C and 63°C
- Bacteria grow most quickly at a temperature of around 37°C, which is the normal temperature of the human body
- Bacteria grow rapidly in a warm kitchen
- Most bacteria are killed by temperatures of at least 70°C providing this is reached at the centre of the food
- In cold conditions, below 5°C bacteria do not grow or grow only very slowly. At very low temperatures some will die, but many will survive and grow again if warm conditions return, i.e. when food is taken from a fridge or freezer and put into the warm kitchen
- Food should always be stored in proper containers after opening, never left in a can
- Cans or cartons should not be used if there is any sign of damage or of being 'blown'
- Frozen food which has defrosted should not be refrozen unless it has been cooked first
- Cooked food should be cooled before putting in the fridge but should not be out for longer than 90 minutes. Keep food covered during this time
- Fridge temperature should be 1° - 4°C**.** Do not overfill the fridge
- Freezer temperature should be minus 18°C
- When removing food or liquids from the fridge always ensure you close the door immediately – even if you are returning the milk back to the fridge once you have poured enough milk for your tea. Leaving the door open for even the shortest time raises the fridge temperature into the danger zone i.e. above 5°C.

TEMPERATURES

Cooking at least 70°C for sufficient time will kill most pathogenic bacteria, providing the food is cooked thoroughly right through to the centre of the thickest park.

At least 70°C is also the recommended temperature for reheating foods. Again this temperature must be reached all through the food.

64°C – Minimum temperature at which cooked foods must be kept hot until serving

37°C – (Body temperature) temperature at which most bacteria can grow very quickly

5°C – 63°C – Temperature Danger Zone

1°C – 4°C – Temperature range for a refrigerator

-18°C – Temperature for a freezer

OVEN TEMPERATURES

Different recipe books and ovens use different temperature scales. The chart below gives the equivalent temperatures

º Celsius Scale *		º Fahrenheit Scale	Gas mark
110ºC	cool	225ºF	¼
130ºC	cool	250ºF	½
140ºC	cool	275ºF	1
150ºC	moderate	300ºF	2
170ºC	moderate	325ºF	3
180ºC	hot	350ºF	4
190ºC	hot	375ºF	5
200ºC	hot	400ºF	6
220ºC	very hot	425ºF	7
230ºC	very hot	450ºF	8
240ºC	very hot	475ºF	9

* For fan assisted ovens, lower the ºC temperature given in the recipe by 20ºC

MICROWAVE COOKING

When using the microwave ensure food is thoroughly cooked or reheated before serving.

Allow sufficient 'standing time' to ensure even heat distribution.

Beware of hot/cold spots in food. Stir, turn or rearrange food during cooking.

Ensure food is heated right through.
Do not allow liquids to overheat.

Great care should be taken in serving food that has been in the microwave as clients could easily be scalded.

CONVERSION CHARTS

Liquid measurements conversion

All measurements are for guidance only. Do not mix more than one measuring system in any recipe.

Metric measure	Imperial measure	US cups
30ml	1 fl oz / 1 tablespoon	1/8
60ml	2 fl oz	¼
90ml	3 fl oz	
120ml	4 fl oz	½
150ml	5 fl oz / ¼ pint	
180ml	6 fl oz	¾
210ml	7 fl oz	
240ml	8 fl oz	1
270ml	9 fl oz	
300ml	10 fl oz / ½ pint	1¼
330ml	11 fl oz	
360ml	12 fl oz	1½
390ml	13 fl oz	
420ml	15 fl oz / ¾ pint	
480ml	16 fl oz	2
600ml	20 fl oz / 1 pint	2½
960 ml		4
1.1 litre	40 fl oz / 2 pints	5

Dry measurements conversion

All measurements are for guidance only. Do not mix more than one measuring system in any recipe.

25g	1 oz	325g	approx 12 oz / ¾ lb
50g	2 oz	350g	just over 12 oz
75g	3 oz	375g	13 oz
100g	4 oz / ¼ lb	400g	14 oz
125g	just under 5 oz	425g	15 oz
150g	just over 5 oz	450g	16 oz / 1 lb
175g	6 oz	675g	22 oz / 1½ lb
200g	7 oz	1 kg	2¼ lb
225g	8 oz / ½ lb	1.2 kg	2½ lb
250g	9 oz	1.3 kg	3 lb
275g	10 oz	1.8 k	4 lb
300g	11 oz	2.2 kg	5 lb

PERSONAL HYGIENE

Leave your outdoor clothes away from food preparation areas.

Hair should be tied back when you are handling food.

Wear a tabard or apron over your clothing when preparing or serving food.

Cuts and grazes must be covered with a blue waterproof plaster.
Inform your Support Team if you have any illness or infection.

You must not work around food if you suffer from a severe cold, diarrhoea, sickness, sores, boils, rashes or other infections or if you have been in contact with someone with food poisoning.

Keep your fingernails clean and trimmed and do not wear any nail products, as this may chip off into the food.

Wash your hands frequently.

Use the hand basin (not the sinks used for preparing food or washing up).

Wash your hands with soap and warm running water.

Dry your hands with a paper towel, if available, and throw the paper towel away.

Take off your jewellery and watch before you start work.

Washing your hands often during food handling keeps the number of bacteria down and prevents cross-contamination.

Never smoke in food rooms.

Remember it is good practices to avoid exposing food to the risk of contamination

SHOW DUE DILIGENCE AT ALL TIMES

Due diligence is taking all reasonable precautions to ensure food safety.

PEST CONTROL

- The safe disposal of waste is important in food safety as waste attracts pests
- Premises should be free from pests
- Put all waste into polythene bin liners inside bins with a well fitting lid
- Empty bins often, never let them overflow
- Clean and disinfect bins regularly
- Keep outdoor bins away from windows and doors
- Look out for signs of pest infestation. Mice droppings, greasy smears left by rats around pipes. Tooth marks on food packaging, pipes or woodwork
- Destroy any damaged packages as soon as you notice them
- If stock is continually rotated then signs of damaged packaging will be noticed early
- Ensure food is stored off the floor and all loose foodstuffs should be kept in airtight, pest proof containers
- Keep all food covered at all times
- Keep domestic pets, birds and wild animals away from food areas
- Keep doors and windows closed unless fly screens are in place
- Avoid spraying insecticides near food
- If you see any signs of pest infestation inform your Support Team immediately. Leave the droppings to be identified by a pest controller and do not try and get rid of the pests yourself.

CLEANING AND DISINFECTION

It is important to realise that carers are responsible for cleaning up after themselves as food places must be kept clean and tidy and disinfected regularly. ‘Clean as you go’.
Before you start cleaning, put away or cover all food.

Methods of cleaning

First – clean using hot water and detergent, rinse area and leave to air dry or use paper towels.
Second – after initial cleaning use disinfectant in high risk areas such as toilets and rubbish bins, and anti- bacterial sprays on kitchen surfaces where food is to be prepared.

Always clear up spills quickly and clean the area appropriately.

It is important to use cleaning agents and disinfectants correctly.
Always follow care instructions on the label.

Remember when you are washing your hands before cooking it is better to use the basin in a bathroom first rather than the kitchen sink.

Remember you should ALWAYS be wearing a tabard or apron over your clothing if you are in the kitchen or serving food.

Cloths pick up bacteria when used to clean worktops, trays, display units and equipment. Once on a cloth, the bacteria can easily be transferred to other parts of the food area. There is a special danger if the cloth is used for wiping areas where raw meat and poultry have been lying and is then used somewhere else.

Where appropriate a paper kitchen towel should be used and thrown away.

Although we think of wiping cloths as a means of keeping things clean they can just as easily become a means of spreading bacteria.

LEGISLATION

The Food Safety Act 1990 covers the entire food chain from the farmer through to food factories to any business involved with food. The intention of the Act is to protect the consumer against bad food. The legislation gives local authorities stronger powers to enforce food laws and increased the penalties the courts can impose if the law is broken. It also enables Ministers to make Regulations and Orders.

Food handlers must:

- Know the main causes and symptoms of food poisoning
- Avoid exposing food to the risk of contamination by washing hands appropriately
- Store food correctly
- Serve food at correct temperatures
- Report to their manager or supervisor if suffering from upset stomachs, infected wounds, cold or coughs
- Keep cuts covered by a suitable waterproof dressing
- Not smoke or spit in the food area
- Keep themselves and their clothing clean and, where appropriate, wear clean protective clothing when on duty
- Know the procedures for the prevention of cross contamination
- Keep hot food above 63°C
- Keep food requiring refrigeration at between 1°- 4°C

SHOW DUE DILIGENCE AT ALL TIMES

Due diligence is taking all reasonable precautions to ensure food safety.

DIET AND NUTRITION

This section has been designed to assist you when considering the client's daily nutritional requirements and any problems that may arise for you to be able to solve using the information provided.
Common Factors
Age—Tastes and textures change with age. Are dentures now worn?
Culture—Remember some cultures celebrate occasions with certain foods or the avoidance of them.
Religion—Some religions/faith eat foods at certain times of year/week/ again occasions.
Allergies—Medical conditions e.g. diabetes, renal disease will require special dietary needs, and of course today a lot is known about food allergies.
Personal Choice—Are they vegetarian? Vegan? Don't eat red meat, fish etc.?
Timing—Is food and drink available at the times they require?
Person Centred Planning—An approach to care planning and support for the individuals to make their own decisions about what they want in their lives. The decision then provides the basis of any plans that are developed and implemented.

Laws

Food Safety Act 1990

The Food Safety Act 1990 is an Act of Parliament and it provides the framework for all food legislation in Britain. It regulates the statutory obligation to treat food intended for human consumption in a controlled and managed way. The key requirements of the Act are that food must comply with food safety requirements, must be of the "nature, substance and quality demanded", and must be correctly described/labelled.

Health & safety at Work Act 1974

This act relates to both the employer and the employee. In respect to the employee, their duties are 'to take reasonable care for the health & safety of themselves and others who may be affected by his acts or omissions at work'.

This includes personal hygiene, hand washing, hair covered or tied back and wearing appropriate clothing whilst preparing and serving food.

General Food Hygiene regulations 1995
All establishments where food is prepared and served are governed by the General Food Hygiene Regulations 1995.

These set out basic hygiene principles that must be followed in relation to staff, premises and food handling.

Care Standards Act 2000
This sets out a range of minimum standards that specifies what social care and health care agencies have to comply with.

Health Care Act 1999
This act is to help local authorities and health workers to work more closely together.

Community Care Act 1990
To provide individuals with fair care services and to allow them to live with dignity and respect.

Mental Health Act 1983
This works with the rights of people with mental health problems to have all the care and support required.

General Data Protection Act 2018
Regulates the way health authorities gather, store and destroy information.

Equality Act 2010
Is concerned with taking steps to ensure fair treatment and support.

REMINDERS

Food Hygiene
Just a reminder to refer to your Carer handbook, Food Hygiene section, for information on Food hygiene.

Personal Hygiene
Again a reminder of the importance of personal hygiene.

Fridge
Keep these clean, check the temperatures and rotate stock.

Temperatures
Hot/Cold, a reminder the temperature needs to be as the individual likes it! How about using a thermometer. RE-HEAT OF FOOD (Carer Handbook).

Variety
Make sure the meals do not get too boring. It doesn't take a lot to make a little change to the same meal.

Size
What size portions are required?

Help to prepare
Can you get them to help prepare, lay the table, and/ or look through a cookery book for new ideas?

Environment
Choice of eating area - is it kitchen/dining room/garden (nice weather)/lounge. Is there a swallowing problem, if so good positioning is essential.

Aids

Is special cutlery etc. needed to help with independence?
IMPORTANT to give them TIME.

What is a healthy diet?

The eatwell plate shows how much of what you eat should come from each food group. This includes everything you eat, including snacks.

So, try to eat:

- Plenty of fruit and vegetables.
- Plenty of bread, rice, potatoes, pasta and other starchy foods – choose wholegrain varieties when you can.
- Some milk and dairy foods.
- Some meat, fish, eggs, beans and other non-dairy sources of protein.
- Just a small amount of foods and drinks high in fat and/or sugar.
- Try to choose options that are lower in saturated fat.

For more information on eating a healthy diet, visit eatwell.gov.uk

PROTEIN

Slightly lower requirements in men than women over 50. Chicken has been used for a long time as a staple diet for muscle building; it contains approximately 7 grams of protein per ounce and little fat. Chicken is one protein that additional flavouring such as salsa, garlic, and spices can be added.

Beef as above (7grams) but this also contains iron, zinc and vitamin B12, all these nutrients are needed to support the immune system and helps us stay healthy. Make sure to use the lean meat and not the fatty pieces. Beef contains amino acids.

Fish is one of the more functional protein sources due to its high amounts of essential fatty acids (7 grams per ounce as others). Fish can be used in many different ways making it very versatile.

Eggs are near the top of the list where protein is concerned, good choice of eggs is those high in omega 3 acids, another effective protein to support the immune system.
Egg white omelettes are great, 6 egg whites contain 22g of protein.
Skimmed milk, low fat cottage cheese are used for body building, every serving you can expect 150-300 mg of calcium. Milk is inexpensive and a high quality protein.

VITAMINS

Vitamin C is needed for many functions in the body including maintaining healthy tissues, healing wounds and helps protect the body against damage caused by toxins. A good source is fruit and vegetables especially the ones in season (not imports) but sometimes they are seen by the elderly as expensive and difficult to prepare.
Frozen fruit and vegetables are not as good as fresh but are better than none. A good consumption of vitamin C, E & A are said to help prevent cancers, cataracts, and heart disease.
As energy levels decrease, a higher protein diet should be implemented for both men and women, this should include pulses.
Vitamin D is needed to absorb calcium from the food and is important for good bones.
A really good source is half an hour of sunlight a day. It is recommended that over 65's take a vitamin D supplement and a good diet of oily fish, margarine, eggs and fortified breakfast cereal should be eaten regularly.

Calcium

Adequate intake of calcium can help slow down age related bone loss, which can result in fractures or Osteoporosis etc. It is recommended 3 portions of dairy products a day - glass of milk/cheese/yogurt - are eaten.

Calcium is also said to reduce risk of cancers such as colon cancer, reduce blood pressure, reduce risk of heart attack, help weight control and aid strong teeth. 700mg per day is recommended for people over 50 years of age.

Folate & Vitamin B12

These 2 work together for good nerve function. A new study has warned that older people who have low levels of folate may have a threefold increased risk of developing dementia. The National Diet and Nutrition Survey in older people identified low folate status in some groups as an area of particular concern. This may be due to poor dietary intake or due to problems with absorption which are more common in older adults due to certain digestive diseases or side effects of certain medications. Not enough Folate is said to lead to poor concentration levels.

Good sources are liver, yeast extracts, green leafy vegetables, pulses and oranges.

Iron

Iron is important for many functions in the body including formation of red blood cells and transport of oxygen to tissues.
Requirements in men over 50 years old remain the same as younger men, however the National Diet and Nutrition Survey of Older adults revealed that iron intake was below the recommended level for 30% of the population.

Iron absorption from the gut may also be reduced in older people, and this coupled with low intakes can increase the risk of iron deficiency anaemia.
Good dietary consumption of iron along with promoters of its absorption such as foods providing vitamin C will help to prevent this risk.

Fibre

Fibre is an important component of a healthy balanced diet. We get fibre from plant-based foods, but it is not something the body can absorb.

This means fibre is not a nutrient and contains no calories or vitamins. Fibre helps your digestive system to process food and absorb nutrients.
Fibre lowers blood cholesterol and helps to control blood sugar levels, which in turn controls appetite. There are two types of fibre, insoluble and soluble.

Insoluble fibre is found in the following foods:

Beans, brown rice, fruits with edible seeds, lentils, maize, oats, pulses, wheat bran, wholegrain breads, wholegrain cereals, whole meal breads, whole meal cereals, whole meal pasta and whole-wheat flour.

Soluble fibre

Soluble fibre contains gums and pectin. This type of fibre lowers cholesterol levels and controls blood sugar. It can be found in all fruit and vegetables, but the following are rich sources: apples, barley, citrus, guar gum, oats, pears and strawberries. Because fibre is central to your bowel health, be careful about suddenly increasing intake and overburdening the digestive system.
You should only aim for a 5g increase over a three to five day period, and drink plenty of water for it to be effective. Make sure you get both forms of fibre in the diet.

Problems

Constipation is common in older people partly due to inadequate dietary fibre. Dehydration is also common in older people and of course can cause constipation, regular fluid intake is vital to ensure good health. Fluid can also stimulate the appetite & assist in nutrients being absorbed by the body. Healthy bones come from a good diet and good mobility. Unwell people can have low energy levels, this can be due to age, medication or condition. Staying active both in mind and body is good all round, even gentle exercise can be beneficial. A report from the National Diet & Nutrition Survey found that people over 65 who had their own teeth had a better intake of vitamins, this could be because people with dentures tend not to eat apples, raw carrots, nuts and seeded bread. Good dental care is advised. Some can have difficulty with swallowing caused by disease but it may be short term as simple as a sore throat. Some drugs and nutrients interact, either with appetite or digestion, diuretics increase excretion of potassium. It is important to know that with PEG feeding there is a risk of overloading the body with fluids.

REMINDER: Document PROBLEMS and contact your Carer Support Team.

Exercise

Make sure exercise is on the day's agenda, again remember this has to be tailored to the needs and abilities of the client. The one problem that follows lack of mobility is weight gain. It is important to remember everyone needs social interaction, this helps with self-esteem, and we all love to 'eat out' on the odd occasion or even special occasion. Any minor illness such as an upset stomach can play havoc on the dietary requirements especially diabetics. Lack of mobility, weight problems, can soon hit a person's confidence.

CLIENT MEDICAL CONDITIONS

All the information in this section of the Carer Guide is Christies Care's interpretation on medical conditions and is for information only. ALWAYS seek medical advice before treating a client.

ALCOHOLISM

The problems associated with alcoholism or alcohol dependence, are wide ranging, and can be physical, psychological, or social. For some with a drink problem, drinking becomes a compulsion and takes precedence over all other activities.

A person with alcohol dependence:

- Has a strong desire to drink alcohol
- Has difficulty controlling their use of alcohol
- Persistently uses alcohol, despite being aware of the harmful effects
- Shows increased tolerance to alcohol
- Shows signs of withdrawal when without alcohol

Alcohol dependence can remain undetected for many years. Although some scientists think that there may be a genetic link to alcohol dependence, it is very difficult to prove. The easy availability of alcohol, and social patterns, can influence the likelihood of a person becoming alcohol dependent.

Risks

Excessive alcohol consumption can affect your physical and mental health, your work, and your social and personal relationships. You are also more likely to find yourself in dangerous situations if you have been drinking a lot, as alcohol affects your judgement and you may do things that you would not consider doing when sober.

Health risks associated with heavy drinking include:

- Liver disease
- Alcohol related anaemia and nutritional disease
- Chronic calcifying pancreatitis
- Heart muscle damage (cardiomyopathy)
- Alcoholic dementia

Heavy drinking also increases the risk of high blood pressure, cerebral haemorrhage (stroke), coronary heart disease and heartbeat irregularities. People who drink large amounts of alcohol over long periods of time are also at much greater risk of liver damage. This may lead to alcoholic hepatitis and cirrhosis.

Psychiatric disorders are also more common in people who drink more than 10 units a day. They include:

- Depression
- Suicide and attempted suicide
- Personality deterioration
- Sexual problems
- Delirium tremens (sudden and severe mental changes, such as seizures, following alcohol withdrawal)
- Hallucinations
- Memory loss

As with any addiction, if you are an alcoholic, the first step is to acknowledge that you have a problem. Once you have accepted that you have a problem, the next step is to seek help.

If you have an alcohol problem, there are many different professional services and support groups that can help you reduce your alcohol consumption, and give you the advice and support that you need to stop drinking altogether.

It is estimated that about 1 in 3 people who have an alcohol problem are able to reduce their drinking, or stop drinking altogether, without the need for professional help.
Some people who have a drinking problem find it extremely useful to talk about their situation with their GP or practice nurse.

Sometimes drinking alcohol is used to mask a range of other, underlying health problems, for example, stress, anxiety, depression.

ARTHRITIS
Arthritis is a term used to describe a number of painful conditions of the joints and bones. Two of the main types of arthritis are:

Osteoarthritis
Rheumatoid arthritis

Osteoarthritis - The most common form of arthritis. Cartilage between the bones gradually wastes away, and this can lead to painful rubbing of bone on bone in the joints. It may also cause joints to fall out of their natural positions. The most frequently affected joints are in the hands, spine, knees and hips.

Rheumatoid arthritis - Also known as inflammatory arthritis, is more severe, but less common. The body's immune system attacks and destroys the joints, causing pain and swelling. It can lead to reduction of movement, and the breakdown of bone and cartilage.

There are over 200 forms of arthritis. Arthritis is often associated with older people, but it can also affect children.

The main symptoms of all forms of arthritis include:

- Stiffness
- Pain
- Restricted movement of the joints
- Swelling
- Warmth and redness of the skin over the joint

Osteoarthritis often develops in people who are between 40-60 years of age and becomes more common with age, with around 12% of people over 65 affected.

It begins slowly with pain, stiffness and restricted movement in the affected joints. For some people, slight stiffness is all that is experienced, but other people go on to have cracking or creaking joints, knobbly bone growths and joints that move out of alignment. The pain and loss of movement tends to worsen as the day goes on.
Rheumatoid arthritis affects between 1-3% of the population, and often starts between 30-50 years of age. Women are three times more likely to be affected than men.
Like osteoarthritis, it begins gradually, with the first symptoms often being felt in small joints, such as fingers or toes.
The condition can then progress to cause pain, swelling and stiffness of other joints, causing lack of mobility. Cold and damp weather may aggravate the symptoms, which are often worse in the morning. The symptoms may improve during the day as the joints are being used. Rheumatoid arthritis can also leave people feeling generally unwell and tired.

In the long term, arthritis can produce worsening pain, loss of mobility and sometimes make walking difficult or impossible. As a result, depression may accompany this condition.

General effects of rheumatoid arthritis may include:
- Loss of appetite
- Tiredness
- Muscle pain
- Lumps

- Inflammation of tendons
- Sight problems
- Anaemia
- Vasculitis

Controlling weight may help to ease pressure on your joints. Weight control can also help avoid stress, or injury, to your joints and can prevent, or reduce, the severity of osteoarthritis.

It is not true that avoiding exercise will help reduce joint problems in later life. Weight bearing exercises, such as walking, will help to prevent osteoarthritis by increasing the strength of the muscles that support the joints.
There is no known way to prevent rheumatoid arthritis.

ATAXIA
Ataxia is the loss of coordination in parts of the body. It affects the parts of the nervous system that control movement and balance.

Ataxia can be a symptom of another condition. For example, multiple sclerosis, cerebral palsy, head injury, alcohol or drug abuse.

Ataxia is also the name given to a group of neurological disorders called cerebellar ataxias. Neurological means that it relates to the nervous system.

Common types of ataxia are:
- Friedreich's ataxia
- Spinocerebellar ataxia type 6
- Ataxia telangiectasia

There are many different types of ataxia. The symptoms vary depending on the type of ataxia a person has, and how severe it is.

If ataxia is caused by another health condition or injury, symptoms can appear at any age, and may get better or disappear over time.

Early symptoms of ataxia can include:
- Poor coordination in the arms and legs
- Slurred speech

As ataxia progresses, these symptoms may get more severe. Other symptoms may also develop such as:
- Difficulty with swallowing
- Lack of facial expressions
- Slow slurred speech
- Involuntary shaking of parts of the body
- Rapid involuntary movement of the eyes
- Overarched foot
- Cold feet

Some people who have ataxia may be severely affected, whilst others only get mild symptoms, for example, a slight lack of balance.
In some people, the symptoms of ataxia will gradually get worse. This means that they may lose the ability to walk. Hearing and vision can also be affected.

Because of the nature of the symptoms of ataxia, some people may have emotional problems too, such as depression.

In ataxia telangiectasia, symptoms may also include:

- Small red veins around the corners of the eyes, and on the cheeks and ears
- Delayed physical and sexual development

In Friedreich's ataxia symptoms may also include:

- Scoliosis (sideways curvature of the spine)
- Weakening of the heart
- Diabetes

There is currently no cure for ataxia. However, there are a variety of different treatments and advice available to ease the symptoms of the condition, such as:

- Occupational therapy
- Speech therapy
- Orthopaedic care and physiotherapy
- Counselling
- Support
- Supplements and diet
- Medication

Friedreich's ataxia can cause problems with the cardiac muscle and diabetes is also quite common. 1-10 people with Friedreich's ataxia develop diabetes.

AUTISTIC SPECTRUM DISORDER (ASD)

Autistic spectrum disorder is a lifelong condition that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them.
ASD is the term that is used to describe a group of disorders, including *autism* and *Asperger syndrome*. The word 'spectrum' is used because the characteristics of the condition vary from one person to another. Those with *autism* may also have a learning disability. Those who have *Asperger syndrome* tend to have average, or above average, intelligence, but still have difficulty making sense of the world.

The characteristics of ASD can vary both from person to person and across different environments. They can also be different for the same person for different times in their life.

The traits of ASD can be divided into three main groups (called the triad of impairments):

- Social interaction
- Social communication
- Social imagination and flexible thinking

A person with ASD may find it hard to relate to other people and may:

- Seem distant or detached
- Have little or no interest in other people
- Find it difficult to make friends
- Not seek affection in the usual way, or resist physical contact, such as kissing and cuddling
- Find it difficult to make eye contact with other people
- Want to have social contact but have difficulty knowing how to initiate it
- Not understand other peoples' emotions, and have difficulty managing their own emotions
- Prefer to spend time alone

A person with ASD may have difficulty using verbal and non-verbal skills, and some people may remain non-verbal throughout their lives.

Some people with ASD may also have difficulty:

- Expressing themselves well
- Understanding gestures, facial expressions, or tones of voice
- Using gestures to communicate
- Understanding instructions

Most people with ASD also have sensory difficulties. This means that they may be oversensitive to specific things like touch, certain textures, light levels, or sound. Sensory difficulties can also lead to problems with movement. A person with ASD may appear clumsy or have an unusual way of walking.

ASD is usually diagnosed in children, but some people are not diagnosed until they are in adulthood, and this is particularly evident in people with
Asperger's syndrome.
There is no treatment that can cure ASD, however there are many ways that a person with ASD can get help and support in order to manage their condition. These are often called interventions. Some people with ASD will require specialist care and support throughout their lives.

Many people with ASD benefit from support with communication in social situations. This may take the form of social groups, behavioural therapies, counselling or speech and language therapy.

You can communicate more effectively with a person who has ASD by:

- Avoiding using metaphors and sarcasm
- Saying exactly what you mean
- Using visual cues where necessary (for example, a fork for mealtimes, or a towel for bath time)

BELLS PALSY
Bells palsy is a condition in which there is a paralysis of the muscles of the face, typically on one side. Approximately 80% of people who have Bells palsy start to improve within 3 weeks.

It is usually temporary with most people making a full recovery within 2-3 months. However 5-10% of people have some slight weakness which remains forever.

Occasionally there may be little or no improvement.

Bells palsy comes on suddenly, and the cause is unknown. It is thought that a viral infection of the facial nerve causes it to become inflamed. There is sometimes a family history of Bells palsy.

Bells palsy can affect men and women of any age, although the highest incidence appears to be in 15-45 year olds. In the UK it affects approximately 1 in 70 people at some point in their lifetime.

The symptoms of Bells palsy often come on very quickly and may include:

- Facial pain around your ear on the affect side for a few days
- Face may droop on one side and may feel numb
- When smiling, only one side of the face may move
- The eye on the affected side may water or become dry and not close fully
- The mouth may be affected, resulting in not being able to chew food properly and dribbling slightly
- Might not be able to frown
- Taste buds might be affected on one side of the tongue, resulting in loss of taste
- Noises may come across as being louder than usual, which can be uncomfortable
- Speaking clearly may be difficult

In most cases, Bells palsy gets better spontaneously, without treatment. There is some evidence the early use of oral steroid is effective in improving the outcome in some people.

BIPOLAR DISORDER
(PREVIOUSLY CALLED MANIC DEPRESSION)
Bipolar disorder causes extreme mood swings. A person with the illness will have periods when they are highly active, excited and happy (this is known as mania). They will also have periods when they feel extremely low and depressed. Some people only experience a few of these episodes during a lifetime, while others have regular 'highs' and 'lows'. This pattern can interfere with everyday life and relationships. The symptoms of bipolar disorder can be treated with drugs, and some people find talking therapies helpful. People with the illness can learn to recognise when they are about to go into a high or low phase, which means they can get help to manage the symptoms.

A client having a ‘manic’ episode might:

- Be full of energy and talk very quickly
- Be over optimistic or euphoric (excessively ‘high’)
- Be unusually impatient or get annoyed easily
- Make irrational or ill-judges decisions, for example they might spend lots of money on something they can’t afford
- Talk about grand plans
- Have an increased interest in sex
- Sleep or eat less than usual
- Behave in a way that is out of character, or do things that seem risky or that could be harmful
- Have illogical thoughts, delusional beliefs or hallucinations

During a ‘depressive’ (low) episode they might:

- Feel a lack of hope, despairing or empty
- Lose interest in day-to-day life
- Feel exhausted and have problems with their sleep patterns
- Have suicidal thoughts

You can help by:

- Maintaining a consistent manner rather than reflecting the client’s mood.
- Acknowledging that the client’s experiences and feelings are real for them. However, it is important not to collude with any unrealistic plans or ideas
- Involving the client in the practical activities of your tasks
- Not showing any impatience or irritation that you might feel
- Reporting any concerns about the client to your carer support team

CANCER

Our bodies are made up of millions of tiny cells. Most of our cells divide and multiply from time to time. When an old cell is worn out or damaged, a new cell is formed to replace it. Each cell contains genes. The proteins inside the gene control when the cell should divide and multiply. If the gene is damaged or altered the cell becomes abnormal. This abnormal cell can then divide and multiply, without knowing when to stop. When a group of abnormal cells clump together and grow, a tumour forms.

There are two types of tumour:

- Benign
- Malignant

Benign tumours are not cancerous and won’t invade space or spread to other parts of the body.
Malignant tumours are the real cancers. They grow very quickly, invade nearby tissues and organs and cause damage. They may even spread to other parts of the body and cause secondary tumours. But not all cancers form solid tumours—cancers of the blood, like leukaemia, develop from abnormal blood cells, which then attack other areas of the body by circulating in the blood stream.

There are about 200 different types of cancer. Some types are more serious than others, some are more easily treated, and others have better survival rates.

Some of the common signs of the disease are:

- Unexplained lumps and swellings
- Tiredness
- Weight loss
- Poor appetite
- Night sweats
- Fever

- Anaemia

Cancer has many causes, and not all of them are known. Sometimes there is no clear reason why cancer develops. Certain cancers, like breast cancer, may be hereditary, meaning they can run in families.

However, most cases of cancer do appear to be caused by a combination of factors, all of which are known to damage cells and therefore increase the risk of cancer.
These factors include smoking, diet and environmental factors such as UV light from the sun.

Sometimes there is no clear reason why cancer develops, and sometimes the risk of getting a particular cancer may be inherited from a relative.
The treatment varies depending on the type of cancer and how far it has spread. Generally there are three main types of treatment:

- Surgery
- Chemotherapy
- Radiotherapy

Surgical removal is the main treatment for most solid tumours, especially when the cancer is in the early stages and has not spread to other areas of the body.

Chemotherapy is different drug combinations, given depending on the type of cancer. The drugs are either given by mouth, or more commonly by injection into a vein, to try and kill cancer cells or stop them spreading. Chemotherapy can also be given to shrink a tumour to make it easier for a surgeon to remove. In most cases, a rest period of one to four weeks is needed after each session.

Radiotherapy aims to destroy the cancerous cells with radiation from X-rays. The dose of the radiation is carefully controlled so it doesn't harm the surrounding healthy tissue. The treatment plan is created to suit your general health, the type of cancer you have and where it is. Radiotherapy affects people in different ways. Some people have side effects such as tiredness, lack of appetite and depression, whilst some have none.

CEREBRAL PALSY
Cerebral palsy is a condition that affects posture, movement and coordination. It is caused by damage to the brain before, during or after birth. The part of the brain that is damaged is called the cerebrum. The cerebrum is the largest part of the brain and is involved with the senses, voluntary movements of the muscles, and thinking and communication. It affects different people in different ways, and symptoms vary from mild to extreme.
Cerebral palsy is not a particular condition, but a collective name for the problems that can happen as a result of damage to the cerebrum. The brain damage is not progressive it does not get worse but some of the secondary effect, such as speech difficulties, can worsen.

There are three main types of cerebral palsy:

- Spastic cerebral palsy, in which the person has muscle stiffness that affects their range of movement and the flexibility of their joints.
- Athetoid or dyskinetic cerebral palsy, in which the muscles stiffen involuntary and which often affects speech and hearing
- Ataxic cerebral palsy, in which the person has problems with balance and coordination

Depending on the cerebral palsy, the paralysis or palsy may affect mainly the legs, or all four limbs, or just one side of the body.

They are also unable to control movement properly and may also move and jerk uncontrollably. They almost always have difficulty in walking, but this may vary from slight to total loss.

Depending on the type of cerebral palsy, other symptoms can include:

- Speech problems
- Epilepsy

- Balance and coordination problems
- Hearing and sight difficulties
- Problems controlling movements

Learning difficulties are not inevitable, but sometimes they can happen because of the damage to the brain that causes cerebral palsy.
Cerebral palsy cannot be cured because it is not possible to repair damage to the brain. However, much can be done to help children control their muscular action and to prevent deformities from forming.

- Physiotherapy is used to help with posture and movement
- Drugs, such as muscle relaxants, can be used to control spasms in the muscles and hyperactivity of the muscles
- Surgery may be required to loosen muscles that have permanently tightened around the joints, called contracture
- Braces can be used to strap up joints and help with movements such as walking

Cerebral palsy can result in physical deformities, due to stiffened joints and reduced mobility.

Involuntary muscular movements, and movement problems, increase the risk of falls and related injuries, including broken bones.

Those who are unable to walk and cannot do weight-bearing exercise, also risk having thinner or brittle bones that break more easily.

Cerebral palsy is also associated with social stigma. It may be a cause of bullying. It is important that people are educated and, to remember, that with help and support, people with cerebral palsy can lead a normal life.

CHRONIC FATIGUE SYNDROME
The main symptoms of CFS is persistent tiredness and exhaustion. This does not go away with sleep or rest, and limits the activities you were once capable of.
Fatigue is mental as well as physical, and some people describe it as overwhelming.

You may also begin to feel that:
- It is a different type of tiredness than what you have experienced before
- After sleep you do not feel refreshed
- It is not due to exhaustion, or
- it is not simply experiencing a loss of motivation, for example like people with depression

Exercising or being physically active can make symptoms of CFS worse. This is called post exertional malaise. The effect of this is sometimes delayed. For example, if you were to play a game of sport, the resulting fatigue may not develop for a few hours afterwards, or it might even develop the next day.

In addition to fatigue, other symptoms are also common, although most people do not have all of them. These include:

- Muscular pain, joint pain, and severe headaches
- Poor short term memory and concentration
- Difficulty organising thoughts and finding the right words
- Painful lymph nodes or glandular swelling around throat
- Stomach pain and other problems similar to irritable bowel syndrome, for example bloating, constipation, diarrhoea and nausea
- Sore throat
- Sleeping problems, such as insomnia and disturbed sleep
- Sensitivity or intolerance to light, loud noise, alcohol and certain foods

- Additional, less common symptoms, such as dizziness, excess sweating, balance problems and difficulty controlling body temperature.

Psychological difficulties, such as depression, irritability and panic attacks may also occur

Depending on your symptoms, CFS is often categorised into four categories, mild, moderate, severe or very severe:

Mild CFS– you are able to care for yourself, but may need to take days off work to rest.

Moderate CFS– you may have reduced mobility and your symptoms can vary from time to time. You may also have disturbed sleep patterns and commonly sleep in the afternoon.
Severe CFS– you are able to carry out minimal daily tasks, for example brushing your teeth, but occasionally you may need to use a wheelchair. You may also have difficulty concentrating.

Very severe CFS– you are unable to carry out any daily tasks for yourself and rely on bed rest for the majority of the day. Often, in severe cases, you may experience intolerance to noise and become very sensitive to bright lights.

DEMENTIA
Dementia is the loss, usually gradual, of mental abilities such as thinking, remembering and reasoning. It is not a disease, but a group of symptoms that may accompany some diseases or conditions affecting the brain. For more information, please referrer to the confusion and dementia section.

DIABETES
Diabetes is a serious life-long health condition that occurs when the amount of glucose (sugar) in the blood is too high because the body can't use it properly. If left untreated, high blood glucose levels can cause serious health complications.

There are two types of diabetes

Type 1- no insulin is produced by the pancreas. Quite often this is an auto immune response which destroys beta cells in the pancreas. Glucose levels get higher and higher and this is only treatable with insulin injections. The symptoms happen quite quickly.

Type 2 – there are slightly more processes at work, one is insulin resistance where fat blocks the glucose getting into the cells. The other is a reduced insulin production. The beta cells wear out and do not produce the insulin. Problems could be lifestyle or genetic. The symptoms happen slowly. Type 2 diabetes can be treated in a number of ways. Initially it may be sufficient to change the diet and lifestyle but it is a progressive disease and medication, or injection therapy may be needed.

Diabetics can suffer from Hypoglycaemia (Low Blood Sugar) where the levels drop below 4mmols/litre.

They can also suffer with Hyperglycaemia (High Blood Sugar) where sugar levels rise above 7mmols/litre or above 11mmols/litre 2 hours after eating a meal.

High blood sugars if left untreated can lead to serious health complications such as Retinopathy (damage to the small blood vessels at the back of the eye), Neuropathy (damage to the nerves) or Macrovascular complications such as heart attacks and stroke.

In some cases it can also lead to Diabetic Keto acidosis in people who are Type 1 diabetic- This happens when a severe lack of insulin means the body cannot use glucose for energy and the body starts to break down other body tissue as an alternative energy source. Ketones are the by-product of this process. Ketones are poisonous chemicals which build up and, if left unchecked, will cause the body to become acidic

Hyperosmolar Hyperglycemic State (HHS) occurs in people with Type 2 diabetes who experience very high blood glucose levels (often over 40mmol/l). It can develop over a course of weeks through a combination of illness (e.g. infection) and dehydration.

DYSTONIA

Dystonia is a neurological disorder that affects muscles and movement.

It can affect males and females of any age, some mildly and others severely. In adults it is more common after the age of 40. Dystonia in a child is different from dystonia in an adult. Childhood dystonia is usually inherited.

If you have dystonia, your brain sends the wrong signals to some of the muscles in your body.

This can cause repetitive muscle spasms, contractions and twitches which can be painful or uncomfortable. None of your other brain functions, such as memory, are affected.

Dystonia is not a life-threatening condition, but it can have a huge impact on your quality of life. It can affect work, relationships, and normal everyday tasks like driving. It can make social interaction difficult.

Focal dystonia's affect one part of the body only, and include:

- Cervical dystonia - this can make the head turn, twist, shake or pull. It can be very painful, and is the most common type of dystonia
- Blepharospasm - this can cause excessive, uncontrollable blinking or eye shutting; it is the second most common form of dystonia. It usually develops gradually over a few years
- Oromandibula dystonia - this can cause the jaw to be held open or clamped shut, and the tongue to be pulled up, back or down, leading to problems with eating or speaking
- Writer's cramp - this can cause painful contractions of the muscles in the hand, often over a long period of writing

- Cranial dystonia - this is a combination of blepharospasm and oromandibular dystonia and is also known as miege's syndrome
- Laryngeal dystonia - this affects the speech muscles

Other types of dystonia include:

- Segmental dystonia - this affects two adjoining parts of the body, for example the neck and the arm
- Hemidystonia - this affects one leg and one arm on the same side of the body
- Multifocal dystonia - this can affect several different parts of the body
- Generalised dystonia - this affects most of the body
- Paroxysmal dystonia - a rare type affecting the whole or part of the body, for short periods of time
- Hemifacial spasm - this is not strictly a form of dystonia, but it is often classified as dystonia, as the symptoms are very similar

Dystonia is usually classified according to the:

- Area of the body affected
- Probable cause
- Age of the person affected

Treatment for dystonia can help manage the symptoms, but cannot actually cure the condition.

The aim of the treatment is to relieve the muscle spasms and reduce any pain:

- Medication - includes muscle relaxants to control spasms and shaking, and drugs that help correct the signals the brain is sending to the muscles

- Surgery - is usually only recommended if other treatment has not worked, and may not be suitable for everyone. Benefits may only be temporary, and there are risks
- Deep brain stimulation - is an alternative to surgical treatment for dystonia.

- Two electrodes are permanently implanted into the part of the brain that is causing the dystonia

- Other treatments - may include speech-language therapy, relaxation therapy, physiotherapy and complementary therapies

Understanding and support from friends and relatives is important.

DYSPHASIA
Dysphasia can be caused by a head injury, loss of blood supply to the brain (for example, during a stroke), infection or inflammation of the brain, or brain tumour. People with dysphasia may have problems in communicating what they are thinking, with their ability to talk and write being impaired. They may also have problems understanding what is said to them.

EPILEPSY
Epilepsy is a condition that affects the brain and causes repeated seizure, also known as fits. The severity of the seizures can differ from person to person. Some people simply experience a 'trance-like' state for a few seconds or minutes, while others lose consciousness and have convulsions (uncontrollable shaking of the body).

HEART ATTACK
Heart attack is when part of the heart muscle dies because it has been starved of oxygen.

Usually this happens when a blood clot forms in one of the coronary arteries, which blocks the blood supply.

The common symptoms of a heart attack are:
- Crushing central chest pain or mild chest discomfort
- Shortness of breath
- Clammy, sweaty and grey complexion
- Dizziness
- Nausea and vomiting
- Restlessness
- Coughing

The pain often travels from the chest to the neck, jaw, ears and wrists. Sometimes it travels between the shoulder blades, back or to the abdomen.

Some people do not feel any pain during a heart attack. This is known as a silent heart attack and tends to affect people with diabetes or those aged over 75 years.

They do say that up to 20% of mild heart attacks are not diagnosed. Factors that increase the risk of a heart attack include:
- Men over 45 and women over 55
- Smoking
- Being overweight
- High blood pressure
- High blood cholesterol
- A diet high in saturated fats
- Diabetes
- Drinking too much alcohol
- Lack of regular exercise
- Severe sudden stress

The risk of a heart attack is also increased if you have:
- Angina
- Have had a previous heart attack, heart bypass surgery or angioplasty

Anyone suspected of having a heart attack should get medical attention immediately. The sooner the treatment, the more effective it will be and the greater the chance of survival.
On arrival to hospital, diagnosis will usually be confirmed using either an electrocardiograph (ECG) or cardiac enzyme test.

Most heart attacks can be successfully treated if immediate medical help is provided.

If the person is not breathing, coughing, moving or responding to stimulation, immediate lifesaving treatment with cardio-pulmonary resuscitation (CPR) should be started.

CPR consists of giving 30 chest compressions to massage the heart for every two mouth to mouth resuscitation breaths.
If the heart has stopped, the medical team at the scene, or in hospital, will try to restart the heart with a device called a defibrillator. This sends an electric shock across the chest to kick start the heart.

To help prevent a heart attack, you can:

- Give up smoking
- Take regular exercise
- Reduce cholesterol
- Lose weight
- Reduce your blood pressure

Drinking too much alcohol and having too much salt can also increase the risk of coronary heart disease, which can lead to a heart attack.

HUNTINGTON'S DISEASE
Huntington's disease (HD) is a hereditary neurological disease for which there is no cure. It damages the nerve cells in the brain and causes degeneration, deterioration and gradual loss of function of some areas of the brain. This affects movement, cognition and behaviour.

Some people start to show symptoms of Huntington's between the ages of 20 and 30, but normally it starts between the ages of 30 and 50. Generally, it progresses and worsens for ten to twenty years until the person eventually dies. Symptoms vary between people, there is no typical pattern.

Huntington's is caused by an error in the genetic code that programmes the way the body works. The mistake lies in a defective gene on Chromosome 4. The parent with the Huntington's gene has one good copy of the gene and one faulty copy of the gene, so there is a 50:50 chance the child will get the faulty gene. If Huntington's is inherited from the father it tends to be more severe.

Movement - Huntington's affects movement and early symptoms include slight uncontrollable movements of the face, and jerking, flicking or fidgety movements of the limbs and body.
Later in the disease, the uncontrollable movements are more frequent and extreme.
People with Huntington's can find eating tiring, frustrating and messy, because the mouth muscles and the diaphragm muscles do not work properly due to the loss of control. Loss of co-ordination can lead to spilling or dropping food.

Swallowing is a problem, so choking on food and drink, particularly thin drinks like water, can be a common problem.

Because of the extra calories used up by the constant movement and because of the problems with eating, people with Huntington's disease are often underweight. This makes them prone to infection, illness, muscle wasting and slower wound healing.

Behaviour - Huntington's disease also affects behaviour; behavioural changes are often the first symptoms to appear. People with Huntington's find they have a lack of concentration, short-term memory lapses and problems with orientation.

A person with Huntington's may seem stubborn, irritable and depressed, and easily frustrated. They may also display a lack of drive, initiative and concentration that may make them appear lazy. This is not the case; it is just the way the disease affects the personality.

People with Huntington's have a higher than average number of psychiatric problems such as obsessive compulsive disorder (OCD), mania and schizophrenia. Loss of inhibitions can bring about a lack of interest in hygiene and self-care.

Communication - Impaired breathing can make speech and articulation difficult.
People with Huntington's often have difficulty putting thoughts into words and slur their speech. They can understand what is being said to them, but cannot necessarily communicate that they understand or respond. Huntington's can be very stressful and upsetting for the family. It is distressing to see a family member's state of mind deteriorate so much that they may not be like their former self at all.

There is no cure, but treatment can be used to manage the associated symptoms:

- Medication - anti-depressants can improve mood swings
- Communication strategies - Speech and language therapy can improve communication skills. Some people find communication aids helpful, for example pointing to symbols on a chart
- Diet - a high calorie diet is needed, because more calories are burnt off with their continuous movement. Help is needed with eating and drinking, food should be easy to chew, swallow and digest. Equipment is available to help with this, such as special straws and non-slip mats
- Physio - This can help with mobility and balance
- Occupational therapist can help with day to day activities

HYPOTHERMIA
Hypothermia happens when a person's body temperature drops below 35˚C (95˚F). Normal body temperature is around 37˚C (98.6˚F). Hypothermia can quickly become life-threatening and should be treated as a medical emergency. Hypothermia is usually caused by being in a cold environment. It can be triggered by a combination of things, including being exposed to the cold for a long time – this can be outdoors in cold conditions, in a poorly heated room or being in cold water. Mild symptoms included shivering, tiredness and confusion. But as the temperature drops, shivering becomes more violent and a person is likely to become delirious, struggle to breathe and may become unconscious.

LEUKAEMIA
Leukaemia is the name for a number of cancers of the white blood cells. White blood cells are the cells that fight infection in the body. There are different types of leukaemia, depending on what type of white blood cells are involved and how they are affected. The two main groups are:

- Chronic leukaemia, when people may live with the symptoms for years. In chronic lymphocytic leukaemia (CLL) there is an increase in the number of white blood cells called lymphocytes.
  In chronic myeloid leukaemia (CML) there is overproduction of another type of white blood cell called myeloid or granulocytes.
  These cells are abnormal, so are not able to carry out the normal functions of white blood cells, such as fighting infection.
- Acute leukaemia's which are more aggressive, and develop quickly. Acute lymphoblastic leukaemia (ALL) is over production of immature (underdeveloped) lymphocytes, called lymphoblast's.
  Acute myeloid leukaemia (AML) is overproduction of immature myeloid while blood cells.
  In acute leukaemia's, the cells reproduce very rapidly and do not become mature enough to carry out their jobs in the immune system.

Acute leukaemia's start suddenly and can cause the person to feel very ill in just a few days or weeks. Symptoms may include:

- Pale skin
- Repeated infections, such as sore throats
- Abnormal bleeding from the gums and into the skin

- Heavy periods in women
- Loss of appetite and weight
- Flu-like symptoms such as tiredness and achiness
- Pain in the joints
- Nose bleeds
- Bruising more easily

In addition to bruising more easily, small red spots called petechiae may appear on the legs or in the mouth.

Chronic leukaemia's begin slowly with a gradual feeling of tiredness. The spleen grows until it becomes massive, causing a dragging weight and pain in the upper left side of the abdomen.
Other symptoms may include:

- Gradual loss of weight
- Aching in the bones
- Nosebleeds
- Unwanted and prolonged erections in men
- Fever, heavy sweating and night sweats
- Swollen lymph glands especially in the neck, groin and armpits
- Bruising easily
- Lack of energy
- Breathlessness

Exposure to certain things may increase the risk of leukaemia:

- Large doses of radiation
- Drugs used to treat certain cancers
- Some industrial chemicals
- Certain viruses

The first treatment of all types of leukaemia is usually chemotherapy. This is a powerful drug treatment that kills the leukaemia cells. This is given in the form of tablets or injected directly into a vein. Bone marrow transplant is also used to treat leukaemia. It can be used in conjunction with chemotherapy to greatly improve the patient's chances of recovery.
The removal of the spleen is often recommended in chronic leukaemia's, and certain types of acute myeloid leukaemia will be treated with a special form of vitamin A called ATRA.

Treatment aims to destroy all the white blood cells affected by leukaemia. When a blood or bone marrow sample is examined under a microscope, and no leukaemia cells can be found, the person is said to be in remission. This is not a guaranteed cure, because leukaemia can return, but it is a sign that the treatment has worked. If leukaemia comes back, this is called a relapse.

LYME DISEASE
Lyme disease is caused by infection with spiral bacteria called 'Borrelia Burgdorferi'. The bacteria are spread by infected ticks when they attach to your skin and feed on your blood. The infection cannot be transmitted directly from person to person.
Ticks are usually found in places such as forests and heathland, so infection is most likely to be caused in these areas. However, they can also be found in some parks. Ticks are very small, about the size of a poppy seed and can easily be overlooked.
Late spring, early summer and autumn are the most likely times for infection, as these are the peak times of the year for tick feeding.

Most ticks are not infected with the bacteria that cause Lyme disease. Even if a tick is infected, it does not spread the bacteria in the first few hours of its feed, so there is a very low risk of infection if a tick is removed quickly.

A tick bite usually looks like a lump with a small scab on the skin surface at the site of the bite. Most people with Lyme disease then develop a reddish skin rash in a ring shape, and this may be the only

sign of infection.

Other early symptoms with early Lyme disease include:

- Tiredness
- Generally feeling unwell
- Headache
- Fever
- Aches in muscles and joints
- Stiff neck
- Swollen glands

Without treatment, these symptoms may last for weeks, or even longer. Rarely, there are serious complications, and in some cases, these can occur several years later.
In rare cases there are more serious complications. These can affect the nervous system, joints, heart and other tissues.

A doctor will usually make the diagnosis based on your symptoms, such as the erythema migrans rash. Lyme disease can be difficult to diagnose, especially if you have been bitten by a tick, but do not realise. Therefore it is important to be aware of the symptoms. It is difficult to identify the bacteria, so the internationally recognised criteria for diagnosis of Lyme disease are based on tests that look for specific antibodies in the blood.
Oral antibiotics are usually recommended for the treatment of early Lyme disease.

Intravenous antibiotics are sometimes necessary in complicated cases. These medicines are very effective for treating the infection, and can prevent serious complications developing.

Complications of Lyme disease are rare, but can be serious. They include:

- Nervous system problems such as meningitis
- Facial palsy (causing weakness in of the facial muscles)
- Radiculopathy (causing shingles)
- Encephalitis
- Damage to the joints leading to arthritis
- Heart block
- Inflammation of the heart muscle
- Inflammation of the bag that surrounds the heart

Early diagnosis and treatment can help to prevent these complications.

The best way to prevent Lyme disease is to be aware of the risks when you visit areas where ticks are likely to be found.
No vaccine is currently available.

MOTOR NEURONE DISEASE

Motor neurone disease (MND) is the name given to a group of relatively rare disorders that cause the motor system to progressively degenerate (break down).
The motor neurones are a complex system of the nerve cells in the brain and spinal cord that control the action of the muscles.

MND is a condition that usually affects adults and it is common among people aged 50 to 70. Men are twice as likely to get the condition than women. Every year, approximately one person in 50,000 will develop motor neurone disease.

Weakness and wasting of muscles usually occurs initially in the arms or legs with some muscles being affected more than others. At first, symptoms are usually mild, and can cause difficulty walking and difficulty holding objects.

Other symptoms may include:

- Twitching of the weakened muscles

- Tiredness
- Jerking of the arm or leg when resting

Some people may develop weakness and wasting in the muscles supplying the face and throat, causing problems with speech and difficulty chewing and swallowing.

MND is generally a steadily progressive disease, but the rate of progression varies greatly from one person to another. Sometimes, there may be a period when symptoms don't get worse for a short while. However severe, there is not normally any effect on hearing, eyesight, intellectual function or awareness. Sexual function and full control of the bladder and bowels are not normally affected.

As symptoms get worse in later stages of the condition, a person may become totally immobile.

The causes of motor neurone disease are unknown and research is continuing. It is thought that certain chemicals that are only found in motor neurones are damaged in some way.

There is also some evidence that MND can run in families.

Around 5-10% of people who have MND have had a family member that has had it.

Diagnosis of motor neurone disease is made by looking at the physical symptoms and by ruling out other muscle and nervous diseases, such as multiple sclerosis.

The patient may be referred by the GP to the neurology department. A neurologist may carry out a series of tests. However, there is no test that can definitely confirm MND. The tests may include:

- An MRI scan
- Blood tests
- Electromyogram (EMG)

There is no known cure for motor neurone disease. Depending on the part of the body first affected, the survival time varies from 2 to 10 years, with some people surviving for more than 20 years.

The National Institute for Clinical Excellence (NICE) has approved the drug, Riluzole (rilutek) for patients with Amyortrophic lateral sclerosis (ALS), the most common form of the disease. Rilutek can slow the progress of the condition and enables individuals to remain longer in the early stages of the disease when symptoms are less severe.
Some people who have MND also take vitamin E, which can slow the progress of the condition.

Support groups can be very important in helping people with MND and their families to cope as the disease progresses.

MULTIPLE SCLEROSIS
Multiple sclerosis (MS) is a progressive condition, which affects the nervous system, for which there is no cure.
MS is the most common neurological disorder among young adults, and it affects about one person in 600 in the UK. MS can occur at any age, but it is rare before puberty and after 60. In most cases symptoms are first seen between the ages of 20 and 40.

Women are affected more often than men, with approximately three women to every two men being diagnosed.

Nerve fibres are normally insulated with a protective sheath of fatty tissue called myelin. In MS, there is a patchy loss and scarring of this myelin sheath (Sclerosis means scars).

This means that where the myelin is damaged, the nerve messages cannot travel normally from the brain to different parts of the body through the central nervous system, affecting many functions of the body.

There are 4 types of MS:

- Benign - MS that starts with a small number of mild attacks followed by complete recovery
- Primary progressive MS - the pattern isn't of relapses and remissions but symptoms gradually develop and worsen over time
- Relapsing-remitting type - the person has relapses followed by remissions. These tend to be unpredictable and their cause is unclear. They can last for days, weeks or months and vary from mild to severe
- Relapsing-remitting MS - This means that the disability does not go away after a relapse and progressively worsens between attacks, or that the cycle of attack, followed by remission is replaced by a steady progression of disability

The most common form of MS is relapsing-remitting, with 80% of people with MS having this type.
50% of people with relapsing-remitting MS later develop into a form known as secondary progressive MS during the first 10 years.

Each person with MS has a different set of symptoms. They change from time to time and vary in severity and duration. Most people will have more than one symptom, but will not experience all of the following:

- Fatigue-debilitating and out of proportion to activity
- Visual disturbances - blurred or double vision, permanent or transient loss of vision or colour, blind spots, pains behind the eyes, jerking eyes
- Altered sensations - pins and needles, numbness, tingling, itching or a burning feeling
- Bladder and bowel problems - frequency and/or urgency when passing water, incomplete emptying or urinary incontinence. Also constipation, a lower digestive system and bowel incontinence
- Cognitive difficulties, short-term memory problems, concentration problems, reasoning and judgement problems, mood swings, untypical emotional outbursts, impaired ability to learn
- Speech or swallowing difficulties
- Muscle spasm, weakness, loss of coordination, unstable walking, clumsiness
- Loss of balance, dizziness, vertigo, tremor

MS is a very variable condition. There is no drug that can cure MS, but treatments are now available which can successfully manage and treat the symptoms.

Treatment of MS will depend on the symptoms and stage of the disease.
If the symptoms are mild, with no relapses, no treatment may be needed.
People with MS should be referred to a specialist neurological rehabilitation service for help with equipment or care.

There is some evidence to suggest the following complementary therapies may help:

- Reflexology
- Fish oils
- Magnetic field therapy
- Neural therapy
- Massage and body work

MUSCULAR DYSTROPHY

Muscular dystrophy is a genetic, inherited condition, where slow, progressive muscle wasting, leads to increasing weakness and disability.
There are over 20 types of genetic muscular disorders, each differing in their symptoms and severity. Most types of muscular dystrophy are very rare, with about 1 in 20,000 babies being born with the condition in the UK each year.

Most forms of muscular dystrophy are caused by cellular changes in the genes that are responsible for the structure and functioning of a person's muscles.
The change affects the muscle fibres and interferes with their ability to contract. As muscle contraction

plays an essential part in the functioning of muscles, muscular dystrophy often results in severe disability.

Some of the main types of muscular dystrophy include:

- Duchenne
- Becker
- Limb-girdle
- Facioscapulohymeral
- Oculopharyngeal
- Myotonic dystrophy

Duchenne muscular dystrophy is the most common and most severe type of muscular dystrophy and is caused by a faulty gene that prevents the production of a protein called dystrophin. It usually affects boys, but can occasionally affect girls as well.

Duchenne muscular dystrophy causes progressive weakness in the muscles of the legs, leading to mobility problems in young children. Most children with the condition will require a wheelchair by the age of 11.

Becker muscular dystrophy is a milder form of Duchenne muscular dystrophy. It tends to be more common in boys, and its symptoms rarely become apparent before the age of 10.

Limb-girdle muscular dystrophy includes about 15 different variations of genetic muscular disorders. It occurs in both males and females equally, and initially affects the muscles around the shoulder girdle and hip girdle. The symptoms usually start in late
childhood, or early adulthood, and often progress to a level of fairly severe disability within 20-30 years.

Facioscapulohymeral muscular dystrophy can affect both males and females. It affects the muscles in the face (facio), shoulders (scapula) and upper arm (humeral). The leg muscles are also sometimes affected. The condition usually develops between 10-40 years of age, and progresses slowly.

Oculopharyngeal muscular dystrophy affects both the muscles of the eye (ocular) and throat (pharyngeal). The condition commonly occurs in people between 50-60 years of age. The first symptoms are droopy eyelids and difficulty swallowing.
Myotonic dystrophy is the most common form of muscular dystrophy in adults. As with other varieties of the disease, it involves progressive weakness and wasting of the muscles. However, it is the smaller muscles, such as those in the face, jaw, neck, and hands that are affected, rather than the muscle groups in the legs. Myotonic dystrophy may appear at any time, from birth to old age and it affects both males and females equally.

NEUROFIBROMATOSIS

Neurofibromatosis is a genetic disorder that mainly affects the nervous system. It is caused by a change in a gene, which affects the DNA coding. The gene can be inherited from your parents, or it may spontaneously change itself for no reason.
In this case, the change usually happens in the egg or sperm, just before conception.
There are two different types of neurofibromatosis:

- Nf1- Von Recklinghausen's disease, or Peripheral Nf
- Nf2- Bilateral Nf

Nf1 is the most common type and Nf2 is generally the more serious. In the UK, about 1 in every 2,500 babies is born with Nf1, and 1 in 35,000 is born with Nf2.

Neurofibromatosis affects men, women and ethnic groups equally and it causes non-cancerous tumours to grow on the nerves throughout the body. These growths cause a number of problems, depending on the type of neurofibromatosis and the number, size and location of the tumours.

There is no cure for neurofibromatosis, but the Neurofibromatosis Association is working towards better treatments and screening and counselling is available for families with a history of neurofibromatosis.

Nf1
The symptoms of Nf1 tend to develop in early childhood. Coffee coloured birthmarks on the skin are one of the first signs. Many people have one or two of these, but if more than six have developed by the time the child is five, Nf1 should be suspected.
Another sign is outbreaks of freckles in unusual places, such as the armpits, groin and under the breasts. As the child gets older, small tumours develop on the nerves in the skin, and occasionally deeper inside the body.

The lumps vary in size, and some may be soft, while others are firm and round. They can increase in size and number as the child gets older.

For some people, Nf1 is little more than a skin condition and they do not experience related medical problems.
However, complications are quite common and can occasionally be serious.

If neuromas press on nerves to the eyes and ears, they can cause sight and hearing problems. In around 60% of children, this can lead to learning difficulties, behavioural problems and a lower than average IQ. Poor co-ordination and spatial awareness, along with short term memory problems are also common.
Some neurofibromas spread around large nerves as they grow and may feel like knots or cords beneath the skin. They are called plexiforms and can grow anywhere in the body. If they are near the skins surface, they can grow quite large and can be painful if knocked, or disfiguring, depending on their size and shape.

Between 30-35% of people with Nf1 have other complications, including high blood pressure, curvature of the spine, bone problems, benign skin tumours, speech problems, increased risk of epilepsy and hearing defects.

Nf2
The symptoms of Nf2 are more serious. Instead of growing in the skin, the tumours develop on nerves deeper inside the body.

The most common symptom is a tumour that develops on the nerve to the ear.
This is called acoustic neuroma and causes a gradual loss of hearing.

Hearing loss doesn't usually develop until the teens and early twenties. It may be worse in one ear than the other, because tumours can grow at different rates. Some people also notice ringing or roaring in the ears, or unsteadiness when walking.

Some tumours grow slowly and don't cause problems for years, and others develop quickly. Regular health checks for people with Nf2 are important, because tumours can often be removed before they cause problems.
Less common features of Nf2 include café au lait spots, which occur in far fewer numbers than Nf1, and cataracts. Cataracts are normally very rare in children, so the presence of them helps to diagnose Nf2. They don't usually cause too many problems and can be treated with glasses or removed.

Tumours on the skin, brain and spinal cord are complications of Nf2 that can sometimes be serious. Brain tumours are normally benign, but if their position puts pressure on the brain, they can cause headaches, vision problems, difficulty balancing and fits.

Tumours on the spinal cord, or nerves surrounding it, can cause symptoms in the limbs, such as trembling, numbness or pain. Spinal tumours around the neck can affect the face, making it hard to blink, smile or swallow.

Tumours on the skin look a bit like swellings that develop in Nf1. They are not cancerous, but should be checked by a doctor if they grow, change or become painful.

OSTEOPOROSIS

Osteoporosis is a condition that affects the bones, causing them to become thin and weak.
It happens more commonly in old age, when the body becomes less able to replace worn out bone.
Special cells within the bones are no longer able to effectively break down old bone and renew it with healthy, dense new bone.
As you get older, you also lose a certain amount of bone, causing the bones to become thinner. The bones become fragile and more likely to break, particularly the bones of the spine, wrist and hips.

Bone is a living tissue that is constantly repairing itself.
It is made of a hard outer shell, which contains mesh collagen, minerals, blood vessels and bone marrow. This mesh looks a bit like a honeycomb, with spaces between the different parts.

Healthy bones are very dense, and the spaces within bones are small. In bone affected by osteoporosis, the spaces are larger, making the bones weaker and less elastic.

Bones are repaired and reinforced by a range of proteins and minerals, which are absorbed from the bloodstream. They include calcium, phosphorus, proteins and amino acids. Change in hormone levels can therefore affect the strength of the bones.

Osteoporosis is very common and, in some cases, can be severe. Approximately three million people in the UK have osteoporosis and there are over 230,000 fractures every year, as a result.

Symptoms

Osteoporosis develops slowly, over several years. The early warning signs may include joint pains, and having difficulty standing or sitting up straight.
When the bones are significantly thinned, breakages of the wrist, hip or spinal bones are common. A cough or sneeze may cause the fracture of a rib, or partial collapse of the bones in the spine.

A fractured bone in an older person can be serious, because the bone is no longer able to repair itself effectively. This can lead to arthritis, and even disability, such as long term problems with mobility.

The characteristic stooping position, that is common in older people, is a visible sign of osteoporosis.
It happens when the bones in the spine are fractured, making it difficult to support the weight of the body.

Causes

Women are at greater risk of developing osteoporosis than men. This is due to the decrease in the hormone oestrogen, after the menopause, which is essential for healthy bones.

The male hormone testosterone also helps to keep the bones healthy.

Men continue to produce this hormone into old age, but the risk of osteoporosis is increased in individuals with low levels of testosterone.

Diagnosis

Osteoporosis is not often diagnosed until the weakening of the bones has led to a broken bone. An X-ray cannot reliably measure bone density, but it is useful to identify spinal fractures.

A bone density scan is used to measure the density of the bones and compare this to a normal range.

Treatment

There are a number of different treatments available for osteoporosis.

Hormone replacement therapy (HRT). HRT is used for women going through menopause, as it helps to maintain bone density and reduce fracture rates.
Testosterone treatment is used for men, in the relatively rare cases when there is insufficient production of the male hormone.

Bishopsphonates are non-hormonal drugs that maintain bone density and reduce fracture rates.

The rate at which cells break down is slowed and the production of new bone increases.

Calcitonin is a hormone made by the thyroid gland. It inhibits the cells that break down bone.

Calcium and vitamin D supplements can be of benefit for older people, male and female, to reduce the risk of hip fracture.

Having enough calcium in your diet when you are young, is important in minimising the risk, especially for women.
Selective Estrogen Receptor Modulators (SERMs) are drugs that have a similar effect on bone as the hormone oestrogen. They help to maintain bone density and reduce the risk of fracture, particularly the spine.

In addition to these treatments, the National Osteoporosis Society (NOS) runs 120 support groups across the country for sufferers. The NOS also have a range of detailed information booklets, and a national helpline (0845 450 0230), offering support and advice.

PARKINSON'S DISEASE
Parkinson's disease is a chronic (persistent), neurological condition, that affects around 120,000 people in the UK. The condition was named after Dr James Parkinson, who first identified it in 1817. Parkinson's disease affects the way the brain coordinates body movements, including walking, talking and writing.

Parkinson's disease affects both sexes, although statistically, men are slightly more likely to develop the condition than women.
The risk of getting the condition increases with age, with symptoms usually appearing in those who are over 50 years of age. However, younger people can also be diagnosed with the disease.

Symptoms
The symptoms of Parkinson's disease usually begin slowly and develop gradually, in no particular order. Parkinson's affects each individual differently and each person with the condition will have a different collection of symptoms and respond differently to treatment.

There are three main symptoms of Parkinson's:
Bradykinesia (slowness of movement). If you have Parkinson's disease, initiating movement, such as starting to get out of a chair, can become difficult, and it can take you longer to perform tasks.
You may also lack coordination in your movements.
People often put this slowness of movement down to old age, and many do not have Parkinson's diagnosed until other symptoms occur.

Tremor (shaking). Tremor usually begins in one of your hands, or arms. It is more likely to occur when that part of your body is at rest, and usually decreases when you are using it. Shaking may become more noticeable when you are stressed, or anxious. Although most people associate Parkinson's disease with tremor, up to 30% of people with the condition will not have this symptom.

Stiffness of muscles (rigidity). If you have Parkinson's disease, your muscles may feel tense, and due to stiffness, you may have trouble performing simple, everyday tasks. For example, you may find it difficult to turn around, get out of a chair, and roll over in bed. Making fine finger movements, facial expressions and body language may also become difficult.

Other symptoms associated with Parkinson's disease include:
- Tiredness
- Constipation and bladder weakness
- Depression
- Problems with handwriting, speech and balance
- Difficulty swallowing

Diagnosis

There are no tests that can definitely prove that you have Parkinson's disease. Your GP will base the diagnosis on the symptoms you are experiencing, your medical history, and the results of a clinical examination.

Causes
Parkinson's disease is caused by a loss of nerve cells in a section of your brain. The nerve cells are responsible for producing a chemical called dopamine, which helps to transmit messages from your brain that control and coordinate your body movements.
If the nerve cells in your brain become damaged, or die, the amount of dopamine is reduced and the messages to your body become slow and abnormal.

When 80% of the nerve cells have been lost, the symptoms of Parkinson's disease will appear.

Treatment
In the early stages of Parkinson's disease, you may not need any treatment, because the symptoms will usually be mild. However, you may need to have regular appointments with your specialist, so that the condition can be monitored.

At the moment, there is no cure for Parkinson's disease, but there are a range of treatments available to help control your symptoms, and maintain your quality of life. Medication is the main treatment option and there are three main types that are commonly used:

Levodopa is a medication that is absorbed by the nerve cells in your brain, and turned into dopamine. It is usually taken by mouth, in tablet or liquid form, and is often combined with other medication, to reduce the side effects of Levodopa, which include nausea, vomiting, tiredness and dizziness.
Dopamine agonists have a similar effect to Levodopa, but they work in a different way. They are mostly prescribed in tablet form, but can also be given by injection. Side effects are similar to that of Levodopa, however episodes of confusion or hallucinations are more common.

Monoamine oxidase-B inhibitors are another alternative to Levodopa, and can cause confusion, but generally have lesser side effects than other drugs. However, monoamine oxidase-B inhibitors can generally only be used during the onset of Parkinson's.
Surgery is sometimes used to treat people who have had Parkinson's disease for many years. However, this is not suitable for everyone.
Although surgery does not cure Parkinson's disease, it does ease the symptoms for many people, particularly if medication is not working well.

Therapies. There are a number of therapies that can make living with Parkinson's easier.

The three main therapies are:
- Physiotherapy (eases muscle stiffness)
- Speech and language therapy (enhances speech loss)
- Occupational therapy (assists with day to day living)

PNEUMONIA
Pneumonia is inflammation (swelling) of the tissue in one or both of the lungs. It is usually caused by an infection. At the end of the breathing tubes in the lungs are clusters of tiny air sacs. In pneumonia, these tiny sacs become inflamed and fill up with fluid. Common symptoms of pneumonia include:

- Difficulty breathing
- Coughing
- Fever

SPINA BIFIDA
Spina bifida is caused by problems in the development of an embryo in the womb. It is known as a neural tube defect, as it results from the failure of the embryos neural tube to develop properly.

The neural tube forms in the first few weeks of pregnancy and eventually goes on to form the baby's

brain, spinal cord and their coverings.

Spina bifida is when the neural tube does not develop properly and this results in an incorrectly developed spine.

The features of spina bifida vary between individuals, but commonly the small bones that make up the spine have not formed fully and may have gaps in them. In severe cases, one or more vertebrae may be missing, exposing the spinal cord.

Symptoms:
The effects vary with the type of spina bifida and how severe it is. The milder forms of the condition, often described as tethered spinal cord, can produce symptoms at any age, although they usually appear in early childhood.

They include:

- Back pain
- Weakness in the lower limbs
- Bowel and bladder problems

In more severe cases, legs may become paralysed or lose all sensation. In the worst cases, the whole of the lower body may be paralysed and there may be no control of the bladder.

Repeated urinary tract infections may lead to kidney damage. Failure of normal circulation of the cerebrospinal fluid may also lead to water on the brain.

Diagnosis:
Spina bifida, especially severe, can be diagnosed before birth, by ultrasound exam. A blood test is used to detect a substance called alphafetoprotein. There is a marked rise in the levels of alphafetoprotein when the foetus has spina bifida.

Symptoms of spina bifida may start in childhood, adolescence or adult life, as bladder problems, such as incontinence and repeated urinary infections. There may be some signs of problems with the neural tube, in the centre of the lower back.
These include:

- A tuft of hair overlying the defect
- A fatty growth under the skin in the area
- A narrow channel running inwards from the surface

Further tests using X-ray, or scanning will reveal the defect. Surgery to correct the defect is usually performed, as soon as possible after birth.

Prevention:
Several studies have shown that folic acid significantly reduces the risk of spina bifida.

The Department of Health recommends that women should take a daily supplement of folic acid while they are trying to become pregnant, and for the first twelve weeks of pregnancy.

SPINAL MUSCULAR ATROPHY
Spinal muscular atrophy (SMA) is a genetic disease that affects muscle movement. It causes the motor neurons, in an area of the spinal cord, to deteriorate. Motor neurons are nerve cells in the spinal cord that send impulses to the muscles, telling them to expand or contract. The deterioration of the motor neurons gradually breaks the link between the brain and the muscles that the spinal cord controls.
As the link is broken, the muscles, used for activities such as crawling, walking, sitting up and moving the head, are used less and less and become weaker or shrink.

Childhood SMA (Types 1,11 and 111) is a recessive disease, which means that for a child to be affected by SMA, both parents must carry the defective gene and both must pass it on to their child.

When both parents are carriers of the defective gene, the chance of both parents passing the gene to their child is 1 in 4.

Spinal muscular atrophy in adults can develop as a recessive disease, or as a dominant disease. Dominant means that the disease can develop if only one parent passes on the defective gene. Occasionally, adult SMA can develop as a result of these changes in the body.
In these cases it is believed that the SMA is non hereditary.

Kennedy's syndrome, only seen in men, is also caused by a defective gene. Men who carry the gene, pass it to all of their daughters, but none of their sons. Women who carry the gene, may pass it to both their daughters and their sons. Daughters who inherit the gene are carriers, and sons who inherit it will develop the disease in adulthood.
As SMA often affects the muscles involved in breathing and coughing, people with the disease have an increased tendency to develop pneumonia and other lung problems.

Symptoms:
SMA1: Babies with SMA Type I have weak, thin muscles that make them limp or floppy, unable to sit without support or to raise their head. They usually have breathing and swallowing problems, due to the weakness of their chest muscles. Children with SMA Type I are unlikely to live past their second birthday.
SMA II: Infants with SMA Type II have less severe symptoms, although they will become weaker over time. They can sit, although they cannot stand or walk unaided. They may have breathing problems, floppy arms and legs, reduced or absent tendon reflexes and twitching of the arm, leg or tongue muscles. They may develop deformities of the hands, feet and chest, and their joints may be affected by shortening of their muscles (contractures), which can reduce movement in their limbs. Due to the weakness of the muscles supporting the bones of the spine, most children with SMA Type II, develop curving of the spine.

SMA Type III: The symptoms of children with SMA Type III vary greatly. They are usually able to stand unaided, but often find walking or getting up from a sitting position difficult, and they may have balance problems, an abnormal manner of walking, or difficulty running or climbing steps.
They may also have a slight tremor of their fingers. However, their muscles will become weaker over time and they may lose the ability to walk, as they get older.

Children with SMA Type III, do not usually have difficulty breathing or swallowing.
SMA Type IV: The symptoms of adult SMA usually develop over the age of 35 and normally progress very slowly. In the majority of cases, weakness starts off on one side of the body, but may progress to both sides. Symptoms may include weakness of the muscles in the hands, tongue and speech impairment.
Diagnosis is generally carried out by establishing the family history, combined with an examination of the muscle tissue, along with a small muscle tissue biopsy.

Treatment:
At present there is no cure for SMA, nor is there treatment that can repair the motor neurons of the spinal cord or reverse the progressive weakening of the muscles caused by SMA. As a result, treatment for SMA focuses on the symptoms and on supportive care.

Respiratory exercises and other breathing techniques are important, to reduce the chance of chest infections and to minimise their effects, if they do develop.

Children or adults who have problems breathing, can be given a range of ventilation assistance, such as oxygen through a mask or mouthpiece, for as many hours a day as they need.

This kind of system comes in many forms and can easily be removed for eating, drinking, talking or breathing normally.

Children who are unable to swallow, can be fed through a tube attached to their abdomen. Modern systems allow this tube to be detached, when not in use.

Physiotherapy can improve the posture of those with SMA. A back brace or corset can also support the child in a specific position to try and direct the spine as it grows.
The permanent solution to spinal curvature is spine straightening surgery, where the vertebrae of the spine are fused together in the correct position.

An occupational therapist can offer advice on techniques and equipment for an exercise routine, that can be performed at home, designed to maintain joint mobility, prevent contractures (shortening of the muscles), maximise respiratory function and maintain muscle strength, to delay muscle wastage.

STROKE
A stroke is when the normal blood supply to part of your brain is cut off. If your brain cells do not get a constant supply of oxygen from the blood, the cells in the affected area become damaged or die.

Blood is supplied to your brain by four main arteries, which then divide into smaller arteries. The amount of damage done, and the part of the brain that is damaged, depends on which artery is affected. If a small artery is affected, you may only have minor symptoms. But if a major artery is affected, it can cause severe symptoms, even death.
In the UK, someone has a stroke every five minutes. They are more common among those over the age of 65, but can happen at any age.
Strokes are the leading cause of disability in the UK, and the third most common cause of death, (after cancer and heart disease).

A stroke is a medical emergency. You should get to a hospital straight aware, as limiting the damage from a stroke is very important to your chances of recovery.

Symptoms:
Symptoms usually come on suddenly, and can include:

- Weakness or numbness down one side of the body
- Weakness or drooping of the face
- Dizziness
- Problems talking and understanding what others are saying
- Problems with balance and co-ordination
- Difficulty swallowing
- Severe headache
- Loss of consciousness
- Confusion

Symptoms can often improve after a few weeks, when the swelling around the damaged part of the brain goes down. With rehabilitation and treatment, the symptoms can gradually get better, but many people are left with some degree of disability after a stroke.

Recognising a stroke in other people:
The Stroke Association recommends using the face-arm-speech-test, to help you recognise the symptoms of a stroke. This is a simple test that can help you find out if someone has had a stroke:

Face– can the person smile, or has their mouth or eye drooped?
Arm– can the person raise both arms?
Speech– can the person speak clearly and understand what you say?

If the person has failed any of these tests, and main symptoms don't disappear within about 30 minutes, they may be having a stroke. Call 999 and ask for an ambulance.
People suspected of having a stroke will need to be admitted to hospital for tests, these may include:

- Brain scan
- Blood tests
- Chest x-rays and an ECG
- Ultrasound

Causes:
The two main types of stroke are ischaemic (reduced blood and oxygen supply) and haemorrhagic (bleeding).

Ischaemic strokes are the most common type, causing 17 out of every 20 cases of stroke.

An ischaemic stroke is when a blood clot blocks an artery and restricts the amount of blood and oxygen that can reach the brain.

Haemorrhagic strokes occur in 3 out of 20 cases. The stroke is caused by a weakened artery bursting, which allows blood to seep out of the artery wall. The blood damages the brain tissue by pressing on it, and at the same time other brain cells can be damaged because they are not receiving enough oxygen.

Treatment:
Emergency and early treatment of stroke
A stroke is a medical emergency. You should get to a hospital straight away, as limiting the damage from a stroke is very important to your chances of recovery.

When you are in hospital, the doctors will be able to assess how the stroke has affected you, and carry out tests to decide if the stroke is ischaemic or haemorrhagic.
Long term treatment of stroke
Long term treatment after a stroke consists of a variety of therapies, and aims to help you get back as much independence as possible. This process of rehabilitation will be specific to you, depending on your symptoms, and their severity. A team of specialists are available to help, including physiotherapists, psychologists, occupational therapists, speech therapists and specialist nurses and doctors.

An essential part of rehabilitation is exercise. The type and amount of exercise depends upon the severity of the stroke, and the parts of the body that have been affected.

A common effect of a stroke is weakness in an arm or leg, and without exercise and physiotherapy, this can lead to a loss of muscle strength.

Exercise is also important for your overall health, and reduces the chances of developing heart disease, osteoporosis or another stroke. Your GP or physiotherapist will talk with you about ways of exercising that will suit you and your lifestyle.

VISUAL IMPAIRMENT
The term visual impairment is used to describe anyone who is blind or partially sighted, as opposed to short or long sighted.

If you are visually impaired, you will have some loss or distortion of your vision. Depending on how severe the sight loss is, the conditions are usually known as partial sightedness or blindness.

Partial sightedness– a person who is partially sighted, or has severe low vision, has a serious loss of sight, but is not blind. This is defined as a person who cannot clearly see how many fingers are being held up at a distance of six metres or less (even when wearing glasses or lenses).
Blindness– a person who is blind has severe sight loss and is unable to see clearly how many fingers are being held up at a distance of three metres or less (even when wearing glasses or lenses). However, they may still have some degree of vision.
Symptoms:
Sight loss can be sudden and severe, or it can be a gradual deterioration, over a long period of time. However, most commonly it is the latter, with distant objects slowly becoming more difficult to distinguish.

As well as a reduction of vision, you may experience other symptoms, such as eye pain, a burning or gritty sensation in your eyes and foggy or distorted vision.

Causes:
There are several causes of blindness. Cataracts and glaucoma cause temporary blindness, but cataracts can be surgically removed, and glaucoma can be treated with eye drops or surgery.

Other causes include:

- Injury or trauma to the eyes
- Abnormal blood vessel growth, following premature birth or diabetes
- Macular degeneration
- Genetic conditions, e.g. retinitis pigmentosa

Other eye related conditions which can affect your vision include:

- Sub-acute glaucoma which may cause a dull, aching pain, foggy vision and rainbow coloured rings around lights
- Macular degeneration which causes distorted vision, straight lines appear wavy, and objects appear larger or smaller than they really are
- Cataracts can cause blurred vision, colours appear faded and bright lights become dazzling
- Dry eye syndrome causes a burning, gritty sensation in the eyes
- Diabetic retinopathy causes double vision and difficulty focusing

In the UK, age related macular degeneration (ARMD) is a common cause of reduced vision, and it is due to wear and tear of the eye. As the name suggests, ARMD is a condition that tends to become more common as you get older.

Also, if you smoke, your risk of being affected by ARMD is more than double that of non-smokers.

However, although ARMD causes a significant loss of vision, it does not cause total blindness, because it only affects the central field of vision, and not the peripheral vision.

Prevention:
Regular eye checks are important to prevent unnecessary damage due to undiagnosed conditions. Early diagnosis for children with sight difficulties is essential, to prevent learning and development problems.

It is particularly important for drivers and people whose eyesight may be affected by their occupation, for example, those who use computers, to have regular eye checks, as well as those with medical conditions, such as diabetes, glaucoma or high blood pressure.

CONFUSION AND DEMENTIA

Confusion

Confusion is a condition that is usually sudden, particularly in elderly people. Common causes are:

- An urinary tract infection (UTI)
- A respiratory tract infection (RTI) or chest infection
- Constipation
- Medication change
- A traumatic event, say the sudden loss of a spouse

There are many other medical conditions, which can cause confusion, and you should always consult your client's doctor when confusion becomes apparent.

Sometimes a course of antibiotics or other medical intervention will cure the cause and your clients will return to their normal selves.

Dementia

Dementia is a condition that affects both men and women. Approximately 1 in 14 people who are over the age of 65 are living with dementia and 1 in 6 of those over the age of 80. A small percentage of the population who live with dementia are below the age of 60. This is known as early onset dementia.

Dementia is an umbrella term for a rage of conditions.

Alzheimer's disease is the most common form of dementia (60-80% of cases) but the cause of it is not fully understood; some forms of dementia have known causes.

Multi-Infarct Dementia (MD), or vascular dementia, is a blockage of small blood vessels causing loss of blood supply to small areas of the brain often due to furred and constricted blood vessels – (Atherosclerosis)

Korsakoff's syndrome is caused by a severe deficiency of Thiamine (Vitamin B1) most commonly caused by alcohol misuse, resulting in the loss of brain cells.

Common signs of dementia:-

Short Term Memory Loss – the individual has difficulty remembering what has happened recently, sometime only minutes before.

Disorientation – this is experienced when the individual begins to misinterpret their surroundings, the people around them and their own self-image and age. Initially, in the early stages of dementia, they may have temporary periods of disorientation, which can cause frustration that at times is exhibited through anger and accusations.
Loss of ability to take care of personal hygiene – this is associated with loss of independence. As the condition progresses, people may no longer recognise the need to wash, bathe, change their clothes, clean their teeth/dentures, comb their hair etc.

This may be associated with poor short-term memory, which results in the person believing that they have just performed some or all of these personal hygiene tasks.

Loss of Concentration – concentration is needed for most of the activities we undertake in the course of everyday life. Reading, watching T.V., doing puzzles, even holding a conversation.

Communication – communication is the process of transferring, imparting or sharing information, ideas, signals and feelings between two or more people. It takes verbal and non-verbal forms. When we communicate we encode ideas and thoughts in either or both of these forms and the receiver decodes them and replies.

In the early phase of dementia it is recognised that the person may have some difficulty in finding the correct words to describe common items, and this can cause frustration and misunderstanding. It is important to not only listen, but look for other forms of communication and the whole content of any conversation to try to understand what the individual is trying to convey.

It appears that although the individual may not fully understand the content of speech, they will often respond and communicate more effectively through non-verbal behaviour. We measure how people feel by their behaviour – not necessarily their speech.
It is important to maintain eye contact with the individual. The general pattern of eye contact in normal conversation is that the listener looks more frequently and for longer periods at the talker, while the talker looks for shorter periods which increase as they are finishing speaking. The carer should always maintain good eye contact to let the person know that they are listening and attentive.

Sensory Stimulation – as dementia progresses, the person may find comfort in touching or stroking pieces of fabric.

Some may sit and fiddle with their clothes. Instead, ensure they have a piece of material or a twiddle muff to caress and play with.

Behaviours that are challenging/disruptive in Dementia

It is estimated that 36% of older people with dementia in care settings will, at some stage, display behaviour that challenges or disruptive behaviour. 85% will suffer memory impairment. Although such behaviour is often seen as a problem for carers, it is important to understand the underlying cause(s) of it, rather than to just try to stop it. These behaviours are often indicative of feelings and needs that the individual is no longer able to express because of the loss of communication skills and memory impairment.

Dementia is the loss, usually gradual, of mental abilities such as thinking, remembering and reasoning. It is not a disease, but a group of symptoms that may accompany some diseases or conditions affecting the brain.

There are many different types of dementia, each with their own causes. The most common dementia symptoms include:

- Problems with memory
- Problems with speech and language
- Confusion
- Change in mood or behaviour
- Difficulty performing simple tasks
- Problems learning new information, ideas or skills

Some types of dementia can cause less common symptoms:

- Hallucinations
- Obsessive or repetitive behaviour
- The belief that they have done or experienced things that have never happened
- Disturbed sleep, or sleeping in the day time and awake at night
- Depression
- Physical deterioration
- Incontinence

If dementia becomes severe, it can cause other symptoms, including:

- Difficulty with swallowing
- Difficulty changing position or moving from place to place without assistance
- Complete loss of short-term and long-term memory

Sometimes those living with dementia are unaware that they have any symptoms, especially symptoms that affect behaviour.

Dementia usually develops slowly, with mild early symptoms, so diagnosing dementia in its early stages can be difficult. Further tests are sometimes needed to make sure that the person does not have a condition that can produce symptoms similar to dementia, such as depression or severe urine or chest infection.

Dementia develops when cells in the parts of the brain involved with mental ability become damaged.

Damage to these cells can be caused by:

- Diseases and infections that affect the brain, e.g.: Alzheimer's disease or meningitis
- Pressure on the brain, e.g.: brain tumour
- Lack of blood and oxygen supply to the brain, e.g.: stroke
- Head injury

The most common type of dementia is that caused by Alzheimer's disease, which is responsible for about 60% of cases. The cause of Alzheimer's disease is unknown, except for a very small percentage of cases that are inherited.

Other less common types of dementia include:

- Lewy Body dementia
- Dementia caused by Picks disease
- Dementia caused by Huntington's disease
- Dementia caused by long-term alcohol misuse

Most types of dementia cannot be cured, but there a few exceptions:

- Dementia related to vitamin or hormone deficiency
- Dementia related to head injury
- Dementia related to medication
- Dementia related to infections

Reminiscence Therapy

Reminiscence can help to build confidence and often arouses good feelings when it is concerned with past pleasant events. However, reminiscence can also evoke unpleasant and painful memories so the carer needs to be aware of this and be ready to deal with the consequences.
It is often useful to allow the individual to lead reminiscence therapy. The carer should listen carefully to what the person is saying and talking about and then ask appropriate questions that will draw out the experiences and memories of the individual.

Continence Management

It is likely that, as dementia progresses, the person may become incontinent through loss of bodily function as well as "having accidents" because their poor memory and mental function means they will be unable to find the toilet or bathroom, or be unable to adequately adjust their clothing if they do not reach the toilet.

Bowel and bladder control is an almost automatic function that has been more or less totally private for most people since early childhood, and it can be an extremely embarrassing situation for someone to suddenly need the help and assistance of another person to carry out these normally natural and private functions.

The golden rule, as with all situations when caring for someone, is sensitivity and tactfulness to the feelings of the person cared for.

Caring for someone with Dementia

People living with dementia may not have actual physical care needs but because of their impaired mental function, may well need prompting, assistance and supervision with tasks to ensure that they are carried out appropriately.

Dressing

Clothes are very much a part of our personality. Enabling someone living with dementia to choose what they wear and to retain their particular style of dressing is a way of helping them to retain their identity. As the dementia progresses, the individual will need progressively more assistance with dressing and with other daily living activities.

Safety in the home

Dementia leads to changes in a person's capabilities and in their intellectual ability. This will often mean that they do not recognise or appreciate the dangers that can often be present in everyday situations.

Diet – Food and Drink

A balanced diet is important for people with dementia to help ensure they stay as fit and healthy as possible. A person living with dementia may experience a poor appetite or experience difficulty in using cutlery etc., due to their impaired mental function. Meal times should be calm relaxed times with good food nicely presented.

In the latter phase of dementia people may not recognise that food is in front of them and you may have to assist at meal times.

No matter what degree of dementia a person is living with, he or she are still first and foremost an individual and should be treated as such, even if it appears that they can no longer understand conversation or simple instructions from you.

Always afford your client the utmost dignity and respect

CARE PROFESSIONALS

Carers are one of a team – sometimes large and sometimes small – which is supporting the client. Being in a team, carers should remember that they:

- Are supported by other members of the team
- Sometimes reach the limits of their skill and need to hand over to someone else at an appropriate time

Few clients have teams, including everyone in the list below but as a primary carer you should know about other team members who may visit or could be involved in your client's care.

General Practitioner (GP) – or family doctor: GP's play a key role in the basic (or primary) care a client receives. It is therefore important that the GP is kept informed about a client's condition and any changes in it. Carer's observations should be reported back to a member of the client's family. The GP's skills are in diagnosing disease or conditions from the symptoms presented and suggesting remedies or prescriptions for drugs to alleviate problems. A prescription can also be made for a wheelchair, but referral to the District Wheelchair Centre is more usual. In addition a GP can refer a client to other services e.g. community nurses, physiotherapists etc.

Community or District Nurse: The Community Nurse is very likely to be working from a community office or from the general practise from which the referral was made. The functions of the community nurse will be clearly detailed in the clients care plan. It is important to know the sort of care a Community Nurse gives, so that any observations you make about a client's condition can be passed to the right person at the right time.

Pressure ulcer care, catheters, sterile dressings and the administration of some drugs are the responsibility of community nurses. They may also undertake manual bowel evacuations and other procedures.

Many of these tasks are referred to as 'invasive procedures' and we advise that they are not carried out by carers. In some circumstances you may be called upon to help with such things, we recommend that it is but only under the supervision or instruction of the nurse. If, during washing, toileting, dressing, transferring or in conversation, a carer's attention is drawn to anything relating to a pressure area, dressing, continence aid or medication that does not seem quite as it should be, we strongly recommend that this is reported directly to the community nurse. However, if you have concerns that this is not being addressed, your Care Support Team may be able to offer help.

Pharmacist: The pharmacist is the member of the team with specialist knowledge of drugs – their composition, their properties and their application. Usually clients take a prescription obtained from their GP to the pharmacist for dispensing. However, there are many drugs which are obtainable without prescription and which are cheaper NOT on prescription. The pharmacist is a source of much valuable information, although he does NOT diagnose. He can advise on drugs that may be cut, those that can be supplied in liquid form if alternatives are required. Some pharmacists set up compliance aides with correct doses of drugs ready for clients or carer and even deliver them. They may also deliver cylinders of oxygen.

Health Visitor: The health visitor is a nurse who has had additional training in health matters in social as well as medical settings and relates to home and family circumstances to a client's health and well-being. An important part of their responsibility rests with the care of elderly people, especially those who are over 80 years of age.
They can advise on diet, the effects of medication and other services available. They have counselling skills and may be able to help with psychological aspects of health e.g. running groups or classes to enable clients to meet with others who may have similar problems or needs.

Community Psychiatric Nurse (CPN): The CPN has specialised training in matters relating to mental health.
Should drugs be needed on a regular basis or by injection, the CPN may call to give this service to save people having to go to the hospital, clinic or GP surgery. Since an individual's mental well-being often depends upon home circumstances or family relationships it is helpful for the CPN to make home visits. The CPN visits on the recommendation or request of the GP as well as on the advice of a psychiatrist. The CPN is also available to give advice on caring for clients with deteriorating mental conditions.

Continence Advisor: The continence advisors is a nurse who specialises in helping people with all aspects of continence. A client can be referred to the continence adviser in the usual way, but advice and help can be obtained directly. The community nurse will be the best person to liaise with the continence advisor.

Social Worker: A social worker's training is designed to assist clients to be self-directing as possible. Social workers are employed by local authorities and usually work in teams linked to particular localities. The social worker may be able to advise on welfare rights, and financial resources.

Occupational Therapist (OT): OT's are employed in both health and social services departments. Their work is about helping people undertake everyday functions with as much independence and ease as possible. OT's have a basic training in medical sciences and have expertise in impairments and disabilities.
From their knowledge of the physical, neurological and psychological workings of the human body and mind, they are able to devise all sorts of methods and aids to compensate for functions which their clients have lost. OT's may also be 'wheelchair therapists' with expertise in both assessment and prescription.
Their advice may be sought about clothing, splints and supports for the limbs, leisure pursuits and activities which give clients a sense of achievement in useful occupation.

Physiotherapist: Physiotherapists have expertise in mobility and movement. Even if someone is not mobile, that is, they cannot get about on their own, they probably have movement in an arm, a leg, a hand, a finger, an eyebrow and this movement can be put to good purpose in daily living. They may visit clients with respiratory problems to give them treatment to help them breathe or cough. They may give clients exercises to do to maintain fitness. Exercises may be 'passive' i.e. someone else has to

help the client make the movements. The physiotherapist will sometimes teach carer's special exercises for individual clients. The positions clients adopt in sitting or lying are important to maintain good posture and prevent pressure ulcers, and physiotherapists may offer advice on this as well as on walking and walking aids.

Speech and Language Therapist (SLT): SLT' are usually based in NHS Trusts and because of their relatively small numbers are not able to make domiciliary visits. They are trained to work with people who have difficulty in communicating with others. This can be due to physical or learning disabilities. They also treat and advise people with neurological diseases, head injuries, cerebral palsy and learning disabilities.

Chiropodist: Podiatrist is the expert in feet, gait and footwear. Chiropody services can be obtained through health or social services but because they are much in demand, and the number of Chiropodists available is limited many people pay for chiropody on a private basis. The chiropodist has training in medical sciences and bio-mechanics. Remember, if your client's toe nails require cutting, we recommend that this should be carried out by a Chiropodist.

Optician: The Optician is the person who, in general terms, deals with your client's eyesight and provides spectacles. However, it may be helpful to know that a client may be referred to an optometrist at the hospital or clinic for measurements to be made of the power and visual range of the eyes.
An ophthalmic Optician detects and measure defects in eyesight and is trained to prescribe and make spectacles to correct them. Many people make private provision for eye tests and spectacles either through their optician or by obtaining a prescription only from an optician and then buying spectacles through other outlets. For reading or sewing, basic magnifying spectacles can be obtained from the local chemist.

Psychiatrist
Psychiatrists are trained to treat mental illnesses and can prescribe drug treatments for behavioural problems. Psychiatrists and psychologists often work together. An old age psychiatrist, or psychogeriatrician, specialises in the mental health of older people.

Psychologist
Psychologists are experts in human behaviour. They provide a range of treatments or therapies such as group therapy, individual psychotherapy and programmes that help people to modify their behaviour.

Rehabilitation engineer
A rehabilitation engineer is a specialist who advises on and provides mechanical and electronic equipment (known as assistive technology) to help people with physical disabilities live more independently.

Dietician
A dietician can assess, diagnose and treat diet and nutrition problems and advise people on how to stay healthy or prevent health problems through their diet. They work with people who have conditions such as diabetes, food allergies, eating disorders, irritable bowel syndrome, heart disease or obesity.

We recommend that Carers:

- Be supportive of the work of other professionals – this may mean carrying out instructions or following up treatment or systems worked out by others
- Be observant of any changes in the client's state or responses
- Liaise with the team, carrying out instructions or reporting observations to other professionals or the client or client's family
- Know when to consult others

MENTAL CAPACITY ACT 2005 (As per point 7.3 in the Code of Conduct for Carers)

The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to making particular decisions for themselves. When you are working with and/or caring for an adult who may lack capacity to make specific decisions you must comply with this Act when making decisions or acting for your client, when your client lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing such as whether your client should move into a care home or undergo a major surgical operation or everyday matters such as what to wear, or what to buy when doing the weekly shopping.

There are certain decisions which can never be made on behalf of your client who lacks capacity to make these specific decisions. This is because they are either so personal to the individual concerned, or governed by other legislation. These are summarised below:-

- consenting to marriage or a civil partnership
- consenting to have sexual relations
- consenting to a decree of divorce on the basis of two years' separation
- consenting to the dissolution of a civil partnership
- consenting to a child being placed for adoption or the making of an adoption order
- discharging parental responsibility for a child in matters not relating to the child's property, or
- giving consent under the Human Fertilisation and Embryology Act 1990
- give the person treatment for mental disorder
- consent to the person being given treatment for mental disorder
- decision on voting
- assisting suicide

However this does not prevent action being taken to protect a client at risk from abuse or exploitation.

There are five statutory principles:-

1) The client must be assumed to have capacity unless it is established that they lack capacity.
2) The client is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3) The client is not to be treated as unable to make a decision merely because he makes an unwise decision.
4) An act done, or decision made, under this Act for or on behalf of a client who lacks capacity must be done, or made, in his best interests.
5) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the client's rights and freedom of action.

What kind of support might clients need to help them make a decision?

- using a different form of communication (for example, non-verbal communication)
- providing information in a more accessible form (for example, photographs, drawings, or tapes)
- treating a medical condition which may be affecting the client's capacity or
- having a structured programme to improve a client's capacity to make particular decisions (for example, helping a client with learning disabilities to learn new skills)
- are there particular times of the day when the client's understanding is better, for example some medication could affect a client's capacity, could the decision be delayed until the side effects have subsided
- are there particular locations where they may feel more at ease
- could the decision be put off to see whether the client can make the decision at a later time when circumstances are right for them
- be aware of cultural, ethnic or religious factors that shape the client's way of thinking, behaviour or communication. For example, in some cultures it is important to involve the community in decision-making. Some religious beliefs (for example, those of Jehovah's Witnesses or

Christian Scientists) may influence the client's approach to medical treatment and information about treatment decisions.

What happens in emergency situations?

In emergency medical situations (for example, where a client collapses with a heart attack or for some unknown reason and is brought unconscious into a hospital), urgent decisions will have to be made and immediate action taken in the client's best interests. In these situations, it may not be practical or appropriate to delay the treatment while trying to help the client make their own decisions, or to consult with any known attorneys or deputies. However, even in emergency situations, healthcare staff should try to communicate with the client and keep them informed of what is happening.

Assessing capacity

Anyone assessing someone's capacity to make a decision for themselves should use the two-stage test of capacity.

- Does the client have an impairment of the mind or brain, or is there a disturbance in the functioning of the mind or brain.

If so, does that impairment or disturbance mean that the client is unable to make the decision in question at the time it needs to be made? You do this by providing evidence that the person has difficulty doing any of the following things:

- Understanding the information related to the decision
- Retaining the information related to the decision
- Using/assessing the information while considering the decision
- Communicating the decision by any means – does not have to be verbal and the person does not have to be literate

An assessment that a client lacks capacity to make a decision must never be based simply on:

- Their age
- Their appearance
- Assumptions about their condition, or
- Any aspect of their behaviour

An example of this:-
Tom, a man with cerebral palsy, has slurred speech. Sometimes he also falls over for no obvious reason.

What proof of lack of capacity does the Act require?

The MCA says that a person is unable to make their own decision if they cannot do one or more of the following four things:

- Understand information given to them
- Retain that information long enough to be able to make the decision
- Weigh up the information available to make the decision
- Communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate. Also you will need to involve family, friends, carers or other professionals.

The assessment must be made on the balance of probabilities – is it more likely than not that the person lacks capacity? You should be able to show in your records why you have come to your conclusion that capacity is lacking for the particular decision.

Anybody who claims that an individual lacks capacity should be able to provide proof. They need to be able to show, *on the balance of probabilities,* that the individual lacks capacity to make a particular

decision, at the time it needs to be made. This means being able to show that it is more likely than not that the client lacks capacity to make the decision in question.

It is important to review capacity from time to time, as some clients can improve their decision-making capabilities. In particular, someone with an ongoing condition may become able to make some, if not all, decisions. Some clients (for example, those with learning disabilities) will learn new skills throughout their life, improving their capacity to make certain decisions. So assessments should be reviewed from time to time. Capacity should always be reviewed:

- Whenever a care plan is being developed or reviewed
- At other relevant stages of the care planning process, and
- As particular decisions need to be made

It is important to acknowledge the difference between:

- Unwise decisions, which a client has the right to make, and
- Decisions based on a lack of understanding of risks or inability to weigh up the information about a decision

Information about decisions the client has made based on a lack of understanding of risks or inability to weigh up the information can form part of a capacity assessment – particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else.

Who should assess capacity?

The person who assesses an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone's capacity to make different decisions at different times.

For most day-to-day decisions, this will be the person caring for them at the time a decision must be made.
For example, a care worker might need to assess if the client can agree to being bathed. Then a district nurse might assess if the client can consent to having a dressing changed.

For acts of care or treatment, the assessor must have a 'reasonable belief' that the client lacks capacity to agree to the action or decision to be taken.

If a doctor or healthcare professional proposes treatment or an examination, they must assess the client's capacity to consent.

For legal transactions (for example, making a will) a solicitor or legal practitioner must assess the client's capacity to instruct them. In cases of doubt, they should get the opinion from a doctor or other professional expert.

More complex decisions are likely to need more formal assessments. A professional opinion on the client's capacity might be necessary. This could be, for example, from a psychiatrist, psychologist, a speech and language therapist, occupational therapist or social worker. But the final decision about a client's capacity must be made by the person intending to make the decision or carry out the action on behalf of the client who lacks capacity – not the professional, who is there to advise.

What is 'reasonable belief'?

Care workers do not have to be experts in assessing capacity. But to have protection from liability when providing care or treatment they must have a 'reasonable belief' that the person they care for lacks capacity to make relevant decisions about their care or treatment.

To have this 'reasonable belief' they must have taken 'reasonable' steps to establish that the client lacks capacity to make a decision or consent to an act at the time the decision or consent is needed. They must also establish that the act or decision is in the client's best interests.

They do not usually need to follow formal processes, such as involving a professional to make an assessment. However, if somebody challenges their assessment, they must be able to describe the steps they have taken.

They must also have objective reasons for believing the person lacks capacity to make the decision in question. Blank forms will be in the care plan folder for this information to be recorded.

The steps that are accepted as 'reasonable' will depend on individual circumstances and the urgency of the decision.

What practical steps should be taken when assessing capacity?

- You should make sure you understand the nature and effect of the decision to be made yourself. You may need access to relevant documents and background information.
- You may need other relevant information to support the assessment (e.g. views of other staff involved in the client's care – pop in agency)
- Family members and close friends may be able to provide valuable background information (for example, the client's past behaviour and abilities and the types of decisions they can currently make). But their personal views and wishes about what *they* would want for the person must not influence your assessment.
- You must again explain to the client all the information relevant to the decision.
  The explanation must be in the most appropriate and effective form of communication for the client.
- Check the client understands after a few minutes. The client should be able to give a rough explanation of the information that was explained. There are different methods for clients who use non-verbal means of communication (for example observing behaviour or their ability to recognise objects or pictures).
- Avoid questions that need only 'yes' or 'no' answer (for example, did you understand what I just said?).
  They are not enough to assess the client's capacity to make a decision. But there may be no alternative in cases where there are major communication difficulties. In these cases, check the response by asking questions again in a different way.
- Skills and behaviour do not necessarily reflect the client's capacity to make specific decisions. The fact that someone had good social or language skills, polite behaviour or good manners doesn't necessarily mean they understand the information or are able to weigh it up.
- Repeating these steps can help confirm the result.

When might professional involvement be needed?

- The decision that needs to be made is complicated or has serious consequences
- You conclude that the client lacks capacity, but the client challenges the finding
- Family members, carers and/or professionals disagree about a client's capacity
- There is a conflict of interest between you and the client being assessed
- The client being assessed is expressing different views to different people – they may be trying to please everyone or telling people what they think they want to hear
- Somebody might challenge the client's capacity to make the decision – either at the time of the decision or later
- Somebody has been accused of abusing a adult at risk who may lack capacity to make decisions that protect them
- A client repeatedly makes decisions that put them at risk or could result in suffering or damage

What if someone refuses to be assessed?

There may be circumstances in which a client whose capacity is in doubt refuses to undergo an assessment of capacity or refuses to be examined by a doctor or other professional. In these circumstances, it might help to explain to someone refusing an assessment why it is needed and what the consequences or refusal are. But threats or attempts to force the client to agree to an assessment are not acceptable.
If the client lacks capacity to agree or refuse, the assessment can normally go ahead, as long as the client does not object to the assessment, and it is in their best interests.
Nobody can be forced to undergo an assessment of capacity. If there are serious worries about the client's mental health, it may be possible to get a warrant and assess the client for treatment in hospital – but the situation must meet the requirements of the Mental Health Act 1983 (Section 135). But simply refusing an assessment of capacity is in no way grounds for an assessment under this Act.

Keeping Records

Although there are no formal requirements to keep records on day-today decisions or consent to care, it is good practice for carers to keep a record of the steps they take when caring for the person concerned. Please see day to day decision form on page 123. We advise that if you are constantly making a best interest decision, that you update the guide to client wishes and discuss with the person in charge of the care package.

It is good practise for professionals who carry out a proper assessment to record the findings in the relevant professional records.

How can someone challenge a finding of lack of capacity?

There are likely to be occasions when someone may wish to challenge your assessment. The first step is to raise the matter, if the challenge comes from the client who is said to lack capacity they might need support form family, friends or an advocate, you would need to :-

- Give reasons why you believe the client lacks capacity to the decision, and
- Provide objective evidence to support that belief

You would need to show you have applied the principles of the Mental Capacity Act.

It might be possible to get a second opinion from an independent professional or expert in assessing capacity. But if a disagreement cannot be resolved, the person who is challenging the assessment may be able to apply to the Court of Protection. The Court of Protection can rule on whether a client has capacity to make the decision covered by the assessment.

Who can be a decision-maker?

Under the Act many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for them. It is the 'decision maker's' responsibility to work out what would be in the best interests of the person who lacks capacity.

- For most day-today actions and decisions, this will be the care worker who will be most directly involved with the client at the time. Where you take time off and a pop in agency worker is involved, they would take over as 'decision maker' in your absence.
- Where the decision involves the provision of medical treatment, the doctor or other member of healthcare staff responsible for carrying out the particular treatment or procedure is the 'decision-maker'.
- If a Lasting Power of Attorney (or Enduring Power of Attorney) has been made and registered, or a deputy had been appointed under a court order, the attorney or deputy will be the decision-maker, for decisions within the scope of their authority.
- There are times when a joint decision might be made by a number of people. For example, when a care plan for a client who lacks capacity is being put together, different healthcare or

social care staff might be involved in making decision or recommendations about the person's care package.

What other factors should a 'decision maker' consider?

- Expressions of pleasure or distress and emotional responses should be considered especially with those who cannot express their current wishes and feelings in words.
- The client may have held strong views in the past which could have a bearing on the decision now to be made.
- Written statements made before the client lost capacity may provide a lot of information about their wishes.
- If the decision maker does not follow something put in writing they must record the reasons why.
- It is important to note the distinction between a written statement expressing treatment preferences and a statement which constitutes an advance decision to refuse treatment.
- Everyone's values and beliefs influence the decisions they make. They may become especially important for someone who lacks capacity, these can be found in:-

    - Cultural background
    - Religious beliefs
    - Political convictions
    - Past behaviour or habits

Respecting confidentiality

'Decision makers' must balance the duty to consult other people with the right to confidentiality of the client who lacks capacity. So if confidential information is to be discussed, they should only seek the views of people who it is appropriate to consult, where their views are relevant to the decision to be made and the particular circumstances.

What protection does the Act offer for people providing care or treatment?

Section 5 of the Act allows carers, healthcare and social care staff to carry out certain tasks without fear of liability. These tasks involve the personal care, healthcare, or treatment of people who lack capacity to consent to them. The aim is to give legal backing for acts that need to be carried out in the best interests of the person who lacks capacity to consent.

Actions which might be covered include helping with:-

- washing, dressing or personal hygiene
- eating and drinking
- communication
- mobility (moving around)
- take part in education, social or leisure activities
- doing the shopping or buying necessary goods with the person's money
- arranging household services (for example arranging repairs or maintenance for gas and electricity supplies)
- providing services that help around the home
- helping someone to move home
- taking someone to hospital for assessment or treatment
- dental care
- giving medication
- providing care in an emergency

Restraint

Anyone considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the client being cared for is likely to suffer harm unless proportionate restraint is used. A carer or professional must not use restraint just so that they can do something more

easily. If restraint is necessary to prevent harm to the client who lacks capacity, it must be the minimum amount of force for the shortest time possible.

Example of proportionate restraint:-

A carer may need to hold a person's arm while they cross the road, if the person does not understand the dangers of roads. But it would not be proportionate response to stop the person going outdoors at all. It may be appropriate to have a secure lock on a door that faces a busy road, but it would not be a proportionate response to lock someone in a bedroom all the time to prevent them from attempting to cross the road.

Independent Mental Capacity Advocate service (IMCA)

The purpose of the IMCA service is to help particularly adults at risk who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. IMCAs will work with and support people who lack capacity and represent their views to those who are working out their best interests.

If you feel your client would benefit from help from the IMCA inform your clients Booking Co-ordinator.

Deprivation of Liberty Safeguards 2009

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005, DoLS came in effect 1 April 2009. They aim to make sure that people who receive care are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that carers or organisations only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interest of the person and there is no other way to look after them.

A Supreme Court judgement in March 2014 made reference to the 'acid tests' to see whether a person is being deprived of their liberty, which consisted of two questions:

- **Is the person subject to continuous supervision and control? *and***
- **Is the person free to leave? – with the focus being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.**

If someone is subject to that level of supervision, and is not free to leave, then it is likely that they are being deprived of their liberty.

Who is affected?

The safeguards apply to people aged 18 or over who have a mental health condition (this includes Dementia) and who do not have the mental capacity (ability) to make decisions about their care or treatment.

A deprivation of liberty authorisation cannot be used if a person has the mental capacity to make decisions, so the person's capacity will be assessed as part of the process.

The safeguards do not apply when someone is detained ('sectioned') under the Mental Health Act 1983.

What are the safeguards?

Those planning care should always consider all options, which may or may not involve restricting the person's freedom, and should provide care in the least restrictive way possible. However, if all alternatives have been explored and the care provider believes it is necessary to deprive a person of their liberty in order to care for them safely, then they must get permission to do this following strict processes.

The key elements of the safeguards are:

- To provide the person with a representative
- To give the person (or their representative) the right to challenge a deprivation of liberty through the Court of Protection

- To provide a mechanism for deprivation of liberty to be reviewed and monitored regularly

What is deprivation of liberty?
There is no single legal definition of 'deprivation of liberty', so it can sometimes be difficult to establish whether it is taking place. It can helpful to think of restrictions of a person's restrictions – deprivations of liberty – at the other end. One large restriction could in itself be a deprivation of liberty (such as sedating a person for non-medical reasons) or many small restrictions could combine to create a deprivation of liberty. It is the amount of control that the care provider or carer has over the person that determines whether the person is being deprived of their liberty.

There have been several test cases in the European Court of Human Rights and in the UK that have clarified which situations may constitute a deprivation of liberty:

- A patient being restrained in order to admit them to hospital
- Medication being given against a person's will
- Staff having complete control over a patient's care or movements for a long period
- Staff making all decisions about a patient, including choices about assessments, treatment and visitors
- Staff deciding whether a patient can be released into the care of others or to live elsewhere
- Staff refusing to discharge a person into the care of others
- Staff restricting a person's access to their friends or family

Authorisation for deprivation of liberty
Carers should always try to care for a person in a way that does not deprive them of their liberty. If they are unable to do this, we would advise the appropriate local authority who would then take over.

Before urgent action is taken, we recommend that steps are taken to consult with carers and family members.
We advise that this is reported to your Carer Support Team as it can place carers at risk of allegations.

SUPPORTING PEOPLE WITH LEARNING DISABILITIES

With positive support, people living with learning disabilities can live fulfilling and inclusive lives. When you are working with people living with learning disabilities, remember the principles of good support. It is to:

- Respect the rights of the people living with learning disabilities
- Treat people as an individual
- Support people to live to live as independently as possible
- Enable people to make good choices
- Develop skills and support developments
- Empower people to be a valued part of their community

About learning disabilities

A person living with a learning disability may have problems with everyday things such as socialising and doing household or financial tasks, things that we take for granted. Learning disabilities affect people throughout their lives. A person may have learning disabilities because:

- Something affected the development of their brain or spinal cord before they were born. For example their mother may have had an illness or accident during pregnancy
- They were born prematurely
- They didn't get enough oxygen during birth
- Their brain was affected by an illness when they were a baby or young child
- They have a genetic condition, such as Down's syndrome

Learning disabilities covers a wide range of abilities from individuals who live and work independently but need support with some aspects of their life to those who have more complex disabilities and need support in many or all areas of their life. This means individuals will need personalised support depending on their ability and what they find difficult to do without support. Individuals with a learning disability may have physical difficulties such as vision, hearing, speech or mobility.

Remember that individuals with a learning disability using your services:

- Enjoy the same activities as other people
- May take longer to learn, and may need additional support to develop new skills
- May need support to complete certain tasks
- May need support to help them make decisions
- May experience difficulty expressing themselves
- May have problems with communication
- May be too trusting of others, and unaware of dangers or inappropriate relationships.
- May be unaware of the boundaries of 'normal' social behaviour
- May display behaviour that is challenging - behaving inappropriately if they are having difficulty being understood

If you are supporting someone with a learning disability:

- Learn about the person as an individual – find out a little bit of history about the person, what they like and don't like, how they communication etc. Speak to the individual's family, carers, friends, advocates (often referred to as significant others). Tailor the support you offer according to the individual's needs and preferences.
- Work closely with the individual's family, carers, friends, advocates etc. so that you are consistent in your approach to support to supporting them. Follow any established routines for basic skills such as washing, dressing, cooking and shopping.
- Support the development of the person's social skills.
- Encourage the individual to join in with any activities of their choice.
- Be prepared to support them to communicate and express his or her needs and feelings. This may involve learning techniques to help you communicate with them – for example if the person uses 'Makaton' you could learn the basics of Makaton. The techniques you develop will depend on the abilities of the individual.
- Provide relief and support for the primary carer – it may help them to share and discuss any issues or problems with you.
- Seek specialist training, supervision and support.

Responding to unexpected episodes of behaviours that challenge

1.0 Where an individual expectantly displays behaviour that challenges and therefore has no plan in place for managing such behaviour, they should be supported to bring the behaviour under control by using the CPI strategies of De-escalation, Protection and Restraint.

1.1 The CPI strategies of De-escalation, Protection and Restraint should be used as follows:-

- De-escalation: should be the first level of response to unexpected behaviour that is challenging should be to apply de-escalation strategies.
- Protection: if de-escalation strategies are unsuccessful and the person continues to behave in a way that is harmful to staff or others, then staff should respond in ways will protect those involved in the incident. In this situation, the following guidelines apply:
  - Remove others from the scene if possible in order to minimise danger to others and to reduce the negative impact an audience may have on the situation.
  - If you are the target, protect yourself by moving away from the person and where possible ensure that there are objects (e.g. chair, table) between the person and yourself try and make sure you are able to leave the room
  - Protection of people take precedence over protection of property.

1.2 Any unexpected episode of a behaviour that is challenging should be reported to your carer support team as soon as possible after the event in order to put strategies in place to try and prevent or minimise future incidents.

END OF LIFE CARE

You may work with client who is dying or within the final 12 months of life. This type of care is known as 'end of life care'. If you are involved in providing end of life care you are likely to be part of a team that may include specialist health and care professionals as well as the person's GP and their relatives. This is called a Multi-Disciplinary Team.

Caring for someone who is dying may be emotionally challenging. However, it can also be rewarding to know that you have been able to offer the person and their family comfort and support during a distressing time.

As with all clients, you should:

- Treat them with dignity and respect.
- Support them to make decisions about their care at the end of life wherever possible.
- Provide care in a way that takes into account their wishes, culture and background.
- Be prepared to provide support that can change rapidly according to their condition.

What happens when a person is dying?

The symptoms that occur at the end of life vary from person to person. The client may:

- Sleep more and more, or be unable to sleep
- Be in pain
- Lose the desire to eat or drink
- Feel sick or be sick
- Find it difficult to swallow, or have a very dry mouth
- Lose control of their bowel or bladder, or have constipation
- Find it harder to breathe because of a build-up of fluid in the lung – their breathing may be noisy
- Feel cold, or their skin may become cold to the touch
- Become confused or agitated

Your role

- To continue to provide safe, dignified and effective care that responds to the client's needs
- Observe changes in the health of clients and be able to recognise any signs and symptoms that could indicate that they are approaching the end of their life
- Know who the members of the person's end of Multi-Disciplinary Team are and who you should contact if there is a change in the person's condition.
- Know who has Power of Attorney (if there is someone) in case the person loses the capacity to make decisions for themselves.

Understanding the person and their wishes

Find out as much as you can about the client's state of health and the support they need. You can find this out from the client themselves, or from the client's family.

- Make sure you are aware of the client's end of life care plan. This may include information about psychological, spiritual and cultural needs as well as their health and care needs.
- Be aware of any wishes and preferences the client has previously expressed (the booking co-ordinator will tell you if there is a valid "advance care plan" or "advance statement" in place). If they discuss any new needs or wishes, bring them to the attention of the appropriate person if you have the client's permission to do so.

- Be ready for the possibility that a client may want to talk about their death and the plans for their care. Think about your role in these discussions – is it appropriate for you to help the client to make plans for their future care, or does the client just want someone to listen? It may be appropriate to refer the client to another professional or a family member.
- Do not put pressure on a client to have these discussions, but offer support and advice if you are asked.
- Encourage clients to contribute to plans about their care for as long as they are able to do so.
- If the client wishes it, be open in your discussions with their friends and relatives about the approaching death.

Physical support

- Try to make sure that the client is physically comfortable.
- Support the client as you would any other client. Don't be tempted to 'take over'.
- Note anything you observe about the client, such as the skin (colour, tone and dryness), breathing and drug routines.
- Be aware of any specific drug regime or equipment that is introduced as a client's condition changes. Make sure that you are trained to use any new equipment.
- Follow instructions given by other members of the care team. Recording fluid intake is very important towards end of life, to maintain hydration and avoid confusion.
- If the person no longer wants to drink, they may find it refreshing if you wipe around their mouth with a swab dipped in clean water. Swabbing the client's mouth with glycerine can also help to relieve a dry mouth.
- Medication is a significant part of end of life care, to control pain and other unpleasant symptoms. Late or missed doses of medication can be extremely distressing and increases a person's pain unnecessarily.
- Meals can be an important part of everyone's day. People at the end of life can experience appetite loss, nausea or difficulty eating. Try and find foods that the person can eat and enjoy, even if they only manage small quantities. Meal replacement drinks may also form part of that person's diet.

Recognising pain

- If the client can no longer communicate easily, observe them carefully and look out for signs of pain. For example, someone who is in pain might:

    - Make noises, such as whimpering or groaning
    - Have a distorted facial expression
    - Have changing breathing patterns – for example short periods when they breathe rapidly or noisily
    - Become pale or have clammy skin
    - Become restless

- If you think a client is in pain, check for wet pads, full bladder, position environment, then report it to the appropriate person – if you are not sure who this is, ask the client's booking co-ordinator.

Emotional support

- Be straightforward with the client – for example don't talk about getting better if the person has accepted that this is not possible. Be as 'normal' as you can in your conversation and in the way you treat the person.
- If the client wants to talk about their pain, or fears and anxieties about dying, encourage this and don't deny that they exist.
- Be prepared to listen to stories about the past and special memories, even if you have heard them before. Telling these stories may give real pleasure to the client.
- If it does not cause pain, physical touch can be very important to someone who is dying, especially if they don't have family or friends around them. Just holding hands can be very comforting.

- Respect the client's need to withdraw from social contact.

Find out from the client or their family about any spiritual, religious or cultural considerations the person would want to be taken into account.

Supporting the client's family

- Respect the knowledge of family members and treat them as partners in the person's care.
- Be prepared to help family members to understand the physical changes that take place at the end of life.
- Be ready to listen if family members want to talk about their feelings. Listen without passing judgement or offering advice, unless you are asked to.
- Relatives may feel helpless or useless – you could suggest things for them to do that would help them and the client.
- The client's booking co-ordinator will tell you how the process of verification and certification of death works in your area, so that you can advise the family if needed.

Looking after yourself

- Seek specialist training on end of life care. Contact the training team at Christies Care for more information.
- Acknowledge your own feelings about looking after someone who is dying. Talk about your feelings to colleagues, your carer support team or in training
- If you feel upset after someone has died, make sure you discuss this with your carer support team. You may need bereavement support yourself.

SELF-EXPRESSION AND SEXUALILTY

Sexuality is a fundamental part of people's lives and plays a big part in how we see ourselves. We express our sexual identity in all sorts of ways, such as how we dress and how we interact with other people, and our friends and family relationships.

It is important to recognise that clients have their own sense of their sexual identity and their own set of attitudes and values relating to sex. It is important to be tolerant of others' views and lifestyles. Never discriminate against a client on the basis of their orientation, whether they are married, are in a civil partnership, have other types of relationships or have none at all.

There are various things to take into account when thinking about client's sexuality:

- Many older clients grew up during a time when attitudes towards sex and sexuality were very different. They may find modern attitudes, for example openness about sex or the acceptance of different sexual orientations, difficult to come to terms with.
- A client's personality, as well as their background, can affect whether or not they are open about sexual matters.
- Some clients may not wish to discuss matters relating to sex, their sexuality or personal relationships because they fear disapproval or prejudice from others.
- Society plays an important part in how people perceive sex and sexuality. Often the sexuality of older people and those who are disabled or ill is overlooked.
- Looking and feeling attractive can play a big part in people's sense of self-esteem.
- Health conditions and disabilities may affect people's sexual health and prevent sexual activity. This can have an impact on their general wellbeing.
- Sexual desire is not necessarily affected by age. However, the physical aspects of ageing may have a negative effect people's sex lives.

Maintaining boundaries

- Maintain appropriate professional relationships with clients. This means respecting their privacy about their sexuality and relationships.
- Behave in a way that is respectful to clients and their families, particularly over the language you use and the subjects you talk about.
- Clients are often interested in the people who provide their care, and may sometimes ask questions about your family relationships. Be cautious about how much information you share and do not divulge any information which you would rather keep private.
- Be clear that you will not take part in jokes or conversation of a sexual nature if they become offensive to you, or others.
- Occasionally you might find that you become the focus of a client's attempt to express their sexuality. Discuss this with your carer support team and ask for advice about how to handle the situation if you need it.
- If a client behaves in a sexually inappropriate way towards you or asks you to be involved in any sexual activity, for example watching adult videos, state firmly but politely that this is something you cannot do. Talk to your carer support team about the situation.
- Humour can be a good way of letting out pent-up feelings and dealing with awkward situations.

USE OF WHEAT BAGS AND HOT WATER BOTTLES

Wheat Bags

Wheat bags are commonly used to treat aching muscles and arthritis, but they can become dangerously hot in a short space of time.
People need to be aware of the risks of using the bags to heat beds where, smothered in sheets and duvets, they continue to heat up and can catch fire.
Because they are made of wheat the bags can quickly become too hot if they are heated for too long, causing an exothermic reaction, or used in a microwave that doesn't have a working turntable which creates 'hot spots'. Instructions which specify how long bags should be heated for should be strictly followed and the bags should only be used for their intended purpose, often to give relief to joints and treat muscular injuries.

Hot Water Bottles

When filling do not use boiling water, very hot water is fine but boiling water can cause splits or leaks and will shorten the life of the bottle.

Do not overfill, three quarters is the maximum. A hot water bottle will give out plenty of heat and work just as well when filled to the correct level. Expel excess air from the bottle by lowering it carefully onto a flat level surface until water appears at the opening.

It may help to use a towel to cover the hot water bottle when adding hot water, this will help avoid any burns. For the unsteady hand a hot water bottle filling stand may be the solution.

When tightening the stopper make sure it is on correctly, finger tight should be adequate. If loose replace with a new stopper but always replace like for like, not all stoppers are generic.

Use the hot water bottle to warm up the bed or area and remove before the person gets in. This helps to avoid any accidental burns to adults at risk. Never sit or lie on top of a hot water bottle.

If using an electric blanket never use a hot water bottle at the same time. Use one or the other but never the two together. Mixing water with electricity is risky and not worth taking a chance. Overheating can also cause problems if using both, a good quality hot water bottle will give plenty of heat.

Always buy a hot water bottle that has the British Safety Standard BS1970 mark. There are low budget hot water bottles that fail to meet to the standard with many product recalls from cheap imports. Not

worth taking a chance on a product that has to work safely each and every time. Latest British Standard update is BS 1970:2012.

If the old bottle is showing signs of wear and tear replace with a new one. Check for splits or perishing and make sure the stopper is a good fit. When storing drain the bottle completely, remove the stopper and store in a cool dark frost free place. Always make a thorough check when using for the first time. A good quality hot water bottle will last 3 years, budget bottles may only survive one winter season. Many of the budget hot water bottles suffer leakage problems with poorly sealed stoppers.

ENVIRONMENTAL SUGGESTIONS

Reduce Paper Use

- Use electronic or phone rather than post information to head office, unless it is an official document.
- Portals for all carers so that all payslips, staff handbooks and other personal documents will be uploaded by head office and avoid the necessity for paper documents to be printed.

Conserve Energy & Water

- Switch off lights when rooms are not in use and, where security is not compromised, use energy saving bulbs where possible
- Switch off computers and other powered equipment when they will be out of use for any length of time
- Do not leave the tap running when cleaning teeth.
- Where possible purchase electrical equipment and light bulbs with the highest energy efficient ratings

Recycle & Waste Reduction

- Recycle or shred your waste paper
- Try to recycle as much of your clients waste as possible

Single Plastic Use

- Try to purchase paper drinking straws rather than plastic
- Try to purchase refillable cleaning products
- Biodegradable refuse sack where possible

Transport

- Where possible use surface public transport before using cars
- Purchase food with low food miles

DO'S & DON'TS

As a self employed worker, we can only advise you on what to do.

We strongly advise you to consider the below Do's and Don'ts

Do

Do – follow the Guide to Client's Wishes at all times

Do – contact your Carer Support Team if you have any queries over what is asked of you by your client and is not covered in the client guide

Do – complete all record books

Do – always afford your client the utmost dignity and respect

Do not

Do not – undertake any procedure that you have not been competently trained for

Do not – complete any record books in advance

Do not – make arrangements or appointments on hand over day

Do not – drink alcohol whilst on duty

Do not - invite friends/partners, bring pets to your client's home

IF A COMPLAINT IS MADE AGAINST YOU

Complaints and allegations can come to us from a variety of sources – the client, family members, social workers, carers from other agencies and even other fellow carers.

Every allegation that is reported to us must be taken seriously whether the initial indications are that they will be unsubstantiated or not. Initially these allegations will be passed to your Carer Support Team. If they can deal with them, they will. If they require further investigation they will pass them on to our Quality and Safeguarding dept.

If the allegation is a safeguarding concern e.g. accusation of theft or neglect of client. We have a duty to inform the local area safeguarding team. If you are working for a private client at the time we will advise your client that there has been allegations made against you and will request permission to replace you. Should the client not wish you to be replaced, you can enter into a private arrangement with the client called "own care", where we will have no further involvement in the care and you and the client will not be covered by our liability insurance. Unfortunately there is no time limit on the amount of time the investigation can take. Where there is police involvement we are not allowed to undertake any internal investigations until they have completed their part, and we are not allowed to advise you of the allegations.

If the police do not wish to be involved we will start our internal investigations. This may mean obtaining statements from witnesses, photographic evidence, and phone conversations. Once we have gathered all supporting evidence (if any) we will ask you to attend a fact finding meeting. You will receive a letter from your Carer Support Team advising you of the allegations and the date and time of the meeting. If you wish to bring a Trade Union representative or colleague with you for support you can. However this must not be a family member and must be agreed with Christies Care beforehand.

You will then be given the opportunity to respond to the allegations made. An account of the meeting will be written up and sent to you to sign as true, accurate and correct. Sometimes these minutes will be requested by the Local Authority or taken to a strategy meeting. Once the outcome of the allegation has been decided this will be passed over to the Senior Carer Support Co-ordinator who will make the decision about what action should be taken. If the decision is that it is unsubstantiated or untrue, you will be offered further introductions. Where we feel compensation should be sought we will support you in this.

If the allegation is substantiated and is a safeguarding issue, you will be referred to ISA and in the worst case unable to work with adults at risk or children again.

CEASING INTRODUCTIONS FROM CHRISTIES CARE

If you wish to cease receiving introductions to clients via Christies Care, we would prefer as much notice as possible in order to find suitable carers to be introduced to the clients.

Please inform your Carer Support Team of your intention to leave as soon as you have finalised your dates. Please note that if you provide less than 2 week's notice without good reason then this may jeopardise any future introductions, should you wish to recommence being introduced to clients via Christies Care at a later date

OUT OF HOURS

We operate an out of hour's duty service for EMERGENCIES ONLY. This service is to be used between the hours of 5pm and 9am weekdays, and over the weekend.

You can ring 01728 605000 and follow the instructions to contact the duty manager. Press 1 to leave a message, 2 to go straight through to the duty manager.

The message option can be used for e.g. client has fallen, family has been advised but the client is unhurt.

Please DO NOT use this option to leave you availability for future bookings, or any other message that can be made within office hours.

Messages are checked –
Weekdays – 5:30pm, 9:30pm and 7:30am
Weekends – 9:30am, 1:30pm, 5:30pm and 9:30pm

Going straight through to the duty manager – this option can be used if you are unwell and cannot find a substitute carer. We can look for a replacement on your behalf and arrange.

Examples of NON emergencies:

- Updating us with your availability
- Client has had a fall but is ok
- Cancelling an introduction for the coming Wednesday on the weekend

Examples of an emergency:

- You need to be replaced urgently because you are unwell or have a family emergency
- You suspect abuse

AIDS AND ADAPTATIONS

There are numerous aids and adaptations that can help clients to remain independent and carry out tasks for themselves. It is not possible to cover them all in detail here, but this section:

- Suggests when an aid might be helpful
- Describes the most commonly used aids
- Lets you know where you can find out more about aids, or source the aids yourself.

The experts on aids and adaptations are Occupational Therapists. However, your day-to-day contact with clients means you are likely to notice when aids and adaptations could become helpful. If you know what is available you will be able to make informed suggestions either to clients and their families or to Christies Care.

When is an aid or adaptation helpful?

You might think that it is best to suggest an aid as soon as you see that a client is finding an everyday task difficult. However, this may not always be the case. In some circumstances, making an effort to carry out a task can:

- Exercise a person's muscles, help their blood circulation and help to keep joints and skin supple.
- Create a sense of satisfaction and achievement for a client and maintain a sense of 'normality'.

However, if any of the following occurs, it is time to think about aids and adaptations:

- A client begins to have accidents, for example dropping or breaking objects, because their eyesight is poor or their grip has become weak.
- A client cannot deal with accidents because of old age, a health condition or injury. For example, a person may not need an aid because they occasionally drop things, but they may need an aid to help pick them up again.
- A task causes continuing frustration or pain for a client.
- A client begins to have accidents, or is at risk of injuring themselves – for example, they burn themselves because they can no longer lift the kettle easily.
- A client's personal appearance and dignity begin to suffer.

What sorts of aids are available?

There are lots of different types of aids, and more are being invented all the time. Some of the most common are illustrated and described on the following pages.

Remember, aids do not have to be custom-made. Everyday household items such as pegs or a tall stool can be used to help a client to perform a task.

It is also worth bearing in mind that an aid is only an aid if it suits the individual client – otherwise it is likely to cause problems of its own.

Aids for general use

Helping hand – This is a 'stick' about 18 inches (46 centimetres) long with a squeezable handle at one end and a sprung gripper at the other. It helps a client to reach further and grasp things that they might find difficult to hold with their fingers. For example, a client might use it to pull curtains that they would otherwise not be able to reach. The weight a helping hand can take will depend on how tightly the client can grip the handle.

Grippers – These help clients with a weak grip to unscrew jars or bottles. They look a bit like a pair of scissors but, instead of blades, they come with rings of different sizes that fit over a container lid. Another useful type of gripper is the sort that looks like a thin rubber mat, which can be used to hold slippery containers or get a good grip on a lid.

Non-slip mat – Flexible, rubbery mats that create a non-slip surface, for example, to prevent a plate and cup from sliding on a tray. They come in different sizes and shapes and can be very useful for all sorts of items in the home, such as a client's tooth mug, writing pad, mixing bowl or telephone.

Pegs – There are many uses for pegs, for example holding clothes, curtains or sheets out of the way, stopping the pages of a book from turning over or attaching messages in visible places. Colourful pegs of different sizes can be bought, but ordinary clothes pegs are a cheaper alternative and are just as effective.

Electrical plugs with handles – These enable a client who has trouble gripping things to plug and unplug electrical appliances.

Portable doorbell amplifier – An amplifier, installed by an electrician, that a client can carry to any part of the house or even the garden so that they can hear the doorbell.

Rubber fingers/rubber thimbles – These are normally used in offices for leafing through paper documents, but they can also be useful in the home, for example, when turning the pages of a book or opening plastic bags.

Tall stools – Stools can be placed at strategic points in the home so that a client can have a rest when going from room to room, for example, or take the weight off their feet while cooking or washing.

Trolley or mobile tray – Trays with wheels that can help a wheelchair user to carry things, or that provide support to help a client walk as well as move things from place to place.

Walking stick – A client should use a walking stick on their weaker side so that it takes the pressure off their injured or painful leg or foot. A walking stick should have a rubber stopper on the end so that it doesn't slip.

Aids for the kitchen

Gas cooker controls – Special Braille controls can be installed for clients with sight problems. The client's gas company will have a department that deals with adaptations to gas appliances.

Kettle and jug tipper – This is a frame, made of wood or plastic, into which a jug or kettle fits. It helps a client to tip liquids from one container to another.

Long-handled or enlarged tap fittings – These are useful in the kitchen and the bathroom. Some types can be clipped over existing taps and do not need special plumbing.

Aid for the bedroom

Eye-level clothes rails – A rail can be used to hang clothes at a height that a client can reach more easily. This can be particularly helpful for a person who uses a wheelchair.

Aids for the bathroom

Mirrors – A mobile, hinged, or retractable mirror can be helpful if a client can no longer see into their bathroom mirror.

Raised toilet seats – These can be fixed permanently to a toilet seat or taken on and off according to use. There are also many kinds of commodes, commode wheelchairs and special toilets.

Suction mats – These can vary in size from small mats for a bar of soap to larger ones that can be placed in the bath to prevent a client from slipping.

Thick toothbrush handles – Useful for a client who has trouble gripping things. Thick handled cutlery, pens and pencils can also be useful.

Toothpaste dispenser – A small device, fixed to the wall at a suitable level, which enables a client to put toothpaste on their brush using only one hand.

Aids for the living room

Book holder/stand and page turner – A slanting wooden or plastic frame on a horizontal 'foot' that supports a book for a client who is unable to hold one. Some come with page turners, or a stick with a rubber end can be used to turn pages.

Computers and electronic equipment – There are many ways in which computers can help people who are living with a disability or are unable to leave their home. A wide range of electronic gadgets, such as voice-controlled lights, can also be fitted to enable clients with little movement to control their own environment. The occupational therapist can advise on these.

Remote control – A client who has problems with their sight may find it helpful if you add labels to their existing remote control. Remote controls with large buttons are also available. Remember to leave remote controls in a place where the client can reach them – a non-slip mat can help to stop them sliding away. For push-button controls on appliances, the client could use a stick with a rubber finger on the end to press the controls. Make sure that the appliance is stable and will not move or fall when the buttons are pressed.

Telephone receiver stand – A stand for the telephone receiver/handset which means the client does not have to hold the phone during a conversation. An alternative to this could be a phone with a loudspeaker, which can be used without lifting the handset.

Trays – A tray with a bean bag underneath will mould to the shape of the client's lap to make a secure surface.

Telecare

The term "telecare" is used to describe remote monitoring and communication services that support people to live at home, for example, a sensor under a doormat that alerts a monitoring centre, if a person living with dementia leaves the house at night.

Telecare includes a wide and expanding range of services. Services in this category may also sometimes be known as "tele-health", "e-medication" or similar names.

Finding out more

- Occupational Therapy departments in hospitals and social services. The client's GP will have names and contact details.
- Voluntary organisations
- Specialist shops
- Aids and adaptations catalogues
- High street shops such as chemist, department stores and supermarkets, which stock many useful gadgets for the home.

STAYING AT CHRISTIES GUESTHOUSE

Only authorised guests are allowed access to any of the guesthouses, no unauthorised visitors are permitted. The reasons for not allowing visitors:

- Unauthorised visitors will not be covered by our liability insurance
- Should an emergency arise and an evacuation takes place, these visitors would not be recorded on our system
- We have a duty of care towards our guests to protect them from unauthorised visitors.

If any persons arrive at the guesthouse after office hours please ask them for identification or if you are not happy to approach the person then call 01728 605000 (Option 2). Any visitors arriving at the guesthouse after office hours and the front door is locked should under no circumstances be let in until you have called the above number and checked with the pager manager that the person is permitted access.

You will respect the fact that there will be other guests staying in the same room or same building and keep noise and disturbance to a minimum.

Under no circumstances should you change rooms unless this has been authorised by the Housekeeper or their representative. We need to know which room you are in in-case of a fire, if you are not in the room we have booked you into, emergency services would not be alerted that you are unaccounted for.
Smoking and vaping is not permitted in any of the buildings, please DO NOT extinguish you cigarette anywhere other than in the cigarette bins provided.

If you wish to leave before the end of your pre-arranged booking you must inform the Housekeeper or their representative or if you are leaving outside office hours you must inform the Pager Duty Manager on 01728 605000 (Option 2). Any refunds due will be arranged either before you leave or the day after.

If your travel arrangements do not allow you to get to see the Housekeeper to pay for your accommodation during office hours or before you leave there are payment boxes situated in all our guesthouses. You should leave your payment in an envelope stating your name, room number and the amount you have deposited.

If you have any problems or emergencies outside office hours please call the duty manager on 01728 605000 (Option 2).

When you arrive at the guesthouse please make sure you have your Christies ID card with you or letter of booking confirmation for the accommodation booked and be prepared to show this when requested as other guests may not know who you are and they are encouraged to ask you for ID.

In the event of a fire:

Activate the fire alarm at the nearest point
Telephone the Fire Service by dialling 999
Leave the building by the nearest fire exit
Do not stop to take your belongings
Do not re-enter the building.

Never use naked flames or candles in your room. In the event of a power failure there are wind-up torches in the emergency cupboard situated in the corridor just outside the kitchen door.

Food Hygiene

As you may well be preparing your own food we ask that you observe good hygiene rules for your own safety and the safety of others staying with you. Following the few basic rules below will help to keep you safe:

- Food that needs to be refrigerated must be kept in the fridge. It must not be stored in your room.
- Food in the fridge must be labelled and not used beyond the given use by date. Anything not labelled will be disposed of by the Housekeeping team every Wednesday and Saturday.
- If you have any half tins of food which are not used at once please empty the contents into a clean dish, cover and label it. DO NOT put half tins of food into the fridge.
- Please clean up after yourself
- Please make sure you take your food with you when you leave or throw it away.

Electricity

Please do not tamper with anything electrical. If you notice anything that you think looks hazardous please do not use it and report it to the Housekeeping team or any other member of office staff.

In the event of a power failure

If the fire alarm is activated during a power failure please call the duty manager.
If there is a prolonged power failure there is an emergency cupboard which is stocked with torches etc.

Gas

At any point if you are worried by a strong smell of gas, please call 01728 605000 (option 2) and the duty manager will go through with you what you need to do. Open the windows, DO NOT light matches or switch on any lights.

Water

If a water leak occurs please place a container underneath the flow or try to reduce the flow if possible. Call 01728605000 (option 2) and the pager manager will talk you through what you need to do.

Emergency first aid

There is an emergency first aid box situated in the kitchen area. The contents of this box are only to be used in an emergency situation but if you require further assistance please call 999 and ask for an ambulance. The accident record book should be completed by you or someone else if you are not able to do so and the form should be passed to your carer support team. Always notify a member of staff should an accident or incident occur. There is a list of emergency numbers in the guesthouse handbook and on the notice board in the kitchen.

Alcohol

You may be contacted at any time to go to an emergency booking and if you have been drinking alcohol you will be unable to go.

If you are in the guesthouse awaiting work/standby, do not drink alcohol.

If you are at the guesthouse for training and the training team feel you are under the influence of alcohol you may be asked to leave the training course and all travel expenses to return home may be forfeited.

CCTV

Please be aware that CCTV is installed over the whole site.

Alarms

All Christies Care Ltd buildings are fitted with fire and burglar alarms. If the fire alarm is activated please follow the instructions above (these instructions are also displayed on the wall of every bedroom). If either the fire alarm or the burglar alarm is activated in any of the offices, please do not take any action as this will be dealt with by our security company.

Parking

Training – If you travel by car to your training, please park your car in the top right hand corner of our car park.

Long Term Parking – If you wish to leave your vehicle at head office when on holiday please park behind the guesthouse and leave your keys with Tanya Howard (Training Department).

DRIVING IN THE UK

A licence issued by any other country is valid for use for one year. To continue driving, a full driving theory and practical test must be taken for the issue of a GB licence.

For more information, please visit the following links:

https://www.gov.uk/exchange-foreign-driving-licence

https://www.gov.uk/driving-nongb-licence

You are classed as a UK resident if you are here for over 6 months (182 days) during one visit. If you have come over for 3 months, then travelled out of the UK and then returned, your 6 months will then start again and so on.

PAYROLL

PAYMENT FOR YOUR WORK

Your payments are processed every Wednesday and the funds will clear in to your bank account the next day. The payroll is run once per week so you will always be paid on this day regardless of whether you work a full or part week. Your wage will be paid through our payroll system and may be subject to deductions of Tax and NI. You need to submit details of your travel cost through the portal system to gain Tax and NI relief on your travel expenses.

For tax year commencing 6th April 2019

In the UK, your tax is accounted for once a year (unless you are an employee when your tax and NI is calculated and paid throughout the tax year). The tax year runs from 6th April to 5th April.

You can earn £12,500.00 in this current tax year, and pay no tax (your personal allowance). You pay 20% tax on your earnings between £12,500.00 and £50,000.00 and 40% tax on anything over £50,000.00.

In this you will find:

1. Common questions asked about tax
2. Common questions asked about NI
3. Tax allowance on travel costs
4. Carers holiday pay
5. Workplace pension scheme
6. Non-resident tax payer
7. Useful telephone numbers

1. Some Common Questions Asked About Tax

Why do I have to pay tax?

All employees are required to pay tax under the Income Tax (Employment) Regulations 1993.

What is a tax code?

A tax code determines how much tax you pay. The most common tax codes are as follows:

1250L – This is the standard tax code for the current tax year. This means that you have £12,500.00 tax free pay. This figure is divided by the 52 weeks of the tax year equating to approximately £240.00 tax free per week. So, in tax week 12 for example, your tax free pay is approximately £2880.00. If your taxable pay is more than this figure you will see deductions of tax on your payslip.

BR – is the tax code used when no P45 or P46 form (explanation of these forms to follow) is given to Christies. Tax is deducted at 20% on **all** your gross pay. (BR = Basic Rate).

Think you're on the wrong code? – we don't set the tax codes, HMRC does this. So, if you feel you are paying too much tax, contact HMRC on 0300 200 3311 as they may have made an error and correct this, or they will be able to explain why your code is set up the way it is - quote our PAYE reference of '245 / G629'.

What is a P45?

This is a document given to you by your previous employer when you leave them. You need to keep hold of part 1 of the form and send the rest in to Christies. This document informs us of your current PAYE code and your taxable pay and amount of tax already paid since the last 6th April. HMRC are made aware of your employment with Christies by an electronic submission when your pay is first processed with us.

What is a P46?

If you have not been employed in the UK prior to coming to Christies you won't be able to give us a P45 form, if this is the case we will send you a P46 to complete. This form is a declaration which you must sign to state your current employment status. We use this form to set your tax code although this is subject to changes from HMRC. Where we do not receive a P45, and until you have completed a P46, your tax code is set at BR.

What is PAYE?

It stands for Pay As You Earn. Your employer will deduct tax from your gross earnings each week. The amount deducted depends on your tax code, your earnings to date, and at which week of the tax year your pay is processed. You may see variations in the amount of tax deducted throughout the tax year due to these variables, you may also see that tax is refunded to you in some weeks.

2. Some Common Questions Asked About National Insurance

Why do I have to have a National Insurance number?

A National Insurance number is a unique reference number, used by the Department of Work and Pensions, to identify your National Insurance contributions. It ensures that contributions paid by yourself (and Christies Care as your employer) are allocated correctly to your account. An NI number is also required to successfully register for self-employment which must be done within three months starting work as a self-employed person.

How do I apply for a National Insurance Number?

Call the National Insurance number application line: 0800 141 2075 or visit:

https://www.gov.uk/apply-national-insurance-number for more details.

Once you have applied you'll get notification from the Department for Work and Pensions asking you to attend a National Insurance number interview at a Job Centre Plus office.

The notification will also tell you which documents to bring to prove your identity, such as:

- passport or identity card
- residence permit
- birth or adoption certificate
- marriage or civil partnership certificate
- driving license

At the interview, you'll be asked about your circumstances and why you need a National Insurance number. You'll also be told how long it'll take to get your National Insurance number.

In the meantime we will allocate you with a temporary NI number made up of your date of birth and gender. For example: TN 01 06 48 F - Temporary Number, 1st June 1948, Female

I worked in the UK in the past but do not know what my National Insurance number is, do I re-apply?

You'll need to contact HMRC on 0300 200 3500 and ask for 'confirmation of National Insurance number'.

HMRC won't tell you your National Insurance number over the phone, they'll post it to you and it'll arrive within 15 working days.

How much is deducted each week for National Insurance?

There is no National Insurance deducted from the first £166.00 of your weekly earnings, the amount of NI deducted is 12% of everything over and above this figure. Christies also pay Employers National Insurance which is 13.8% of earnings above the first £166.00.

How do I know when I stop paying National Insurance?

The pension age used to be 65 for men and 60 for women. Once over pension age, you would not have to pay National Insurance. Although, Christies Care will continue to pay Employers NI contributions.

The state pension age is increasing for both men and women, you can check you state pension age at the below link, simply input your gender and date of birth:

https://www.gov.uk/calculate-state-pension

I have other queries regarding NI?

Ring their enquiry line on **0300 200 3500**

3. Tax allowance on Travel Claims

You can claim **Tax and NI relief** on the actual cost of your travel expenses from home to client, from client to client, or from client back home again. When working with Employed clients we pay you a wage which is inclusive of travel expenses.

To enable us to pay part of this wage to you as travel expenses (free of Tax and NI deductions) we need you to submit a form to us through our portal detailing the actual cost of the journey.

You may use several different transport methods during one journey, these can all be claimed on one form, you need just need to itemise the different costs on the form. You are able to include costs for bus / coach journeys, train / tube costs, and mileage if you use your own car. You can also claim for Taxi journeys but we require a copy of the receipt to be emailed in to us, there is a link to the email address on the portal.

Traveling to a client may require you to pay for a flight, for example if you are booked to a client in Scotland or on Jersey. The cost of this flight (also additional cost for luggage etc.) can also be submitted through this form. The cost of flights from overseas to the UK should not be included on these forms.

When we receive the submitted forms from you they are checked and filed ready to be used with the next payroll payment we make to you. We can also use these travel claims to reduce the amount of Tax and NI deducted from your holiday pay payments (explained in the next section).

You will see your travel expenses as both a payment and a deduction on your payslip. We pay the travel on top of your wage as a tax free expense payment. But, as the actual amount for travel is included within the wage, we then have to deduct it back as a pre-tax overpayment (this will show as 'Travel Adjustment' on the deduction side).

Payments	Units	Rate	Amount
Basic Weekly Fee	77.00	9.0909	700.00
Travel Expenses	1.00	40.0000	40.00

Deductions	Amount
PAYE Tax	84.00
National Insurance	59.34
Travel Adjustment	40.00

The net result of this is a reduction in the amount of taxable and NI'able pay. You will see this in the totals for this period section of your payslip:

This Period	
Total Gross Pay	740.00
Gross for Tax	660.00
Earnings for NI	660.00
Payment Period	Weekly

Please note: These claim forms are to be used for journeys with regards to employed clients only. Journeys with regards to self-employed jobs need to be accounted for through your tax return form separately.

4. Holiday Pay

When working with employed clients you are entitled to holiday pay payments. These payments are paid out to you automatically throughout the year, you don't need to do anything to claim holiday pay.

The holiday pay payments are processed three times throughout the year, at the end of February, June and October. The exact date will vary as these payments have to be processed on a Wednesday as this is the standard weekly pay day. If you are booked to work with a payroll client the same week that holiday pay is processed it will be paid on top of your wage and appear on the same payslip.

How is your holiday pay calculated?

As a carer you are free to work as many or as few weeks in the year as you would like to, due to this fact it is difficult to operate the holiday system a normal way. For example working 48 weeks in a year and taking four weeks off as holiday.

So, we pay back to you a percentage of your gross payroll wages as holiday pay. We pay 8.62% of your gross pay, this percentage equates to the statutory leave entitlement. For example, if your gross pay is £635 per week this earns you £54.74 in holiday pay.

Bank Holiday pay
Extra pay paid to you with regards to bank holiday days works differently to regular holiday pay. The standard bank holiday days throughout the year are paid at double pay. Christmas, Boxing Day and New Year's day are paid at 3x the standard daily rate.

Only the regular UK bank holiday days are processed this way. For Example, if you are working on Jersey you won't be paid double pay for their Liberation day bank holiday.

5. Workplace Pension Scheme

You may be given the option to opt in to our workplace pension scheme, the scheme provider is NEST. If you are eligible to join the scheme we will write to you with more information when we add you to our payroll system (when you work with your first employed client). As an employer Christies will pay a contribution to your pension. An 'opt-out' form is also sent with the info, should you not wish to join this scheme you need to complete and this to us.

6. Non-Resident Tax Payers

If you are non-resident in the UK but are working here there is a centre for Non-residents which can explain in greater detail your tax liabilities whilst in the UK. You can find a lot of useful information using the following link or giving them a call on **0300 200 3300** or **+44 135 535 9022** from outside the UK.

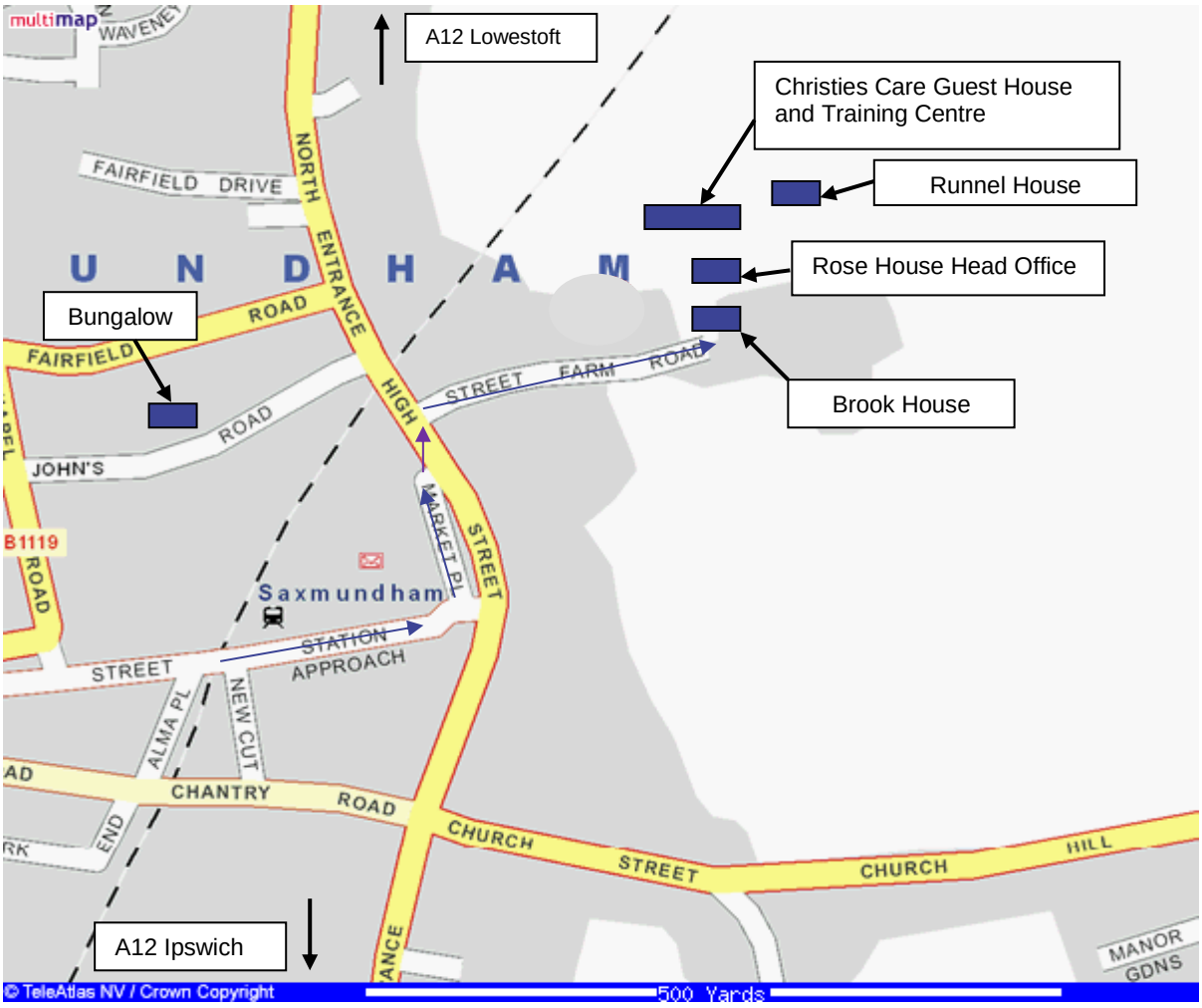
Search for Non-UK residents: Income Tax and Capital Gains on www.gov.uk or key this in to your browser:

https://www.gov.uk/government/organisations/hm-revenue-customs/contact/income-tax-and-capital-gains-tax-enquiries-for-non-uk-residents

7. Useful Telephone Numbers

National Insurance enquiry line	**0300 200 3500**
Self-employed help line	**0300 200 3504**
Employee HMRC help line	**0300 200 3311**
Quote our PAYE reference: 245/G629	
Inland Revenue – non-residents section	**0300 200 3300**

Map Of Christies Care Properties



Christies Care

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CONFIDENTIALITY AGREEMENT

POLICY ON CONFIDENTIALITY

The Company, its Employees, Associates and Personnel will respect the confidentiality of information held about clients and care workers. In principle, no information will be passed to anyone without the prior approval of the person concerned, except where we are obliged by law to disclose it, or in an emergency. Care workers and clients have the right of access to their records.

PROCEDURE ON CONFIDENTIALITY

All carers and administration staff will be required to sign a confidentiality agreement when joining the Company. This will commit them to the principles set out in the confidentiality policy. The importance of confidentiality is highlighted during induction. Records held about carer workers or clients will be treated as confidential and every effort made to ensure that such records are kept securely and are not accessible to unauthorised people. If confidential information is made public, the Company will at once tell the person whose right to confidentiality has been breached.

Should a care worker or client wish to have access to their records, they should write to the Registered Manager giving three clear working days' notice and enclose the appropriate fee (£10). Copies of records may be made but originals may not be removed from the office. The GDPR (General Data Protection Regulations) may apply. Information provided by a third party will not be disclosed without the permission of the information provider.

Name: …….

I have read and understand this confidentiality agreement and agree to be bound by its terms. I understand that breach of this agreement may render me liable to legal action. I agree that my personal file can be accessed by any local authority Christies Care is contracted to whilst undertaking an inspection.

Signature: …… Date: ……

Christies Care

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CONTRACT FOR SERVICES

PERSONAL CARE, HEALTH AND SUPPORT NEEDS

This contract for services is made this day of 20

Between, on the one hand,

a) Reference number only

(hereinafter called “the Client”) and

b) of

(hereinafter called “the Carer”)

The Parties shall be “the Client” and “the Carer” as defined in this Agreement.

These Definitions apply to this agreement unless the context requires a different interpretation:

“The Client” means the person signing this Agreement or the person on whose behalf this Agreement is signed and shall be the person to whom services are to be provided under this Agreement.

“The Carer” means the person signing this Agreement who shall be the person providing the services under this Agreement.

“Assignment” means the work to be done under this contract as fully described in paragraph 3.

“Client Guide” means the document setting out the personal care, physical and other support needs of the Client, as well as any special preferences, which will act as an important guide to the services to be provided by the Carer during the Assignment. Where there is more than one Client Guide, the most up to date version shall be deemed to be the current Client Guide applicable to the Assignment.

“Confidential Information” means all information about both the Client and Carer without limit. It includes information in the public domain.

“Initial Fee” means the weekly fee proposed in the initial letter of confirmation of introduction.
It shall be expressed as either ‘plus travel’ or ‘including travel’

The terms of this Agreement are:

1 Purpose of Agreement:

1.1 The purpose of this agreement is to regulate the relationship between the Client and Carer in connection with the work described in paragraph 3.

2 Relationship of parties:

2.1 This agreement does not create any partnership or joint venture between the parties.

2.2 The Carer is not an agent of the Client and does not have authority to enter into any commitment on behalf of the Client.

3 Assignments:

3.1 The Assignment is to provide personal care and support services in accordance with the Client Guide for the Client.

3.2 If the Client offers one or more further Assignments to the Carer they are deemed to be regulated by this contract unless agreed to the contrary.

The Carer may accept or decline any Assignment.

3.4 The Carer acknowledges that this agreement imposes no obligation on the Client to provide the Carer with any additional Assignment.

4 **Carer's Obligations:**

4.1 By accepting an Assignment the Carer agrees to provide services of an appropriate level of skill and experience to meet the needs of the Client set out in the Client's Guide.

4.2 In providing Care Services to the Client the Carer may apply his / her own method of work.

4.3 In providing Care Services to the Client the Carer agrees that the manner in which he/she provides the Care Services is not subject to (or to the right of) supervision, direction or control by any person.

4.4 Each Assignment will be completed in accordance with the following timetable:

4.5 The Carer shall be available to meet the needs of the Client as set out in the Client Guide which will involve taking breaks at agreed and appropriate times during the day and being available during the night to meet needs identified in the Client Guide or should the health and safety of the Client otherwise require it (for example, in an emergency).

4.6 The Carer agrees that whilst engaged in any Assignment on the premises of the Client, he/ she will comply with:

a) all laws and regulations relating to the work involved in the Assignment work including Health and Safety laws; and

b) all reasonable standards of care including standards recognised in good practice guidance for health and social services.

4.7 The Carer will respect the Client's home and personal possessions, including any pets or domestic animals, and take all reasonable steps to protect the Client's home and possessions from damage caused in carrying out, or failing properly to carry out, the Assignment.

4.8 The Carer will not engage in any work or employment where the other work is such that the Carer may for any reason be less capable of dealing efficiently and promptly with any Assignment.

5 Care and Support:

5.1 In meeting the Client's needs under the Client Guide, the Carer shall have regard to the following:

5.1.1 Personal Care

Dressing, undressing, washing and bathing - If the Client needs assistance, the Carer will help with dressing, undressing and choosing clothes for the Client. The Carer will also, subject to the needs of the Client, assist with washing and this may range from helping a client into and out of the bath, to giving bed baths and dealing with incontinence.

Care of teeth and hair - The Carer will, subject to the needs of the Client, help the Client with oral hygiene and care of hair, make-up and shaving.

Assisting with mobility - The Carer will be sufficiently experienced to use a range of equipment to help with the Client's mobility including: portable or fixed hoists (electrically or manually operated), turntables, sliding boards and slings.

Assisting with feeding - Subject to the needs of the Client, the Carer shall give assistance with feeding including, where necessary, assistance using mechanical aids to feeding.

Skin and pressure area care - The Carer shall ensure that the Client's skin is maintained in as good a condition as possible between visits from the Community Nursing Service and will liaise with the Community Nurse Service in accordance with best practice.

Bladder and bowel incontinence - Subject to the needs of the Client, the Carer will provide assistance with managing incontinence including, where necessary, the use of colostomy, ileostomy or catheter bags and deal with the consequences of bladder and bowel incontinence.

Giving medicines - The Carer will provide, subject to the Client's consent, any necessary assistance to the client in taking medication and, in doing so, shall comply with current best practice and health and safety requirements. Wherever possible, the Client shall provide written consent to the Carer allowing the Carer to assist with medication.

Dosset boxes - It is not the Carer's responsibility to fill the Client's dosset box. If the pharmacist is unable to fill the box, the task should be carried out by the Client's GP. If the GP or pharmacist will not fill the dossett box, we recommend that the client's medicines are kept in their original packaging.

5.1.2 **Housekeeping and Social Duties Companionship** - the Carer will provide basic companionship and will ascertain whether the Client would like him / her to be general

available to accompany the Client or be available on stand-by until a task needs doing.

Shopping and handling money - the Carer will agree with the Client how to manage household expenditure, including whether this will be retained by the Client or delegated (all or in part) to the Carer. The Carer will provide receipts and basic accounts for all expenditure involving the Client's money.

Preparing food and cooking meals - the Client will inform the Carer whether the Client would like to be involved in preparing meals. The Carer will be able to provide simple meals for the Client and up to one guest of the Client and will follow any special diets. The Carer shall be entitled to decline to cook for large numbers.

Pet care - The Carer shall feed pets and give them daily exercise, provided the animals are docile and house-trained.

Housework - The Carer shall keep the Client's house tidy. The Carer will not be responsible for heavy cleaning such as scrubbing carpets, cleaning outside windows and washing curtains.

Driving - If the Carer can drive, the Client may ask the Carer to run basic errands and make trips and visits, either with or without the Client. Where the Carer drives the Client's car, it is the responsibility of the Client to make sure that proper insurance is in place to cover the Carer. The Client will be responsible for insurance, fuel and other associated costs. The Carer is required to have a valid UK driving licence or other legal rights to drive in the UK.

5.2 In carrying out his or her duties in the Client's home the Carer will work to a personal code of conduct which shall incorporate the following:

a) The Carer will treat the Client with respect and call the Client by the name they wish to be used;

b) The Carer will work to maintain the Client's privacy, modesty, dignity, choice, independence and self-determination.

c) The Carer will maintain confidentiality at all times whilst giving the Client access to any records the Client has asked to be kept;

c) The Carer will not discriminate against the Client on the grounds of age, race, gender, sexual orientation, religious belief or disability;

e) Unless agreed otherwise the Carer will not:

i) Smoke in the Client's home;

ii) Have alcoholic drinks in the Client's home;

iii) Invite visitors into the Client's home;

iv) Make calls on the Client's telephone except to the previous and the next Carer regarding handover of care or to make calls to head office; or

v) Act as signatory or witness to any legal document, other than this Agreement.

6. Carer's fees and expenses

6.1 The Carer shall be paid at the rate set out as the Initial Fee or at such rates as shall from time to time be agreed by the Client and Carer. It will normally be a fee that includes travel expenses.

6.2 Unless specified to the contrary in any Assignment, the Client will pay the Carer the sum set out in this Agreement.

6.3 The Client will pay the Carer the sum in this Agreement no later than every week (seven days) in arrears.

6.4 The sum set out in this Agreement shall include whatever reasonable expenses the Carer has incurred in working on any Assignment provided such expenses have been approved in advance by the Client and are evidenced by receipts or vouchers.

6.5 If the Carer's fee is plus travel expenses, they are payable by the Client to the Carer, calculated at the rate of second class public transport. If the Carer uses their car, an allowance of 45 pence per mile shall be paid for the first 40 miles of the journey and 35 pence thereafter.

The Client is responsible for the Carer's travel to the Client's home at the commencement of each Assignment and may also pay the Carer's return expenses if they are not going on to another Client. Travel reimbursement will be capped at up to £40 for the first week of an engagement but a further charge of up to £20 per consecutive week of engagement may be made until full travel costs are reimbursed.

7 Health and Safety at Work

7.1 The Carer has a duty to take reasonable care to avoid injury to him / herself and the Client at all times.

7.2 The Carer is required to carry out a risk assessment procedure with regard to all aspects of the Care Services that he/she provides. The Carer is also required to carry out risk assessments on an ongoing basis with all new tasks that he/she undertakes in providing the Care Service.

7.3 Due to the nature of the Care Service provided the Carer is required to monitor risks around the Client's property, including but not limited to: the effectiveness and working order of smoke alarms, the use of protective equipment, and the use of household equipment and cleaning products.

Confidentiality

8.1 The Carer is aware that in the course of the performance of the Agreement the Carer will have access to and be entrusted with sensitive personal information and other personal information in respect of the Client all of which information is to be treated as confidential. Accordingly, the Carer undertakes that both during and after Completion of the Agreement:

8.2 Not to divulge to any person whatsoever or otherwise make use of (and shall use their best endeavours to prevent the publication or disclosure of) any confidential information.

8.3 To make all relevant employees, agents and sub–contractors aware of the confidentiality of information and the provisions of this paragraph and to take all such steps as shall from time to time be necessary to ensure compliance by those people with these provisions.

9 Duration and termination

This agreement shall commence of the date of this agreement and shall continue until terminated:

a) By one party giving 7 days' notice of termination to the other; or

b) Immediately on acceptance of any repudiatory breach by either party.

10 Matters after termination

10.1 Notwithstanding termination of this agreement for whatever reason, all the provisions that are intended to operate or have effect termination or expiration shall continue in full force and effect.

10.2 Without regard to the reason why this agreement ends, the Client will pay the Carer for all work done to the time the notice of termination is received by the Carer, calculated to the nearest one hour.

11 Data Protection

For the purposes of the Data Protection Act 1998 the Carer consents to the processing of all or any personal data (in manual, electronic or any other form) relevant to this agreement, by the Client and / or any agent or third party nominated by the Client and bound by a duty of confidentiality. Processing includes but is not limited to obtaining, recording, using and holding data and includes the transfer of data to any country either inside or outside the EEA.

12 Successors to this agreement

12.1 Neither party shall be entitled to assign this agreement nor all or any of their rights and obligations hereunder without the prior written consent to the other.

12.2 The Carer undertakes to exercise all reasonable care to ensure that any person to whom the contract is assigned is capable of meeting the needs of the Client as set out in the Client Guide being, at that time, the most up to date Client Guide.

12.3 The benefit and obligations of this agreement shall be binding on any successor in title.

13 Notices and service

Any notice to be served on either of the parties by the other shall be delivered by hand, sent by first class post or pre-paid recorded delivery or by facsimile and shall be deemed to have been received by the addressee within 72 hours of posting or 24 hours if sent by facsimile to the correct number.

14 Headings

The headings in this document are for reference only.

15 Dispute Resolution

In the event of a dispute arising out of or in connection with this Contract and which has not

been resolved following discussions and negotiations between a person or persons appointed or authorised by the Client and the Carer then they undertake to attempt to settle the dispute by engaging in good faith with the other in a process of mediation before commencing arbitration or litigation.

16 Waiver

The failure by either party to enforce at any time or for any period any one or more of the terms or conditions of this Contract shall not be a waiver of them or of the right at any time subsequently to enforce all terms and conditions of this Contract.

17 Jurisdiction

This Contract shall be interpreted according to the Laws of England and the parties agree to submit to the exclusive jurisdiction of the English courts.

SIGNED: ……..... **SIGNED:** .....
(Client) **Carer)**

Christies Care
Est. 1987
Living independently at home

Christies Care Ltd
Rose House
Street Farm Road
Saxmundham
Suffolk IP17 1AL

01728 605107
(f) 01728 604483
www.christiescare.com

CONFIDENTIAL DECLARATION OF CRIMINAL RECORD

The Job/Role that you are applying for at Christies Care Ltd is classed as a *Regulated Activity*, and therefore is exempted from the provisions of the *Rehabilitation of Offenders Act 1974 and* requires a criminal record check.

You are required to disclose details of any criminal record. Only relevant convictions and other information will be taken into account, so disclosure need not necessarily be a bar to a successful application. If you have declared a criminal record and we believe this to have a bearing on the requirements of the Job/Role you have applied for, we will discuss the matter with you at the interview. If we do not raise the record with you, it is because we have taken the view that it should **not** be taken into account in deciding your suitability for the Job/Role you have applied for.

The information you provide on this form will be treated in the strictest confidence and will be stored securely with restricted access. The GDPR (General Data Protection Regulations) requires that personal information is obtained and processed fairly and lawfully; and is only disclosed in appropriate circumstances; is accurate, relevant and not held longer than necessary.

Surname: _____

Forename(s):
_____

Job/Role: *Live-In Carer*

The Job/Role you are applying comes under the Safeguarding Vulnerable Groups Act 2006 and the 'Excepted' list Exemptions Order 1975 from the *Rehabilitation of Offenders Act 1974*. This means that all convictions, cautions, reprimands and final warnings etc. on your criminal record need to be disclosed. You must answer both questions below.

1) Have you ever been convicted by the Courts of a criminal offence, cautioned, reprimanded, given a final warning or other information (e.g. acquittals and some bind-over's) by the police?

Yes/No (delete as appropriate)
If **yes** please give details below:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2) Are you aware of any police enquiries undertaken following allegations made against you, which may have a bearing on your suitability for the Job/Role you have applied for?

Yes/No (delete as appropriate)

If **yes** please give details below:

_____
_____
_____
_____
_____
_____
_____
_____
_____

3) Is there anything of any relevance you feel we should be aware of?

Yes/No (delete as appropriate)

If **yes** please give details below:

_____
_____
_____
_____
_____
_____
_____
_____

By signing this 'applicant declaration,' I confirm that all the information I have provided in support of this application is complete and true and I understand that knowingly to make a false or misleading statement for this purpose, may be a criminal offence and will result in any offer being withdrawn.

I am obliged to inform Christies Care of any further convictions, cautions or bind overs that I subsequently incur. Failure to do so may result in Christies Care being unable to introduce me to other clients.

Signature:_____Date_____

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(f) 01728 604483
www.christiescare.com

SPECIAL FEATURES OF WORK AS A LIVING-IN CARER

Name of Carer:- ……

Staff No: ……

1. PAYE AND SELF-ASSESSED/TAX

When you are employed by us, we deduct tax through the PAYE system. When you are self-employed, you pay tax through the SA (self-assessment) system. If there is a change in your employment status, Her Majesty's Revenue and Customs (HMRC) are allowed to go back up to six years. We think this is very unlikely but, if it happens, we need your agreement to allow access to your records. That is why we ask you to sign the mandate below:

Signed: ……

Date: ……

CODE OF CONDUCT FOR CARERS

As a Carer, you make a valuable and important contribution to the delivery of high-quality **care and support**. Following the guidance set out in this Code of Conduct will give you the reassurance that you are providing safe and **compassionate** care of a high standard, and the confidence to challenge others who are not.

As a Carer you must:

1. Be **accountable** by making sure you can answer for your actions or **omissions**.

2. **Promote** and **uphold** the privacy, **dignity, rights**, health and **wellbeing** of our clients.

3. Work in **collaboration** with your colleagues to ensure the delivery of high quality, safe and compassionate healthcare, care and support.

4. Communicate in an open, and **effective** way to promote the health, safety and wellbeing of our clients.

5. Respect a person's right to confidentiality.

6. Uphold and promote equality, **diversity** and inclusion.

7. Adhere to the training and best practice guidelines provided to Carers by Christies Care laid out in the Carers Guidebook.

8. Be fit and able to work.

9. Uphold and maintain Professional Boundaries.

Purpose

This Code is based on the principles of protecting clients and carers by promoting best practice. It will ensure that you are working to the required standard, providing high quality, **compassionate**, **care and support**. The Code describes the standards of conduct, behaviour and attitude that is expected. You are responsible for and have a duty of care to ensure that your conduct does not fall below the standards detailed in the Code. Nothing that you do, or **omit** to do, should harm the safety and **wellbeing** of your client.

How does the Code help me as a Carer?

It provides a set of clear standards, so you:

• can be sure of the standards you are expected to meet.

• can know whether you are working to these standards, or if you need to change the way you are working.

• can identify areas for continuing professional development.

• can fulfil the requirements of your role, behave correctly and do the right thing at all times. This is essential to protect our clients

How does this Code help clients?

The Code helps our clients to understand what standards they can expect of our care workers. The Code aims to give people who use health and care services the confidence that they will be treated with **dignity, respect** and **compassion** at all times.

How does this Code help Christies Care? The Code helps Christies Care to understand what standards we should expect of our care workers. If there are those who do not meet these standards, it will help us to identify them and their support and training needs.

Glossary You can find a glossary of terms and key words (shown in **bold** throughout the Code) at the end of the document.

Please sign here to confirm that you to read this document in its entirety and have fully understood its content.

Print name: ……

Signature: ……...

Date: ……

1. Be accountable by making sure you can answer for your actions or omissions

Guidance statements

As a Carer you must:

1. be honest with yourself and others about what you can do, recognise your abilities and the limitations of your **competence** and only carry out those tasks agreed in your job description and for which you are **competent**.

2. always behave and present yourself in a way that does not call into question your suitability to work in a health and social care environment. This includes wearing appropriate and suitable footwear and clothing applicable to your role.

3. be able to justify and be **accountable** for your actions or your **omissions** – what you fail to do.

4. report any actions or **omissions** by yourself or colleagues that you feel may compromise the safety or care of clients and, if necessary, use **whistleblowing** procedures to report any suspected wrongdoing.

5. be able to identify yourself to your client, their family members, your colleagues and any medical professional or outside agency, using your Christies Care ID card provided to you on induction.

6. be vigilant in asking to see any incoming carers ID card upon arrival.

7. restrict the use of mobile phones to a time when use will not pose a threat to the health & safety of staff, nor annoy, offend or distract clients in their own homes. Use should be restricted to time off or standby time or in the event of an emergency where the use of such equipment is necessary to call for assistance

8. provide the office with copies of a valid driving licence, MOT certificate and insurance certificate if you intend to drive to your bookings and/or drive whilst at a booking with your client in the car. Please note that in order to drive a client in your own car you must also have the appropriate insurance policy.

2. Promote and uphold the privacy, dignity, rights, health and wellbeing of your clients

Guidance statements

As a Carer you must:

1. Always act in the **best interests** of our clients.

2. Always treat people with **respect** and **compassion**.

3. Put the needs, goals and aspirations of our clients first, helping them to be in control and to choose the healthcare, **care and support** they receive.

4. **Promote** people's independence and ability to **self-care**, assisting clients to exercise their rights and make informed choices.

5. Always gain **valid consent** before providing **care and support**. You must also **respect** a person's right to refuse to receive healthcare, **care and support** if they are capable of doing so.

6. Always maintain the privacy and **dignity** of our clients.

7. Be alert to any changes that could affect a person's needs or progress and report your observations.

8. Always make sure that your actions or **omissions** do not harm an individual's health or **wellbeing**. You must never **abuse**, neglect, **harm** or exploit those who use the service. Please refer to the Carers Guidebook for more detail on safeguarding and forms of abuse.

9. Report dangerous, abusive, discriminatory or exploitative behaviour or practice.

10. Always take comments and complaints seriously, respond to them in line with Section 2 of the Carers Guidebook, Safeguarding Adults.

11. Inform Christies Care in advance if the client is planning a holiday, giving the following information; destination including full address and contact numbers, dates from and to, anticipated time of arrival and mode of transport. During this time we still expect that carers adhere to the Code of Conduct.

3. Work in collaboration with your colleagues to ensure the delivery of high quality, safe and compassionate healthcare, care and support

Guidance statements

As a Carer you must:

1. Understand and value your contribution and the vital part you play with regards to those involved in the client's care package.

2. Recognise and **respect** the roles and expertise of your colleagues both from Christies Care and from other agencies and disciplines, and work in partnership with them.

3. Work openly and co-operatively with clients and their families and treat them with **respect**.

4. Actively encourage the delivery of high-quality **care and support**.

5. Arrive at your client's by 10am if you are coming from a week off unless prior arrangements with the office are made.

6. Not leave a client's home until the incoming Carer has arrived.

7. Arrange personal appointments during allocated time off or when not working with a client.

8. Not book flights in or out of the country on Wednesday.

9. Make contact with the incoming/outgoing Carer by the Monday before change over day, to discuss the handover and give an approximate time of arrival.

4. Communicate in an open and effective way to promote the health, safety and wellbeing of clients

Guidance statements

As a Carer you must:

1. Communicate **respectfully** with clients, their families and Christies Care in an open, accurate, **effective**, straightforward and confidential way.
2. Comply with all reasonable instructions given by your Support Team and Booking Co-ordinators and Local Area Advisors;
3. Communicate **effectively** and consult with all those involved in the clients care as appropriate.
4. Always explain and discuss the care, support or procedure you intend to carry out with the person and only continue if they give **valid consent**.
5. Maintain clear and accurate records, in black ink, of the **care and support** you provide not only in the Care Record Book but the MAR sheets, Account Record Book and if necessary, Professional Record Book. Immediately report to your support team or the clients Booking Coordinator of any changes or concerns you have about a Client's condition. Please refer to Section 2 of the Carers Guidebook, Record Keeping, for further guidance.
6. Communicate with Christies Care and report to your support team any changes to your client's condition, updates to your clients Support Plan and any relevant or noteworthy incidents or information relating to your client.
7. Honour your work commitments, agreements and arrangements and be reliable, dependable and trustworthy. Contact Christies Care if for any reason you are unable to get to your client, are going to be late or need to leave during a booking. Please refer to Section 1 of the Carers Guidebook, No Reply, for further information on the relevant procedures.
8. Advise your Support Team of your mode of transport, route, time of departure and estimated time of arrival, when travelling to a client.
9. Not use social media inappropriately or in a way that may have a detrimental effect on the Company or our clients. This includes writing/posting photos about your work unless authorised by a member of Christies Care staff. Make derogatory, offensive or discriminatory comments about the Company, clients, staff members or fellow carers. Do not disclose any secret or confidential information relating to the company, clients, staff or carers.
10. Contact your Support Team if your client is admitted to hospital. If admission is out of hours contact the office after 9am the following morning. If admission is an emergency ensure that you give paramedics all the up to date information about your client along with the Medication, Administration Record Sheet.

11. Contact your Support Team if your client is discharged from hospital and inform them of applicable changes to your client's condition if any. Once home inform the Christies Care Office if you observe any unexplained bruising or pressure areas.

12. Contact your Support Team if a client has a fall or a near miss. You may be required to fill in a body map depending on whether there are any injuries following the fall.

13. Contact your Support Team if you notice any unexplained bruising, marks or pressure areas and complete a body map.

5. Respect people's right to confidentiality and follow GDPR guidelines given at Induction and/or update

Guidance statements

As Carer you must:

1. Treat all information about our clients as confidential.

2. Only discuss or **disclose** information about clients in accordance with legislation and the training you have received; please refer to Section 1 of the Carers Guidebook, Confidentiality and Data Protection, for more detailed information.

3. Always seek guidance from your Carer Support Team regarding any information or issues that you are concerned about.

4. Not use the clients address for any correspondence, official documents such as driving licence or car insurance, or as contact details with a doctor's surgery or bank, or for receiving any deliveries.

5. Not invite family or friends to the client's home or to meet the client. If being dropped off by a family member or friend, make sure you are dropped off away from the client's address to ensure confidentiality.

6. Not take photographs of a client or their property without permission from the client or an advocate.

7. Not have access to your clients' PIN, bank accounts or bank cards. A cash card should be provided where Carers are required to make purchases by card.

6. Uphold and promote equality, diversity and inclusion

Guidance statements

As a Care Worker you must:

1. **Respect** the **individuality** and **diversity** of our clients, and your colleagues.

2. Not **discriminate** or condone discrimination against clients or your colleagues.

3. **Promote** equal opportunities and inclusion for clients.

4. Report any concerns regarding **equality**, **diversity** and **inclusion** to your Carer Support Team as soon as possible.

7. Adhere to the training given, and best practice guidelines provided to Carers by Christies Care

Guidance Statements;

As a Carer you must;

1. Attend, and adhere to information given on the induction training and two-day annual update. Please note that you are required to attend the Update Training annually, Carers who have completed less than 12 weeks work through Christies Care following their previous Update Training will be required to pay a deposit of £250 prior to attending the training. You are able to claim this back upon completing 12 weeks work in the following year. However, for all University/college students, this fee will be waivered on presentation of your student ID card.
2. Attend any specialist training that may benefit your clients' needs.
3. Complete the Care Certificate.
4. Follow training and best practice information found in the Carers Guidebook. We expect that you refer and adhere to the guidance given in the following sections;

<u>Section 1</u>

- Health and Safety at Work
- Administering Medication and Invasive Procedures
- Nutritional Needs
- Safe Restraint
- Bathing/Showering

<u>Section 2</u>

- Promoting Independence
- Safeguarding and Adults at Risk

<u>Section 3</u>

- First Aid
- Moving and Handling
- Assistance with Personal Hygiene and Appearance
- Infection Control
- Mental Capacity

*It is your responsibility to inform us if you are unable to access the above information for any reason.

8. Be fit and able to work effectively

Guidance Statements;

As a Carer you must;

1. Update Christies Care with any health issues that may affect your work and ability to provide care and support to a client.
2. Contact your Support Team regarding any issues that might affect your ability to do your job **competently** and safely. If you do not feel **competent** to carry out an activity, you must report this.
3. Always call your Support Team in the office for guidance if you do not feel able or adequately prepared to carry out any aspect of your work, or if you are unsure how to **effectively** deliver a task.
4. Not consume alcohol whilst working with your client, this includes time off and holidays, trips or excursions with your client.
5. Not bring alcohol belonging to yourself onto the client's premises
6. Not use or possess drugs whilst working with your client; this includes time off and holidays, trips or excursions with your client.

9. Uphold and maintain Professional boundaries with clients, relatives and colleagues

Guidance Statements;

As a Carer you must;

1. Establish and maintain clear and appropriate professional boundaries in your relationships with clients, relatives, carers and colleagues at all times. Please refer to Section 2, Page 2 of the Carers Guidebook, Professional Boundaries, for further advice.
2. Treat the clients home with respect and not misuse the client's property.
3. Never accept any offers of loans, gifts, benefits or hospitality from anyone you are supporting or anyone close to them which may be seen to compromise your position. Carers may accept low-value gifts such as a box of chocolates, where it would offend a client or relative to refuse them.
4. Not use their own money for housekeeping or purchasing any items for the client on their behalf.
5. Have no involvement in the making or benefiting from client's wills or soliciting any other form of bequest or legacy or acting as an executor or being involved in any way with any other legal document. Should it occur that a Carer is bequeathed a sum of money or specific item from the estate of a Client, this should be reported immediately to the office.
6. Never leave belongings or store belongings at a client's home, you must take everything with you when you leave.
7. Leave the client's property after a sufficient handover has taken place unless approved by Christies Care.
8. Not visit or stay at a client's home outside of a booking.
9. Refer to the client's Support Plan with regards to whether you are able to smoke whilst working with a client and whether there is a given designated smoking area. Carers that are able to do so must not smoke inside the client's property and should not do so at the detriment to the clients care.
10. Ask permission to use the client's telephone or internet before using; if found using the client's phone or internet inappropriately or without permission Carers may be required to reimburse the cost to the client plus a £15 admin fee. Carers are not allowed to access via the internet, pornographic or other obscene material which may cause offence to any other person, either on the client's computer or their personal computer whilst working in a client's home.

A. Carers Benefits and Entitlements

1. Holiday/sick pay (SSP) /maternity pay (SMP)

Holiday;

The Working Time Regulations 1998 and subsequent Acts gives all Carer Workers the right to claim 28 days holiday pay which includes the statutory bank holidays. This is calculated pro-rata basis for part-time workers.

You will understand that the holiday entitlement only applies to you when working for Christies Care Ltd as a Zero Hours Contract Worker and not for the time that you are a self-employed Carer. It also makes no difference to your status as a short-term employee each time.

Holiday pay will be calculated on a pro-rata basis depending on the number of weeks worked as a Care Worker over the holiday year July to June and is paid every four months.

The following bank/public holidays are those recognised by Christies Care:

New Years Day	Spring Bank Holiday
Good Friday	Late Summer Bank Holiday
Easter Monday	Christmas Day
May Day	Boxing Day

If Carers are working for a client on any of the above public holidays, they will automatically be paid double time for these days with the exception of Christmas, Boxing and New Year's Day which will be paid at triple pay.

Sick Pay;

Certain carers are entitled to receive pay when they are absent from work due to sickness, as long as they qualify as per the guidelines set by the Government This is known as Statutory Sick Pay (SSP) and is paid out and administered by employers on behalf of the State.

Qualification for SSP

Carers must be earning enough each week to be paying National Insurance Contributions.

Notification

SSP cannot be paid to a Carer unless and until the employer receives written evidence of the Carer's sickness as follows:

- For the first 7 days of sickness absence – a Self-Certification form or Absence Record Form.
- For 8 or more days of sickness absence – Doctor's Certificate and Absence Record Form.
- It is important to remember that if there are any periods of sickness absence not covered by a certificate, no payment can be made.

When is SSP Payable?

- SSP is only paid for a day or days an employee normally works. For example, if an employee works Monday to Friday and not at weekends, SSP will only apply to those five days.
- The first three days of an employee's sickness are called 'waiting days' and therefore SSP is not payable for these three days. SSP starts on the 4th day and continues for as long as the employee is absent up to a maximum of 28 weeks in any one period of sickness.
- SSP is paid to Carers in the same way as normal wages/salary.
- The entitlement to SSP depends on the Carer's average earnings. The rate is set by the Government and the amount will be shown on the pay statement.
- Should a Carer be absent due to sickness within eight weeks of a previous period of sickness, providing the second absence is for four days or more, SSP will be paid for the whole of the second period of absence and not just after the first three days.

SMP;

Refer to Section 1 in the Carers Guidebook

B1. Support For Carers

Carers are each allocated a Support Team when they attend induction training (blue, green or yellow). Each Support Team has at least two staff members who are available for the Carer to call during office hours, and who will give Carers a feedback call after each assignment. The Carer Support Teams are managed by the Head of Carer Support.

Initial Support Period

A Local Area Advisor will visit new Carers within the first four weeks of their assignments to observe their practical performance and re-test their medication and safeguarding knowledge. Following this Carers will be monitored for at least 12 weeks of work to ensure that they are meeting the required standards as per the Code of Conduct. This will include checking Carer feedback from clients or client's relatives. It will be down to the discretion of the Head of Carer Support as to whether a Carer completes their initial Support Period, whether it is extended or whether we feel we can no longer offer that Carer any further work.

Supervision

A minimum of **four** supervisions per Carer per year (pro-rata if they work less than 12 months) will take place, spread evenly throughout the year i.e. at least one supervision per person in every three month period. All formal supervisions will be face to face and records will be kept of each meeting. These records will be dated and signed by the supervisee and the supervisor (usually the Local Area Advisor). One of these supervisions will be an assessment of the training and development need for the forthcoming year and will be undertaken when the Carer attends their annual manual handling update at head office. The other three supervisions will be observational to ensure appropriate and safe support is being delivered to the client.

Stress Management

Christies Care Ltd is committed to maintaining a healthy and safe working environment for all its Carers and recognises that it has a duty of care for its Carers health and mental wellbeing.
Christies Care Ltd will:

- Identify internal and external sources of assistance for Carers suffering with stress.
- Assist and advise Carers who are stressed.
- Provide access to a range of Stress Management courses including sessions on Time Management, Assertiveness, and Dealing with Difficult Situations.
- Be signed up to the Mindful Employer Charter.

Right to Privacy

Christies Care will endeavor to seek the right of privacy for a Carer in their own bedroom.

If a Carer believes that a client or a client's relative is knowingly invading their privacy by going into their bedroom without permission, they should inform their Carer Support Team at once.

The Carer Support Team and the Booking Co-ordinator will liaise with the client to establish why this privacy is being invaded.

If the client does not agree to privacy for the Carer, this will be recorded at head office so that Carers are advised before they accept the booking to the client.

However, if there is suspicion that Carers may have unauthorised items in their bedrooms e.g. alcohol, drugs, dangerous weapons, a room search may be undertaken with the permission of the client. This search will always be undertaken with the Carer present, and usually by the Local Area Advisor.

B2. Guesthouse

Christies Care's Guesthouse is available for Carers to stay when visiting the office for training or when not working. Please see Section 4 of the Carers Guidebook, Staying at Christies Guesthouse, for more information.

B3. Out of Hours

The out of hours duty service is available for EMERGENCIES ONLY. You can ring 01728 605000 and follow the instructions to contact the Duty Manager.

The message option can be used for various situations e.g. client has fallen, family has been advised but the client is unhurt.

Please DO NOT use this option to leave your availability for future bookings, or any other message that can be made within office hours.

Going straight through to the Duty Manager – this option can be used if your call is an emergency and you cannot wait for the office to open.

Examples of an emergency are:

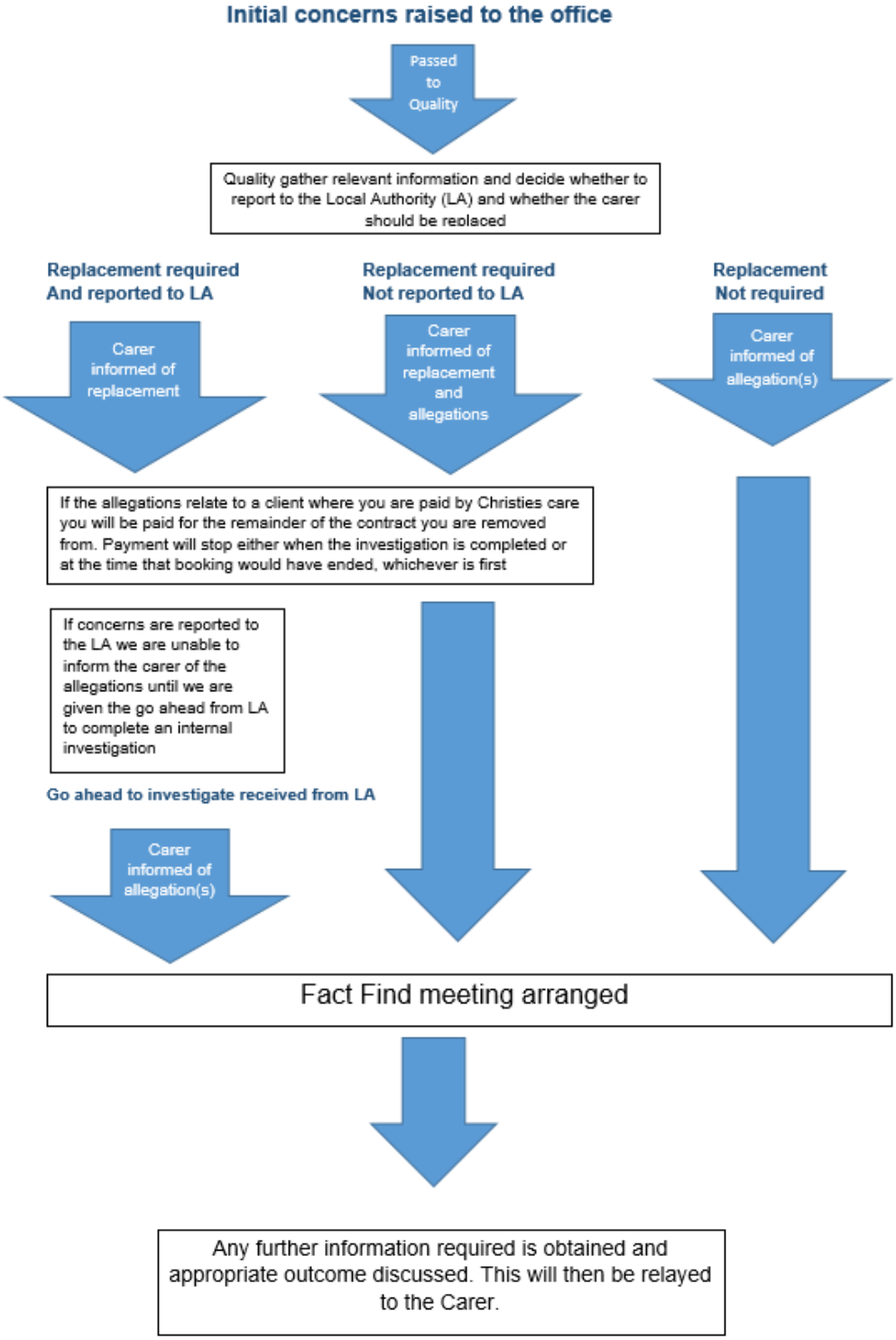
- You need to be replaced urgently because you are unwell or have a family emergency.
- You suspect abuse.
- You feel that you are at risk.

Examples of NON emergencies are:

- Updating us with your availability.
- Client has had a fall but is ok.
- Cancelling a job for the coming Wednesday on the weekend prior.

Please leave a message if your client passes away or requires hospitalisation after 9.30pm and up to 7.30am, unless you require urgent assistance or are concerned about anything.

C1. Process of dealing with complaints or allegations*



*Please note that all investigations are dealt with on an individual basis therefore there may be times where we are unable to follow this procedure exactly.

Glossary of terms:

ACCOUNTABLE: accountability is to be responsible for the decisions you make and that you are answerable for your actions.

BEST INTERESTS: the Mental Capacity Act (2005) sets out a checklist of things to consider when deciding what's in a person's 'best interests'.

CARE AND SUPPORT: care and support enables people to do the everyday things like getting out of bed, dressed and into work; cooking meals; seeing friends; caring for our families; and being part of our communities. It might include emotional support at a time of difficulty or stress or helping people who are caring for a family member or friend. It can mean support from community groups or networks: for example, giving others a lift to a social event. It might also include state-funded support, such as information and advice, support for carers, housing support, disability benefits and adult social care.

COLLABORATION: the action of working with someone to achieve a common goal.

COMPASSION: descriptions of compassionate care include: dignity and comfort: taking time and patience to listen, explain and communicate; demonstrating empathy, kindness and warmth; care centered around an individual person's needs, involving people in the decisions about their healthcare, care and support.

COMPETENCE: the knowledge, skills, attitudes and ability to practice safely and effectively without the need for direct supervision.

COMPETENT: having the necessary ability, knowledge, or skill to do something successfully.

CONTINUING PROFESSIONAL DEVELOPMENT: this is the way in which a worker continues to learn and develop throughout their careers, keeping their skills and knowledge up to date and ensuring they can work safely and effectively.

DIGNITY: covers all aspects of daily life, including respect, privacy, autonomy and self-worth. While dignity may be difficult to define, what is clear is that people know when they have not been treated with dignity and respect. Dignity is about interpersonal behaviours as well as systems and processes.

DISCRIMINATE: discrimination can be the result of prejudice, misconception and stereotyping. Whether this behaviour is intentional or unintentional does not excuse it. It is the perception of the person discriminated against that is important.

DIVERSITY: celebrating differences and valuing everyone. Diversity encompasses visible and non-visible individual differences and is about respecting those differences.

EFFECTIVE: to be successful in producing a desired or intended result.

EQUALITY: being equal in status, rights, and opportunities.

INCLUSION: ensuring that people are treated equally and fairly and are included as part of society.

OMISSION: to leave out or exclude.

PROMOTE: to support or actively encourage.

RESPECT: to have due regard for someone's feelings, wishes, or rights.

UPHOLD: to maintain a custom or practice.

VALID CONSENT: for consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question. This will be the patient, the person who uses health and care services or someone with parental responsibility for a person under the age of 18, someone authorised to do so under a Lasting Power of Attorney (LPA) or someone who has the authority to make treatment decisions as a court-appointed deputy). Agreement, where the person does not know what the intervention entails, is not 'consent'.

WELLBEING: a person's wellbeing may include their sense of hope, confidence, self-esteem, ability to communicate their wants and needs, ability to make contact with other people, ability to show warmth and affection, experience and showing of pleasure or enjoyment.

WHISTLEBLOWING: whistleblowing is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest' and may sometimes be referred to as 'escalating concerns.' You must report things that you are not comfortable with, are illegal or if anyone at work is neglecting their duties. This includes when someone's health and safety is in danger; damage to the environment; a criminal offence; that the company is not obeying the law (like not having the right insurance); or covering up wrongdoing.

Background

Christies Care Limited (the Employer) cannot always predict the exact staffing levels it will require. The Employer therefore requires Zero Hours Workers because of the fluctuating demands of the business and it is entering into this agreement to record the terms of the working relationship is entering into.

1. STATUS OF THIS AGREEMENT

This agreement governs your engagement from time to time by the Employer as a Zero Hours Worker. This is **not** an employment contract and does not confer any employment rights on you (other than those to which workers are entitled). In particular, it does not create any obligation on you to perform work for the Employer or on the Employer to provide work to you and you will work on a flexible, "as required" basis.

2. COMPANY'S DISCRETION AS TO WORK OFFERED

It is entirely at the Employer's discretion whether to offer you work and it is under no obligation to provide work to you at any time, nor is it under an obligation to give any reasons for its decision to offer or not offer work. Where you are offered work, it does not give rise to a presumption that the Employer will continue to offer your further work, as you are engaged as a Zero Hours Worker.

3. NO PRESUMPTION OF CONTINUITY

Each offer of work by the Employer which you accept shall be treated as an entirely separate and severable assignment (also known as an engagement or a booking). The terms of this agreement shall apply to each assignment but there shall be no relationship between the parties after the end of one assignment and before the start of any subsequent assignment.

The fact that the Employer has offered you work, or offers you work more than once, shall not confer any legal rights on you and, in particular, should not be regarded as establishing an entitlement to regular work or conferring continuity of employment.

4. RIGHT TO WORK

You confirm that you are legally entitled to work in the UK without any additional immigration approvals and agree to notify the Employer immediately if you cease to be so entitled at any time.

5. ARRANGEMENTS FOR WORK

If the Employer wants to offer you any work it will be discussed with you personally informing you of the type of work, the working days and hours available and the rate of pay. You are under no obligation to accept any work offered by the Employer at any time. However, if you accept an assignment, you must inform the Employer immediately if there is any emergency situation that prevents you from completing it. An emergency is an illness/sickness which prevents you from carrying out your role, or an emergency involving a dependent. In any other situation we would expect that you would complete any assignment accepted.

The Employer reserves the right to terminate an assignment at any time for operational reasons. You will be paid for all work done during the assignment up to the time it is terminated.

6. TYPE OF WORK

The Employer may offer you work from time to time as a Carer. If you accept any offer of work, your duties will include those as stated in the confirmation of booking and you will usually report to the Carer Support Team. The precise description and nature of your work may be varied with each assignment and you may be required to carry out other duties as necessary to meet business needs. You will be informed of the requirements at the start of each assignment.

If you have a problem with your work you should contact the Employer immediately. There is an answering machine for out of hour's calls. You can either leave a message or, if urgent, phone the Duty Manager (listen to the answering machine for instructions). You must never walk out on a client.

7. PLACE OF WORK

The Employer may offer you work at various locations. You will be informed of the relevant place of work for each assignment in the booking confirmation.

8. HOURS OF WORK

This is a zero hour's agreement. You will work such hours and at such times as are agreed between you and the Employer. The Employer is not under an obligation to offer you any work and you are under no obligation to accept any work offered. The Employer has specifically reserved the right to reduce your working hours whenever necessary. There is emphatically no guarantee of work or of minimum hours under this agreement.

As you are not guaranteed work each week and in a particular week you may receive no work at all from the Employer, you are free to engage in other work or

activity for other employers (including self-employed activities or involvement in a spouse's, partners or family business).

You will be paid by reference to the difficulty and duration of the tasks undertaken on each assignment, not the amount that you work. Therefore, during each assignment your working hours will constitute unmeasured working time for the purposes of Regulations 44, 45(b) and 49 of the National Minimum Wage Regulations 2015.

There is no obligation for you to work for any particular number of hours in any day or week. However, once you have accepted a booking for a client, and are working as your client's carer, you are required to spend such time as is necessary to complete the tasks set out in the care plan and such additional tasks as are necessary in order to ensure the satisfactory fulfilment of your caring duties.

As an unmeasured worker, your working hours will be calculated by reference to a Daily Average Agreement, which will set out a realistic assessment of the average daily number of hours you are likely to spend in carrying out the task(s) set out in the care plan (or any additional task(s) necessary for the proper discharging of your caring duties) each day during the assignment in question. This may vary according to the client you are working with. By taking a booking, you will have agreed to the Daily Average Hours Agreement for that particular assignment.

9. PAY

You will be paid in accordance with your confirmation of booking form. You will be paid by BACS directly into your bank account, every Thursday, in arrears. The Employer will make all necessary deductions from your salary as required by law and shall be entitled to deduct from your pay or other payments due to you any money which you may owe to the Employer at any time.

10. WORKPLACE PENSION

If eligible, you will be given the opportunity to be enrolled in to our Workplace Pension Scheme. The Scheme is provided by NEST. Christies Care will pay a contribution to your pension. An opt-out form will be sent to you when we add you to our payroll should you not wish to join this scheme.

11. HOLIDAYS

Please refer to the section 'Carers Benefits and Entitlements' in the Code of Conduct.

12. SICKNESS

Please refer to the section ‘Carers Benefits and Entitlements’ in the Code of Conduct.

13. DATA PROTECTION

You consent to our holding and processing, both electronically and manually, the data that we collect about you, in the course of your working relationship with us, for the purposes of the administration and management of our staff and our business and for compliance with applicable laws, procedures and regulations.

14. COMPANY RULES AND PROCEDURES

During each booking you are required at all times to comply with the Code of Conduct, a copy of which is available at your client’s home. The Code of Conduct does not form part of the terms and conditions of this agreement.

15. CONFIDENTIAL INFORMATION

You shall not use or disclose to any person, either during or at any time after your engagement by the Employer, any confidential information about the business or affairs of the Employer , its clients or any of its business contacts, or about any other matters which may come to your knowledge as a result of carrying out assignments. For the purposes of this clause, **confidential information** means any information or matter which is not in the public domain and which relates to the affairs of the Employer or any of its business contacts.

The restriction in this clause does not apply to:

(a) Preventing you from making a protected disclosure within the meaning of section 43A of the Employment Rights Act 1996; or

(b) Use or disclosure that has been authorised by the Employer or is required by law or in the course of your duties.

16. EMPLOYER PROPERTY

All documents, manuals, hardware and software provided for your use by the Employer, and any data or documents (including copies) produced, maintained or stored on the Employer's computer systems or other electronic equipment (including mobile phones), remain the property of the Employer.

Any Employer property in your possession and any original or copy documents obtained by you in the course of your work for the Employer shall be returned to

Carer Support at any time on request and in any event at the end of each assignment.

17. CLIENT PROPERTY

Please refer to sections 5 and 9 of the Code of Conduct

18. HEALTH & SAFETY

We have a joint responsibility to ensure the health and safety of your and our clients. You are not to take risks which compromise or potentially compromise you or the clients' health or safety. You should ensure that you are aware of current regulations and get in touch with your Carer Support Team for guidance if you need help or support. Please ensure that you read and are familiar with the Health and Safety guidance contained in the Code of Conduct. You should report any accident or incident to the Employer as soon as possible after the event so as to enable us to comply with RIDDOR regulations.

Please also refer to Section 1 of The Carers Guidebook

19. TERMINATION

If you no longer wish to be considered for zero hours work by the Employer you should inform your Carer Support team as soon as possible.

You will be expected to honour any confirmed bookings.

If we are unable to contact you for four consecutive weeks, to confirm your future availability for bookings, we will consider that you are no longer available for work and will not contact you further.

The Employer may terminate this agreement immediately by giving notice to you if it reasonably considers that you have committed any serious breach of its terms.

For the avoidance of doubt, on the termination of this agreement (howsoever caused) you will not be entitled to any further payments from the Employer other than any outstanding salary and holiday pay.

20. TOTALITY OF TERMS

This agreement is intended to fully reflect the intentions and expectations of both parties as to our future dealings and in the event of any dispute regarding your engagements as a zero hours worker by the Employer it shall be regarded as a true, accurate and exhaustive record of the terms on which we have agreed to enter into a

zero hours work relationship. Any variation of the agreement will only be valid where it is recorded in writing and signed by both parties. You confirm that you have read and understood the contents of this document and have had the opportunity to take advice where necessary.

21. CHANGING TERMS AND CONDITIONS

The Employer may review its requirement for Carers from time to time and/or may update the terms on which it offers such work. In the event of any changes to the terms on which it is prepared to Carers the Employer may terminate this agreement with immediate effect by giving notice in writing to you and you may, at the Employer's absolute discretion, be offered a new agreement for work.

22. ENTIRE AGREEMENT

This agreement contains the entire and only agreement between us and supersedes and abrogates all previous agreements, assurances, arrangements or understanding between you and the Employer.

23. GOVERNING LAW

This agreement will be governed by the law of England and Wales.

Signed.....

Name …….

Date.....