AUSTRALIAN HEALTHCARE
QUALIFICATIONS & TRAINING

CHC43015 – Certificate IV in Ageing Support

Learner Guide Book 2

Units Covered

- CHCDIV001 Work with diverse people
- HLTAAP001 Recognise healthy body systems
- CHCCCS025 Support relationships with carers and families
- CHCPAL001 Deliver care services using a palliative approach
- CHCHCS001 Provide home and community support services
- CHCAGE002 Implement falls prevention strategies
- CHCCCS017 Provide loss and grief support
- CHCAGE003 Coordinate services for older people
- CHCPRP001 Develop and maintain networks and collaborative partnerships

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CHCDIV001 - Work with diverse people

Welcome to the learning resource for the unit CHCDIV001 – Work with diverse people.

On completion of this unit you will have covered the requirements for:

1. Reflect on own perspectives
2. Appreciate diversity and inclusiveness and their benefits
3. Communicate with people from diverse backgrounds and situations
4. Promote understanding across diverse groups

You will be able to demonstrate your ability to:

- Undertake a structured process to reflect on own perspectives on diversity
- Recognise and respect the needs of people from diverse social and cultural backgrounds in at least 2 different situations:
- Select and use appropriate verbal and non-verbal communication
- Recognise situations where misunderstandings may arise from diversity and formed appropriate responses

You will gain knowledge about the:

- Concepts of cultural awareness, cultural safety and cultural competence and how these impact different work roles
- Concepts and definitions of diversity
- Own culture and the community attitudes, language, policies and structures of that culture and how they impact on different people and groups
- Features of diversity in Australia and how this impacts different areas of work and life:
    - Political
    - Social
    - Economic
    - Cultural
- Legal and ethical considerations (international, national, state/territory, local) for working with diversity, how these impact individual workers, and the consequences of breaches:

Discrimination:

- Age
- Disability
- Racial
- Sex

Human rights:

- Universal declaration of human rights
- Relationship between human needs and human rights
- Frameworks, approaches and instruments used in the workplace
- Rights and responsibilities of workers, employers and clients, including appropriate action when rights are being infringed or responsibilities not being carried out.

Key areas of diversity and their characteristics, including:

- Culture, race, ethnicity
- Disability
- Religious or spiritual beliefs
- Gender, including transgender
- Intersex
- Generational
- Sexual orientation/sexual identity - lesbian, gay, bisexual, heterosexual

Key aspects, and the diversity, of Australia's Aboriginal and/or Torres Strait Islander cultures, including:

- Social, political and economic issues affecting Aboriginal and/or Torres Strait Islander people
- Own culture, western systems and structures and how these impact on Aboriginal and/or Torres Strait Islander people and their engagement with services

Potential needs of marginalised groups, including:

- Protective factors
- Physical, mental and emotional health issues/care needs
- Consideration of impacts of discrimination, trauma, exclusion and negative attitudes
- Resources that support individuals and organisations to embrace and respond to diversity
- Language and cultural interpreters
- Imagery
- Influences and changing practices in Australia and their impact on the diverse communities that make up Australian society
- Impact of diversity practices and experiences on personal behaviour, interpersonal relationships, perception and social expectations of others

A copy of the full unit of competency can be found at: http://training.gov.au/Training/Details/CHCDIV001

This learning resource is designed to support your learning and act as a guide to further research. We encourage you to access other texts which include; standards and legislation and other resources relating to your industry that can be sourced throughout the internet or library.

Element 1: Reflect on own perspective

Understanding cultural diversity

- In this section you will learn about:
- What is culture?
- Understanding cultural competence
- Reflect on own culture

What is culture?

As a support worker it is important that you have an understanding about culture and diversity.

'Culture is the characteristics and knowledge of a particular group of people, defined by everything from language, religion, cuisine, social habits, music and arts."

Culturally and linguistically diverse (CALD) individuals often find it hard to communicate effectively, to feel validated and understood. Breakdowns in communication can occur and this can lead to low self-esteem, frustration and even behaviours of concern. We discuss in more detail the barriers to communication later in this chapter. You will encounter a range of individuals from different cultures when working as a support worker.

It may be that you are supporting an individual and their family or friends, a colleague, or stakeholder who are from a different background to you. Working cross culturally is important and is a fundamental factor in ensuring you are effective in your role.

It is not only up to you to be aware of working cross culturally, your organisation is required to provide a work environment that is culturally inclusive and culturally competent. Being competent in cross-cultural functioning means learning new patterns of behaviour and effectively applying them in the appropriate settings, like your community services workplace.

Diversity and multiculturalism

Diversity in a team has many benefits for all stakeholders within an organisation and for the greater community services industry in general. Team members will have different cultural backgrounds and a variety of qualifications, training and experiences. Accepting and respecting individual differences is very important for building strong and cooperative working relationships with others.

Respecting cultural diversity means recognising and accepting that people can have different views and habits due to their cultural background. By doing this you are able to deliver services in a non-judgemental way that respects the individual's differences.

Examples of how you could contribute to building workplace relationships that are inclusive and accepting of diversity include:

- Using communication styles that can be adapted to different cultures.
- Using non-discriminatory language.
- Get to know people within your workplace.
- Follow policies and procedures in regards to inclusivity, discrimination, harassment.

Respecting diversity means:

- Showing mutual respect and collegiality.
- Displaying honesty and tolerance.
- Being receptive to the diversity of cultures, ideas and peoples.
- Having an appreciation of and support for Indigenous perspectives and reconciliation.
- Appreciating and respecting diversity.
- Acting with integrity as part of local, national, global and professional communities.
- Working collaboratively and engaging with people in different settings.
- Recognising how culture can shape communication.
- Accepting others' opinions and beliefs.
- Being open to new ideas and innovations.

Cultural diversity in aged care is becoming increasingly important as our post-war migrant population ages and newer population groups enter our aged care system. Over 20 percent of Australian seniors are from culturally and linguistically diverse backgrounds and in our main cities this figure is much larger. Ensuring that these consumers receive the aged care they are entitled to is a significant challenge for policy makers and providers. Providing culturally competent aged care services is a vital aspect to service provision to ensure an appropriate and equitable aged care system.

Diversity in aged care organisations may incorporate:

- Diverse life experiences.
- Varied work experiences.
- A range of different qualifications and training.
- Diverse social/ethnic/cultural backgrounds.
- Different philosophies.
- A spread of age in both individuals and staff.

In the community services industry, there is an increasing need for a more appropriate mix of culturally competent mainstream services, multicultural services and ethno-specific services. Organisations must also ensure that they make an appropriate use of language and cultural interpreter services where required. In addition to this, it is essential for organisations to consider workforce planning to build and maintain a well-trained workforce which includes the recruitment of bilingual staff.

Multiculturalism

Multiculturalism is the co-existence of diverse cultures, where culture includes racial, religious, or cultural groups and is manifested in customary behaviours, cultural assumptions, and values, patterns of thinking, and communicative styles."

Source: www.aifla.org

Australia's Multicultural Access and Equity Policy acknowledges that we live in a multicultural society. Government departments and agencies have an obligation to provide access to services regardless of the cultural or linguistic background of individuals.

The Multicultural Access and Equity Policy is broken up into six different dimensions.

1. Leadership
2. Engagement
3. Performance
4. Capability
5. Responsiveness
6. Openness

We will discuss this further in the next section of the learner guide.

Australia's culture

Australian society today is a diverse mix of cultures, languages, and socioeconomic status made from a range of multiculturalism. Today more than 40 percent of Australians were born overseas or have a least one parent who was born elsewhere. Diversity is continually changing and evolving.

Considering Aboriginal people had been in Australia for at least 50,000 years prior to British colonising Australia in 1788, we have come a long way in terms of diversity and embracing new cultures.

One of the main influences on Australian culture has been war, particularly after the Second World War, when Australia introduced an immigration program welcoming 6.5 million migrants from 200 nations.

Today Australia has a strong focus on empowerment and equality for all Australians. For example, the recent introduction of Aged Care Reforms and National Disability Insurance Schemes, Marriage equality, gender equality, and push for fair work across industries influences the way Australian culture is growing and adapting the needs of society.

"Because mainstream Australian society has become accustomed to new languages, religions and cultural practices it has become more tolerant than it was before World War II. There is greater understanding of other parts of the world and more tolerance of different lifestyles. Australia now has many subcultures, particularly in the larger cities"

The variety of cultures in Australia can be broadly classified into the following cultural sub-groups:

- Aboriginal and Torres Strait Islander cultures.
- Anglo-Australian (Anglo-Celtic and Anglo-Saxon) culture.
- Immigrant (i.e. post 1945) cultures, including:
    - German
    - Italian
    - Dutch
    - Greek
    - Chinese
    - Vietnamese
    - Philippines
    - Pacific Islands

Aboriginal and Torres Strait islander cultures

A variety of cultures can be found in the Aboriginal and Torres Strait Islander communities of Australia. However, there are similarities amongst them which include:

- A strong sense of identity with their land and environment.
- A spiritual connection to nature which is often expressed in ritual and creativity.
- Strong family and kinship ties.
- Communal social practices.

However, the legacy of colonisation and government interventions in their affairs is still starkly obvious. The cultural impact of dispossession and despair has left Australia's indigenous communities struggling to deal with health issues related to substance abuse, suicide, domestic violence, and depression. Indigenous people have a much lower life expectancy than the general population and one possible reason for this may be because they do not easily fit into mainstream residential care.

Elderly Aboriginal and Torres Strait islands people need to stay in their own communities. This is often in remote areas where access to aged care services may be limited. A strategy of supporting flexible aged care services attempts to cater for the varied needs of Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander cultures have to deal with three divergent cultural heritages:

- Traditional indigenous cultures.
- The damaging socio-cultural effects of European colonisation.
- Responding to these cultural circumstances requires approaches that are sensitive to the strengths of the indigenous cultures and encouraging of self-determination.

The following changes show how each has impacted on Australia's diverse communities.

Influences and changing practices	How these changes have impacted on Australian society
Introduction of the National Disability Insurance Scheme (NDIS)	Greater access and equality for people living with disabilities Challenges societies perception of disability
Immigration and multiculturalism	A variety of cultures – different food, more celebrations and events
Aboriginal representation in sport	Acknowledgement of racism and how to eliminate it/stand against it More awareness around racism and its impacts
A move towards marriage equality	Recognises that same sex couples have the same rights as everyone else

Understanding cultural competence

A culturally competent workplace means that the organisation has behaviours, attitudes, and policies in place that work together to ensure that staff are supporting CALD individuals using best practice methods. Cultural competence is viewed an ongoing process and an ideal to work towards. It is a process that continually evolves.

There are five essential elements that contribute to this being effective.

- Valuing of cultural diversity – acknowledge cultural difference.
- Conducting a cultural self-assessment – understanding your own culture.
- Managing the dynamics of difference – engage in a self-assessment.
- Acquiring cultural knowledge and skills – integrate an understanding of different cultures.
- View behaviour of self and others within a cultural context – adapt behaviour.

To ensure you are working and interacting effectively together it is crucial you have the ability to be open to the backgrounds, options, and lifestyles. You need to remain objective and not judgmental even if you strongly disagree with another culture.

Ways you can develop your cultural competence may include:

- Being aware of your own beliefs.
- Researching cultures and having and understanding of the cultures background.
- Developing tolerance for cultures different to your own.
- Learning to communicate with cultures different your own – using appropriate communication protocols.
- Being open minded.

Reflect on own culture

Understanding individuals' own personal culture and how these personal cultural values may impact on the provision of care to the person, regardless of race or ethnicity.

Cultural safety incorporates cultural awareness and cultural sensitivity and is underpinned by good communication, recognition of the diversity of views nationally and internationally between ethnic groups.

Cultural awareness

Cultural awareness recognises that all people are shaped by their cultural background. This influences how individuals interpret the world around them and how they relate to others from different cultural backgrounds.

Cultural influences

Cultural Influences can affect the way someone chooses to interact with others or influence the way an individual responds. Different factors make up a person's culture, such as a person's nationality, race and gender and factors that contribute and shape a person, for example,

- Spiritual beliefs including religion.
- Culturally specific healing practice.
- Racial or ethnic self-identification.
- Environmental history.
- Migration.
- Experience of cultural bias.

Cultural influences	
Religious and other beliefs	• Religious beliefs of co-workers and clients • Religious beliefs will affect how we behave, what we eat, how we dress etc
Attitudes to family	• Relationships between family members vary between cultures • We all have different attitudes to young, the old, parents, brothers and sisters
Attitudes to work	• The importance of work and family varies between cultures • Attitudes to "the boss" changes between cultures
Roles of individuals in society	• Different cultures have different beliefs about the roles of individuals • Men, women, young people, old people, sick people, or children are treated differently within different cultural groups
Food	• Different cultures have different food preferences • People eat at different times in different ways • Some foods have special significance in certain cultures
Holidays and celebrations	• Different cultures have different holidays • We all celebrate major events in different ways

Self-Identity – views, values and beliefs

As Individuals we all have our own values, beliefs and attitudes that we have developed throughout the course of our lives. These views, values and beliefs form our 'personal identity'.

As an example, an individual might 'identify' as being a forty-year-old, Catholic, Greek male. Our family, friends, community and the experiences we have had all contribute to our sense of who we are and how we view the world. As community services workers, we are often working with people who are vulnerable and/or who may live a lifestyle that mainstream society views as being different or unacceptable. If, as community services workers, we are to provide a service that meets the needs of our target groups and helps them to feel empowered, we need to be aware of our own personal values, beliefs and attitudes and be prepared to adopt the professional values of our industry.

A person's values, beliefs and attitudes help them determine what is right and wrong and the right way to approach a task or decision. When we are in a work environment and especially in the Community Services industry, we need to be careful that we do not try to impose our values and beliefs onto others but understand that everyone has the right to formulate and believe in their own and live their lives according to them.

Values

Values are principles, standards or qualities that an individual or group of people hold in high regard. These values guide the way we live our lives and the decisions we make. A value may be defined as something that we hold dear, those things/qualities which we consider to be of worth. Values can influence many of the judgments we make as well as have an impact on the support we give individuals. It is important that we do not influence individual's decisions based on our own set of values.

We should always work from the basis of supporting the individual's values. Our values come from a variety of sources. Some of these include:

- Family.
- Peers (social influences).
- The workplace (work ethics, job roles).
- Educational institutions (Schools, Universities or TAFE).
- Significant life events (death, divorce, losing jobs, major accident and trauma, major health issues, significant financial losses and so on).
- Religion.
- Music.
- Media.
- Technology.
- Culture.
- Major historical events (world wars, economic depressions, etc.).

We are all influenced in varying degrees by the values of our family, culture, religion, education, and social group. Knowing your own values can help you work effectively with individuals, resolve conflicts, and support the organisation's philosophy of care appropriately.

External factors that may have influenced your cultural identity may include:

- Family structure.
- Communication style.
- Customs – dressing style, how to greet others.
- Dietary habits.

Work with awareness of your own limitations

To undertake reflective practice, it is important that you have a good understanding of your limitations about self-awareness and social awareness. To be able to work inclusively means knowing how you will respond in different situations and how others respond to you. This refers to the insight we have about our own and others' strengths and weaknesses and how this affects our ability to deal with challenges as they arise. As we develop self-awareness regarding what triggers our emotional responses, we are then able to interact differently with others as we learn better ways of responding than we have in the past. To improve your abilities to respond well in times of change you need to develop self-awareness and the ability to understand and communicate with others.

The main areas for developing self-awareness include our personality traits, personal values, habits, emotions, and the psychological needs that drive our behaviours. Each of these is explained in the following table:

Personality	An understanding of our personality can help us to identify situations in which we will thrive and avoid situations where we may experience too much stress and cope less well. It can also help us to understand how others may perceive us and to adjust our communication style to facilitate more efficient communication with a range of other different personality types.
Values	Focusing on our personal values is important during the workday as there may be many problems and opportunities that can come up which collectively exceed the time we have to do them. When we focus on our values, we are more likely to accomplish what we consider being most important rather than on lower priority activities.
Habits	Our habits are the behaviours that we repeat routinely and often automatically. Some of our habits can decrease our effectiveness in communication, time management, and prioritising tasks so being aware of these and seeking to change them or minimise their impact can help us to improve in all of these areas.
Needs	There are psychological needs that drive our behaviours such as needs for esteem, affection, belongingness, achievement, self-actualisation, power, and control. One of the advantages of knowing which needs to exert the strongest influence on our behaviours is the ability to understand how they affect our interpersonal relationships. All people have needs and requirements are a powerful source of motivation. When a person's needs aren't satisfied, it can cause frustration, conflict, and stress.
Emotions	Understanding your feelings, what causes them, and how they affect your thoughts and actions is emotional self-awareness. Those with high emotional self-awareness understand the internal process associated with emotional experiences and, therefore, can manage their emotional reactions and responses better which can help to improve workplace relationships, communication, and decision-making.

Reflective practices

Reflective practice refers to thinking about how we currently assess ourselves and how we could do it better.

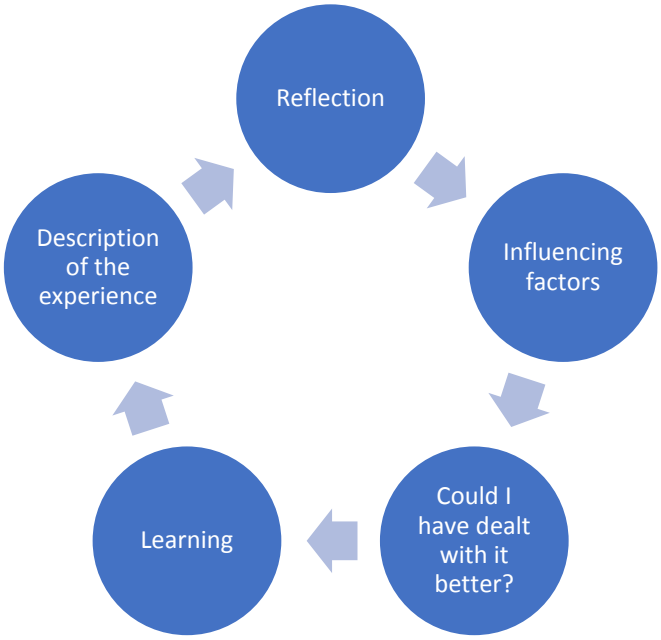
Reflective practice may be formal or informal and is the foundation for the improvement of professional practice.

In thinking about the significance of culture, it is often helpful to start by examining one's own 'cultural self-awareness'. Often aspects of cultures other than one's own seem particularly noticeable or different, perhaps even strange. It is very easy to forget that each individual is affected by his or her own cultural background. In short, what seems unusual to you may be perfectly acceptable in another culture, while your modes of interaction might be surprising to someone from another cultural background. You might start by making some observations about your own cultural influences:

- What cultural groups do I identify with?
- How do my experiences working, living, or studying within different cultures affect my practices and interactions with others?
- What interactions with others do I find especially challenging?
- How might my own cultural background affect my interpretation of these interactions?

Johns Model of reflection

Johns model is based on five cue questions which enable you to break down your experience and reflect on the process and outcomes.



Johns Model of Reflection
Description of the experience
Describe the experience and what were the significant factors?
Refection
What was I trying to achieve and what are the consequences?
Influencing factors
What things like internal/external/knowledge affected my decision making?
Could I have dealt with it better
What other choices did I have and what were those consequences?
Learning
What will change because of this experience and how did I feel about the experience
Description of the experience
Describe the experience and what were the significant factors?
Refection
What was I trying to achieve and what are the consequences?
Influencing factors
What things like internal/external/knowledge affected my decision making?

Cultural diversity in the workplace

As discussed in the previous section, Australian society today is a diverse mix of cultures, languages, and socioeconomic status made from a range of multiculturalism. In the community services industry, there is an increasing need for a more appropriate mix of culturally competent mainstream services, multicultural services, and ethno-specific services. Organisations must also ensure that they make an appropriate use of language and cultural interpreter services where required. In addition to this, it is essential for organisations to consider workforce planning to build and maintain a well-trained workforce which includes the recruitment of bilingual staff.

In this section you will learn about:

- Addressing bias and discrimination.
- Supporting diverse needs.
- Responding to diversity.

Element 2: Appreciate diversity and inclusiveness, and their benefits

Addressing bias and discrimination

Australia is a multicultural and diverse society. It is unlawful to discriminate on the basis of age, disability, race and sex. It is important for care workers to understand that certain actions, words and attitudes may be culturally inappropriate in the workplace as they may cause offence, anxiety, discrimination and anger.

This includes anything that may be construed as:

- Cultural stereotyping.
- Prejudice.
- Bias.
- Racism.
- Discrimination.

Discrimination can be defined as the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age or sex.

In Australia and throughout the world, it is illegal to discriminate against people for many reasons, including based on someone's culture. There are international and Australian laws that ensure all people are treated equally and all cultures are respected.

Australian **legislation** relating to **discrimination** includes the:

- Australian Human Rights Commission 1986 (Cwth)
- Disability Discrimination Act 1992 (Cwth)
- Sex Discrimination Act 1984 (Cwth)
- Racial Discrimination Act 1975 (Cwth)
- Australian Human Rights Commission Act 1986

Each state and territory also have their own anti-discrimination laws; for example, the Racism and Religious Tolerance Act (Vic) and the Anti-Discrimination Act 1991 (Qld).

Aged care, community care and disability standards have also been developed for various areas of the community services industry. This includes the Aged Care Accreditation Standards which refer to a person's cultural and spiritual life and state that a person's individual interests, customs, beliefs and cultural and ethnic backgrounds must be valued and fostered.

Aged care facilities and home and community care organisations should have an anti-discrimination policy that is available to Individuals upon request. On top of this, they must also have a complaints policy and procedure in place, and it must be available to Individuals without them fearing persecution or being treated differently because they lodge a complaint.

If you observe discrimination in the workplace, you should report it to the appropriate person.

A person discriminated against on the basis of race, sex, ethnicity, marital status, religious or political beliefs, or physical or intellectual handicap may complain to the relevant anti-discrimination board or the Equal Opportunity Commission.

Older people have the right to high quality care, delivered in an environment in which they feel safe, free from discrimination, intimidation, abuse, and without regard for their ability to pay. Individuals have the right to protection of their health by measures to prevent and relieve disease and disability, the right to respect and dignity, the right to the best care possible, to be treated as individuals and to be respected at all times. Services must be free from discrimination and exploitation. Care workers should actively facilitate and support individuals in their endeavours so as to maintain their self-respect and self-esteem.

Ways you can eliminate bias and discrimination in the workplace may include:

- By participating in cross cultural training
- Using interpreters and translation services
- Using culturally sensitive resources
- Providing an inclusive environment

Stereotypes in society

A stereotype is when an understanding of, or attitude towards, persons or groups is based on superficial observations and experiences.

Cultural stereotyping is applying the same traits to all people from a particular culture or group. Stereotyping is often negative, so the traits presented give a poor view of the culture. When we generalise about people, we fail to treat them as individuals. Some examples of stereotyping are:

- Indigenous people are all lazy.
- All older individuals have dementia.
- All English people are reserved.
- All Asians are nerds.
- All Australians like to drink beer.
- All black people are good at sport.
- All white people are racist.
- All Muslims are terrorists.
- Men are stronger than women.
- Women are better at cooking.
- Men are messy and unclean.
- All transgender individuals are homosexual.
- All lesbians are 'butch.'
- All gay men are drag queens.

Stereotyping is very common in society. When you are working in a culturally diverse environment, avoid stereotyping and treat everyone as an individual.

Addressing stereotypes

Stereotypes can cause low self-esteem and can leave people feeling isolated. They may also feel like they have lost a send of self and self-identity.

To address stereotypes, you could do the following:

- Promote equality.
- Attend professional development.
- Older people have a lot of knowledge to share with society. Their experience is irreplaceable.
- Older people have a lot to offer, they have experience and skills which can be passed down to new workers.
- Older people have the right to access the same health services as all individuals.
- Older people have the same basic needs as all individuals. They have every right to express their sexuality.
- Older people are encouraged to stay active and age positively.

Marginalised Groups

Marginalisation describes a state in which individuals are living on the fringes of society because of their compromised or severely limited access to the resources and opportunities needed to fully participate in society and to live a decent life. Marginalised people experience a complex, mutually reinforcing mix of economic, social, health and early-life disadvantage, as well as stigma."

Marginalised people came from stigmatised groups, including Aboriginal people and single, welfare dependent mother with many factors contributing to the circumstances of marginalised individuals, long term unemployed, disabilities, mental illness, lack of education and exposer to education and opportunities, financial crisis, economic and social exclusion, intergenerational poverty.

The Australian Bureau of Statistics have a set cultural definition of homelessness, this identifies shared community standards about the minimum housing people have a right to expect. "The minimum community standard is a small rental flat – with a bedroom, living room, kitchen, bathroom, and an element of security of tenure".

http://www.homelessnessaustralia.org.au/index.php/about-homelessness/homeless-statistics

There is a model of homelessness within Australia, by dividing people living outside of the minimum standards into five groups

- **Marginally housed:** people in housing situations close to the minimum standard
- **Tertiary homelessness:** people living in single rooms in private boarding houses without their own bathroom, kitchen or security of tenure;
- **Secondary homelessness:** people moving between various forms of temporary shelter including friends, emergency accommodation, youth refuges, hostels and boarding houses;
- **Primary homelessness**: people without conventional accommodation (living in the streets, in deserted buildings, improvised dwellings, under bridges, in parks, etc.); and
- **Culturally recognised exceptions**: where it is inappropriate to apply the minimum standard, e.g. seminaries, goals, student halls of residence.

According to statistics by Homelessness Australia, the national peak body for homelessness in Australia, there are currently (Nov 2015) 105,237 people in Australia who a homeless. (Approximately 49 out of every 10,000 people).

The statistics show that 56 % are male with 44% female. 25% (or 26,744) are Aboriginal and Torres Strait Islander Australian.

The ageing population take up a large percent of:

- 45 – 55-year old's 12%
- 55-64-year old's 8%
- 65 – 74-year old's 4%
- 75+ 2%

The Assistance with Care and Housing for the Aged (ACHA) is an Australian Government initiate program that assists individuals who are financially disadvantaged and offer support and assistance to access services, seek and find affordable housing options.

- 50+
- who are low income
- housing ACT tenants, renting, living with family or friends
- Boarding or have any issues relating to housing or homelessness

The ACHA Program, through the service coordinators, provides a range of services including: Assistance and advice for people accessing housing services and related financial and legal services:

- Relocation planning, setting in and assistance in negotiating to improve accommodation
- Referral to services that assist with support needs
- Linking to local community support to improve quality of life
- Follow – up and short – term monitoring of the effectiveness of services provided

The support offered is tailored to meet the needs of each individual and assist in networking supports to help the individual access to housing and care.

Homelessness – Fact sheet

What is homelessness?

When a person does not have suitable accommodation alternatives, they are considered homeless if their current living arrangement:

- Is in a dwelling that is inadequate
- Has no tenure or if their initial tenure is short and not extendable
- Does not allow them to have control of, and access to space for social relations

Human rights that homelessness impacts on:

- Right to adequate housing
- Right to health
- Right to personal safety
- Right to privacy
- Right to education
- Right to work

- Right to non-discrimination
- Right to social security
- Right to vote

Why do people often become homeless?

- Shortage of affordable and available rental housing
- Domestic and family violence
- Intergenerational poverty
- Financial crisis
- Long term unemployment
- Economic and social exclusion
- Severe and persistent mental illness and psychological distress
- Exiting prison
- Severe overcrowding/housing crisis

Causes of homelessness in older people may include-

- Lack of affordable housing
- Declining rate of home ownership
- Unable to live on the government pension
- Death of a spouse
- Financial crisis
- Age and gender discrimination
- Leaving a violent partner or spouse

Impact of homelessness on older people

- Homelessness impacts on the physical and emotional health of individuals. It can lead to depression and respiratory disorders. Older people become socially isolated when faced with homelessness and are often at risk of death within 5 years of being made homeless.

Why are older women at more risk of experiencing homelessness?

- Being forced out of the workforce early
  having insufficient superannuation/savings to fund the costs of living discrimination in the housing market
- The death of an income earning spouse
- Poor health or serious illness often resulting directly or indirectly from abuse separation/divorce

How does the Assistance with Care and Housing for the Aged (ACHA) programmes assist older people?

- Assisting them to find appropriate accommodation, providing advice on housing application forms and coordinating the move assisting them to access accommodation related financial or legal assistance, for example: rent relief, bond assistance, tenancy advice and legal service

Supporting diverse needs

Once educators begin to understand and develop cultural competence, they are able to support and appreciate diversity and multiculturalism in an early childhood setting. Cultural diversity recognises the differences between individuals including customs, traditions, language, and religion. Valuing and respecting diversity encourages people to accept individual difference amongst individuals and groups.

Supporting cultural diversity in an early childhood setting involves building relationships with children, families, and other educators. To promote cultural diversity children should be given every opportunity to:

- Learn about their cultural background.
- Learn about the backgrounds of people who are different from them.
- See themselves, their families and their communities represented throughout the centre.
- Learn to enjoy, appreciate and seek out differences.
- Participate fully in activities and feel included.

When children are given these opportunities, they develop a strong sense of identity and feel recognised and respected for who they are. Your role as an Educator is to promote a sense of community within the early childhood setting and to plan experiences that encourage appreciation of diversity.

Support and respect the Individual's expression of sexuality

Sexuality is how people experience and express themselves as sexual beings. Human sexuality may also involve a person's sexual attraction to another person and can refer to issues of morality, ethics, theology, spirituality, or religion. Quite often it is an aspect of one's need for closeness, caring, and touch.

Sexual identify is defined as how someone thinks of them self in terms of who they are attracted to. It reflects and makes up a part of an individual identity.

Sexual orientation is a person's sexual identity in relation to the gender or sex they are attracted to. Sexual orientation may refer to identifying as being heterosexual, homosexual or bisexual

Sexual activity is more common in the elderly than society tends to think. Needs vary between individuals but catering for the need for sexual activity, as required, is an essential part of providing a holistic and appropriate service to older individuals. An individuals' expression of their individuality, and sexuality is part of being an independent, unique and worthwhile human being. They are entitled to be supported and encouraged to express these needs and feelings in a safe and supportive environment, without others imposing their values and attitudes upon them.

Different Individuals will have different ways of expressing their sexual identity. Some of these ways may include:

- Their demeanour: how they treat and interact with others.
- Their attitude to decision making in their lives (i.e. taking charge, submissive, consultative, etc.)
- Touch: holding hands, hugging, kissing; sexual intimacy.
- Physical appearance: formal, casual, physical shape, slim, strong, etc.
- Their clothing and the way they dress including makeup, tattoos and jewellery.
- Personal items: decorations, aids and equipment, pictures, books, etc.
- Privacy and discretion: some Individuals will require more privacy than others and act in a more discreet manner than others who may be flamboyant and act out their feelings, expression and emotions
- You can support sexual expression and an active sexual life in older persons by:
    - Providing information: Individuals and their partners may need basic information, understanding and practical advice on how to manage changes and live a full sexual life as they age.
    - Providing privacy: provision of privacy in institutions is most important, for example simply knocking on a door before entering helps the Individual feel their privacy is respected.

Sexual expression in aged care

In residential aged care sexual expression can be challenging for a number of reasons. Firstly, it may challenge staff members who don't expect older people to be sexual. Consequently, staff may be shocked and uncomfortable when residents express themselves sexually. Staff may not have been taught how to respond when sexual expression occurs, or when they find out someone, they are caring for is gay, lesbian or bisexual. These challenges can be intensified when cognitively impaired residents express themselves inappropriately.

Some barriers for individuals to freely express their sexuality can be;

- Lack of privacy (i.e. single room)
- Lack of staff discretion.
- Embarrassment.
- Physical mobility.
- Same sex relationships - in institutional care there is the presumption of heterosexual relationships.
- Social prejudices and stereotypes.

It is important to recognise that older Individuals often have unmet needs in relation to their sexuality. Sexual needs are not just about intercourse; they include challenges, warmth, love, touching and sharing between people. Each Individual has an inherent need for love and belonging, which is often met sexually. It is important for care workers to understand that as the Individual experiences ageing, the onset of disease and even impending death, sexuality can be an important form of communication that helps in coping.

The need for affection is not reduced by advancing age. This does not only include receiving affection but giving affection and sharing affection as part of a family.

When your Individual is still active there is no reason why sexual activity should not continue. Sometimes physical adjustments have to be made, thus making sexual relationships a pleasurable experience, actually enhancing communication and love.

Men and women in same sex relationships will face additional problems in institutional care with a health system that presumes heterosexual relationships. This may increase isolation and loneliness.
Where an Individual's sexual needs are not being met, discussion with the Individual and your supervisor is required to explore the possibility of referral to an appropriate person.

Culturally appropriate spiritual support

Culturally appropriate spiritual support assists your Individuals to express their unique spirituality in an open and non-judgemental environment by helping them to maintain important practices, beliefs and networks.

Identifying current and desired practices and beliefs will assist you to meet the needs of your Individuals from culturally and linguistically diverse backgrounds; simply asking to which religion a person belongs does not adequately determine spiritual needs.

The religious beliefs of some of your Individuals may require strict adherence to ritual and influence all aspects of their daily life. The needs of your Individuals may also change over time; some people may become more aware of and interested in spiritual matters, perhaps for the first time in their lives. Regular reviews of your Individual's spiritual needs will ensure the support you provide is relevant to their needs.

An understanding of particular religious practices and beliefs will assist you in the provision of culturally appropriate spiritual support. However, it is always important to identify individual needs and preferences and not assume that all people who speak the same language practice the same religion, or that all people following the same religion practice the same rituals or share the same beliefs.

The spiritual needs of your individuals may include:

- Formal and informal religious observance.
- Need for private time and space for contemplation.
- Privacy and respect for religious customs and practices.
- Access to religious leaders and/or places of worship.
- Ceremonial observances.
- Special dietary needs.
- Special times to pray.

Supporting the needs of Aboriginal and Torres Strait Islander people

As a support worker you may at times be required to provide care for individuals from an Aboriginal and/or Torres Strait Islander background. You may need to consider the following wo ensure you provide culturally appropriate support:

- When communicating verbally face-to-face, it is customary in Aboriginal culture to not look people in the eye and not necessarily face the person when speaking.
- Learn about and understand Aboriginal ways of communicating.
- Be aware of the Aboriginal culture.
- Be aware of how people from an Aboriginal background grieve the loss of family and their traditional home.
- Contact an Aboriginal health worker.

Responding to diversity

Each person is an individual and has the right to be treated as such and as an equal with all others. Differences must not only be respected but provided for, so all aged care individuals have an equal opportunity to maintain their individuality and quality of life.

A commitment to access and equity principles must be demonstrated by a non-discriminatory approach to all people using the service, their family and friends, the general public and co-workers

Access and equity

Access and Equity incorporates the following:

- Promoting fairness in the distribution of resources, particularly for those most in need.
- Recognising and promoting people's rights and improving the accountability of decision makers.
- Ensuring that people have fairer access to the economic resources and services essential to meeting their basic needs and improving their quality of life.
- Providing people with better opportunities for genuine participation and consultation in relation to decisions affecting their lives.

Australia's Multicultural Access and Equity Policy

The purpose of this policy is to:

- The policy acknowledges that Australia is a multicultural society and there is an obligation on Australian Government departments and agencies to provide equitable access to services regardless of the cultural or linguistic backgrounds of clients.
- It acknowledges the importance of the principles of non-discrimination, equality, participation, and inclusion.

You can apply the principles of access and equity in aged care by:

- Providing a person-centred approach when delivering services
- Delivering services in a non-discriminatory manner
- Respecting individual differences regardless of culture, physical differences, religious preferences, spirituality, sexual preferences/orientation and socio-economic status
- Meeting the needs of individuals

All care givers within the community services sector should be aware of access, equity and human rights issues in relation to their own area of work. All workers should be able to recognise certain issues facing and be able to demonstrate their ability to work in our culturally diverse environment.

Equal Employment Opportunity

Equal Employment Opportunity legislation prohibits discrimination against individuals on the basis of race, gender, sexual preference, religious or political belief, pregnancy or marital status, union activity or age. All individuals are entitled to equal consideration and respect when being dealt with.

Over the past 30 years the Commonwealth Government and the state and territory governments have introduced anti-discrimination laws to help protect people from discrimination and harassment. The following laws operate at a federal level and the Australian Human Rights Commission has statutory responsibilities under them:

- Age Discrimination Act 2004
- Australian Human Rights Commission Act 1986
- Disability Discrimination Act 1992
- Racial Discrimination Act 1975
- Sex Discrimination Act 1984

The charter of Public Service in Culturally Diverse Society

In 1998, the Australian Government endorsed the Charter of Public Service in a Culturally Diverse Society to ensure the needs of the culturally and linguistically diverse society are being met.

The charter ensures that Government services are being delivered nationally, using a consistent approach within economic, social and cultural life that is considerate and sensitive to the language, and cultural diversity of all Australians.

The charter aim is to ensure that all Australian Government agencies are considering cultural diversity with:

- Strategic planning.
- Policy development.
- Budgeting and reporting.

The Charter consists of seven principles, central to the design, delivery, monitoring, and evaluation and reporting of quality Government services in a culturally diverse society.
These are:

Access: Government services should be available to everyone who is entitled to them, regardless of where they live, and should be free of any form of discrimination on the basis of birthplace, language, culture, race or religion

Equity: Government services should be delivered on the basis of fair treatment of Individuals who are eligible to receive them

Communication: Government service providers should use strategies to inform eligible Individuals of services and their entitlements, and how they can obtain them. Providers should also consult with the community regularly about the adequacy, design and standard of government services

Responsiveness: Government services should be sensitive to the needs and requirements of different communities, and responsive to the particular circumstances of individuals

Effectiveness: Government service providers must be 'results oriented', focused on meeting the needs of Individuals from all backgrounds

Efficiency: Government service providers should optimise the use of available public resources through a user-responsive approach to service delivery which meets the needs of Individuals

Accountability: Government service providers should have a reporting mechanism in place which ensures they are accountable for implementing Charter objectives for Individual

Element 3: Communicating with people from diverse backgrounds

The section of this Learner Guide will look at how you as can effectively communicate with people from diverse backgrounds. Effective communication occurs when two or more people are engaged in a positive and responsive conversation. Barriers to communication may occur due to some different reasons:

- Language differences.
- Cultural differences.
- Attitudes.
- Stereotyping.
- Values.
- Assumptions
- Environment
- Communication delivery

Negotiation, conflict resolution, teamwork, and adaptation of work practices all rely heavily on communication skills. Excellent communication skills are basic tools for anyone working as a carer; you will use these skills every day.

Every day you need to put into practice appropriate communication techniques, often in a way that is quick but effective. As carers we need to ensure that we are communicating relevant information during that time.

There are many ways in which we can communicate:

- Verbal communication
- Gestures
- Body language
- Facial expressions
- Written communication
- Signs
- Sign language
- Interpreters

A person's experience and perceptions can alter the way they communicate or even the way that they understand something being said to them. At these times you may try using body language or gestures to help make yourself understood and to show that you understand (or don't understand) what they are trying to tell you.

Where a family uses a different verbal language than you, it is especially important that you find a way to communicate effectively. Interpreters can be brought in to help you with these types of communication barriers.

These are people that are trained to understand and speak two or more languages. They listen to one person speaking a language and then translate the words into the other person's language so that both people can understand what is being said. You can also arrange to have any information written in a different language or provide written information that can be translated by another person or family member. The family may also like to bring a friend or family member to help with the translation, but you need to be mindful of confidentiality and ensure that private information remains private.

The important thing to remember is to do your best to ensure that you and your service are as welcoming and helpful as you would be to another family and you should ensure that the child's and family's needs are being met in spite of any language barriers.

Care plans help identify language ability and language needs and put in place strategies to address them. Some strategies to overcome language barriers include:

- Using basic word and picture dictionaries
- Providing information in a person's first language
- Demonstrating an activity or a request
- Using multilingual staff members (where appropriate)
- Using a language tool if appropriate
- Using an interpreter if needed for important health/care issues

When overcoming a language barrier, you need to be sensitive and avoid being condescending whilst communicating with the Individual.

Below are some strategies you can use:

- Speak slowly and clearly, never shout
- Repeat and/or rephrase sentences if you think have not been understood
- Try to use words the Individual might know and keep sentences simple
- Give instructions in a logical sequence
- Work out what you want to say in your mind before you commence
- Present one idea at a time and don't give too much information in one go
- Try to check understanding by asking questions or getting the Individual to repeat
- Be aware that Individuals from some cultural backgrounds may avoid disagreement at the expense of being honest
- Allow time for questions and clarification
- Use communication aids when necessary such as:
  - Professional interpreters
  - Bilingual doctors and care staff
  - Telephone interpreter services
  - Tolerance and acceptance

Seeking assistance from interpreters

At times you may need to work with interpreters and translators to provide effective care and support to Individuals from diverse backgrounds. Interpreters and translators are highly skilled communicators who are fluent in English as well as at least one other language and can assist you to communicate with your Individuals and their family members.

An interpreter can assist you to communicate verbally with someone when you don't share a common language. A translator, on the other hand, is someone who converts written information from one language into another language.

When using an interpreter, you must ensure that they speak not only the right language, but also the right dialect. Sensitivity to culture also needs to be kept in mind. For example, if you have an Individual who is from Bosnia and Herzegovina, you would not use a Serbian interpreter, as these two countries were at war for many years

When to use a professional interpreter

- The information to be given is important
- There is a need for accuracy
- The information is significant for health/health outcomes (N/B: there is a legal obligation that interpreters are used in situations relating to medical, legal and confidential matters)
- There is a need for confidentiality and/or privacy, or the issue is sensitive
- The Individual has an Interpreter Card
- The Individual is assessed as needing an interpreter

Interpreting services:

- The Translating and Interpreting Service (TIS National) – Department of Immigration and Border Protection
- Australian Multilingual Services
- Australian Interpreting Service Pty Ltd

If an interpreter is needed the supervisor from your organisation would contact a service by phone or via website on the internet and state the language you need interpretation for, the day, the time and if the interpreter is coming to the office, its location and any applicable directions. The service would also need too:

- Seek permission from the client that they are happy to use an interpreter
- Determine the correct language for which an interpreter is required
- Book a room or private area at your workplace which would ensure privacy
- Book the interpreter service
- Arrange the room with enough chairs (if service is to be provided in person at the office)
- If the interpreter service is to be accessed by phone you will need to organise the time and day of the phone call with the client

Other ways organisations provide care to older people from different cultures and who speak languages other than English include

- They employ staff who understand or have some knowledge of the cultures of their clients
- All staff have appropriate induction and training in cultural awareness
- The physical environment and social activities reflect the needs of different cultures
- There is no bias or prejudice allowed in the workplace (i.e. literature or signage that excludes or discriminates)
- There are cultural diversity policies and procedures in place with which staff are familiar and required to follow

Problems using family members to interpret

Using a family member to interpret can be a useful and easily accessible communication tool. However, there are factors to consider before having a family member interpret:

- They may provide their own personal interpretation of what has been said rather than a literal interpretation of what the Individual is saying
- They may not translate objectively as their relationship with the Individual may affect their objectivity

- Family members are not professional interpreters and as such they may misunderstand what has been said and this may cause misunderstandings
- Individuals may not wish to mention certain details in front of family members
- The privacy and confidentiality rights and needs of the Individual need to be considered and observed

If you need access to a translator or interpreter, call the Translating and Interpreting Services (TIS National) on 131 450. TIS covers more than 100 languages and is available 24 hours a day, 7 days a week, for the cost of a local call.

In December 2012, the Australian Government released the *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*. The strategy will help the government respond to the needs of individuals from CALD backgrounds and better support the aged care sector to deliver care that is sensitive and appropriate.

Source (www.myagedcare.gov.au)

Resolving cross-cultural misunderstandings and conflict

From time to time, there may be disagreements or problems between an individual and a care worker or the service provider. There is always the possibility for conflict in a care environment where there are lots of personal interactions between carers and Individuals.

You may have to deal with a conflict or problem that is due to a cultural difference. It is important that you can resolve these situations effectively. To do this, you need to know what caused the problem, what solutions are available and your ability and authority to resolve the situation.

What is conflict?

Whenever you work with a diverse group of people, you are likely to face some conflict situations. Conflict may occur as a result of a similar disagreement; for example, over basic routines and practices; or stem from a clash in values and expectations. Everyone deals with conflict differently, and this is generally a learnt behaviour from childhood. An example of this might be; some people deal with conflict head on, and others may try to ignore or avoid it until it goes away.

When resolving cross cultural conflict, it is a mutual understanding that when we face it head on and work together, the conflict can lead to change.

Conflict in itself is not necessarily negative, even though you may find conflict hard to deal with or resolve. In reality, conflict and its resolution often lead to stronger relationships as people work together to resolve their differences.

As a community become more diverse in its cultures and backgrounds, there is a greater likelihood that cross-cultural misunderstandings or conflict may arise. Because of this, we need to ensure that we are continually developing and building trusting relationships. If you assume that everyone thinks and sees things the way that you do, you will be risking conflict and misunderstandings. You need to take the time to discover, appreciate, and learn from other people's differences and use this information to see things from other people's perspectives. This will, in turn, help you to provide a broader and more enriched environment for all.

Your background may have an impact on interactions and relationships with people from other cultures:

- Different beliefs may cause conflict about certain issues/topics
- Different beliefs may influence who you associate yourself with, form relationships with cross-cultural conflict and challenging interactions may involve a person behaving in any of the following ways towards another person on the basis of their cultural or linguistic background:

- Name calling
- Use of offensive language
- Degrading comments in reference to a person's ethnicity, culture, religion or background

- Ridicule based on a person's physical appearance
- Teasing or put downs
- Shouting/abuse/aggressive language
- Excluding/isolating/ignoring

A person being subjected to any of the above behaviours may react by feeling:

- Angry
- Upset/sad
- Ashamed
- Frightened
- Isolated
- Intimidated

Resolving differences

It is important to remember that when conflict occurs, it will not usually be possible to change a person's attitudes. However, we can often change someone's actions. You need excellent communication skills to handle conflict effectively, especially as you may be working with people who are angry, frustrated, or abusive. Some people may instead remain silent and make it difficult for you to find out what's wrong.

When dealing with conflict there are four steps you can take:

1. Define the problem
2. Identify the causes
3. Suggest possible solutions, then act on the agreed solution
4. Check that the problem has been resolved

There are a variety of conflict resolution strategies that can be employed when conflict occurs. These include:

- Remaining calm and not allowing your emotions to dictate your reactions
- Trying not to take the behaviour personally
- Seeing if you can find and emphasise common ground between the two people in conflict rather than the differences
- If there is common ground, explore possible solutions or compromises which will allow both persons in the conflict to 'win' (i.e. Achieve some of their aims)
- Encouraging those in conflict to listen to each other and respect each other's views, even if they are opposed
- Acknowledging that there are differences which may have a cultural basis and that this is 'okay.'
- If there has been unacceptable behaviour, tell the instigator promptly, clearly and calmly that their behaviour or actions have caused distress to others and to stop the behaviour – if they apologise, accept the apology, if they choose not to, do not try to force them to apologise. However, if they resume the behaviour, take immediate action in line with your organisation's policies and procedures.
- Always treat all persons in a conflict with dignity and respect even if they are not behaving in the same manner toward you or others
- Use a mediator if necessary

Conclusion

Australia has a unique history that has shaped the diversity of its peoples, their cultures, and lifestyles today. Australia's demographic make-up are a diverse Indigenous population, a British colonial past, and immigration from many different countries and cultures. The different cultures and backgrounds have placed a large emphasis on cultural awareness and cultural competency. Your role as a support worker is to work towards becoming culturally competent and culturally aware by reflecting on your own practices. Becoming culturally aware and developing cultural competence, allows you to recognise cross-cultural misunderstandings and respond appropriately to these. Further to your role, you need to be able to use verbal and non-verbal communication to promote understanding across diverse groups.

HLTAAP001 - Recognise healthy body systems

Welcome to the learning resource for the unit HLTAAP001 Recognise healthy body systems.

The focus of this unit is to apply the skills and knowledge required in order for you to identify networking and collaboration needs and develop formal and informal partnerships to enhance service delivery and improve professional practice

On completion of this unit you will have covered the requirements for:

1. Work with information about the human body
2. Recognise and promote ways to support healthy functioning of the body

You will be able to demonstrate your ability to:

- Work effectively with information about the human body and its healthy functioning in at least 3 different situations.

You will gain knowledge about the basic structure and functions of the body systems and associated components, including:

- Cells, tissues and organs
- Cardiovascular system
- Respiratory system
- Muscular-skeletal system
- Endocrine system
- Digestive system
- Urinary system
- Reproductive system
- Integumentary system
- Lymphatic system
- Nervous system, including sensory systems – eye and ear
- The special senses – smell, taste, vision, equilibrium and hearing
- Immune system

Processes, conditions and resources required by the body to support healthy functioning body regulation including:

- Maintenance of body temperature
- Fluid and electrolyte (including PH) balance
- Elimination of wastes from the body
- Maintenance of blood pressure
- Protection from infection
- Physical activity – active and passive

A copy of the full unit of competency can be found at: https://training.gov.au/Training/Details/HLTAAP001

This learning resource is designed to support your learning and act as a guide to further research. We encourage you to access other texts which include; standards and legislation and other resources relating to your industry that can be sourced throughout the internet or library.

Element 1: Work with information about the human body

As your work may involve helping clients carry out daily activities such as moving in bed, from bed to chair, grooming, showering, dressing and eating, supporting with activities, you may be able to notice changes in a client's skin condition, respiration, swallowing, temperature, weight, behaviour, general health and wellbeing. Therefore, your understanding of the body systems function will help you recognise and report signs that suggest the body may not be functioning well. You also need to know what factors help people maintain a healthy body to maintain clients' health.

Correctly use and interpret health terminology that describes the normal structure, function and location of the major body systems

Throughout your role as a support worker you may be required to undertake assessments, provide personal care, develop care plans and provide support to a variety of people. Within these roles, it is important that you apply and understanding of many basic aspects of the human body and you are able to recognise and support or report any issues or areas of concern that may affect or currently affecting a person's physical and/or mental wellbeing.

To be able to provide others with accurate information, it is important to become familiar with some basic anatomy, physiological functions and the related terminology. Medical terms communicate a precise meaning and it is crucial that medical terms are used correctly. To assist you in the development of these skills you may like to review further literature surrounding medical terminology, talk with colleagues or supervisors, listen to others and record notes for future reference, or spend time with other healthcare professionals.

Below is a list of terminology that will be useful in your studies.

Anatomy is the study of the structure of the body and of the relationship of its constituent parts to each other. To address physiological needs there is a need to know some basic anatomy and physiology.

Physiology is the study of the functions of the normal human body. The body is made up of many tissues and organs, each having its own particular function to perform.
Cardio: relating to the heart
Osteo: relating to bones
Posterior: the back
Anterior: the front
Organ: independent part of the body that carries out one or more special functions
Cell: the basic structural and functional unit of all organisms

Prefixes and suffixes

If you understand the prefixes and suffixes of medical terms, it will help you to determine the overall meaning of the word; for instance, 'pneumo' means referring to the lungs, as in pneumonia.

Below are common suffixes and prefixes that alter the meaning of the root word and will provide clues to the definition.

A–D	E-H	I – N
a- or an- (prefix) without	-ectomy (suffix) surgical removal	inter- (prefix) between
ab- (prefix) away from	- edem- (prefix) swelling	intra- (prefix) inside
ad- (prefix) towards -algia (suffix) pain	endo- (prefix) within	-ism (suffix) condition
anti- (prefix) against	epi- (prefix) upper	-itis (suffix) inflammation
asthen- (prefix) weakness or lack	hyper- (prefix) excessive	
bi- (prefix) two	hypo- (prefix) deficiency	
-cele (suffix) swelling		

Basic structure and functions of the body systems and associated components

The human body is a complex and fascinating thing. This topic introduces the language of anatomy used to describe and locate specific positions, directions, regions and structures of the body. You will learn how the body is organised as an interdependent system (from simple to complex levels), the systems that make up the human body, and how the body is constantly working to maintain a balance. The human body is composed of cells, tissues and organs.

Cells, tissues and organs

Cells

The cell is the basic unit of the human body. A typical cell has cell membrane, cytoplasm and nucleus. Cells are adapted to perform special functions of the organ or tissue they are found in.

Human beings have an estimated 100,000,000,000,000 (100 trillion) cells. While each cell has the same basic structure, the function, the size and shape of the cells may be different. For example, fat cells are spherical, red blood cells are disc-shaped, and nerve cells are branching. Although no one cell type is exactly like all others, cells do have many common features. Each cell can take in nutrients, convert these nutrients into energy, carry out specialised functions, and reproduce as necessary. Each cell stores its own set of instructions for carrying out each of these activities.

The three main parts of each cell are:

The Cell Membrane
Is the outer covering which holds the cell together and encloses all the cell contents. It allows food, water and oxygen to pass into the cell from the outside and waste material from inside the cell to pass to the outside.

The Nucleus
Which is the control centre of the cell. It directs the work of the cell and enables the cell to reproduce. Nucleolus is a spherical structure found within the nucleus where RNA is produced (RNA is related to DNA).

The Protoplasm
Which is a jelly-like substance made up of water, protein, glucose and salt; the activities of the cell take place here.

Tissues
Cells combine together to form tissue. Below is a summary of the different types of tissue in the body:

Epithelial tissue:
Covers internal and external body surfaces. Epithelial cells fit close together to form continuous sheets. Epithelial tissue lines the nose, mouth, respiratory tract, intestines and stomach. The hair, nails, skin and glands are also composed of epithelial tissue. Epithelial tissue does not have a blood supply.

Connective tissue:
Binds and supports other tissues. Is found everywhere in the body. It provides an anchor, connects and also supports other body tissue. This type of tissues binds and supports bones, tendons, ligaments, and cartilage are connective tissues. Blood is also a form of connective tissue.

Nervous tissue:
Controls body functions. Carries and receives impulses between the brain and body parts. Nerve tissue makes up the brain, spinal cord and nerve fibres.

Muscle tissue:
Contractile tissue that assists movement. Allows the body to move by contracting and stretching. Because of their elongated shape, muscle cells are called fibres.

Organs

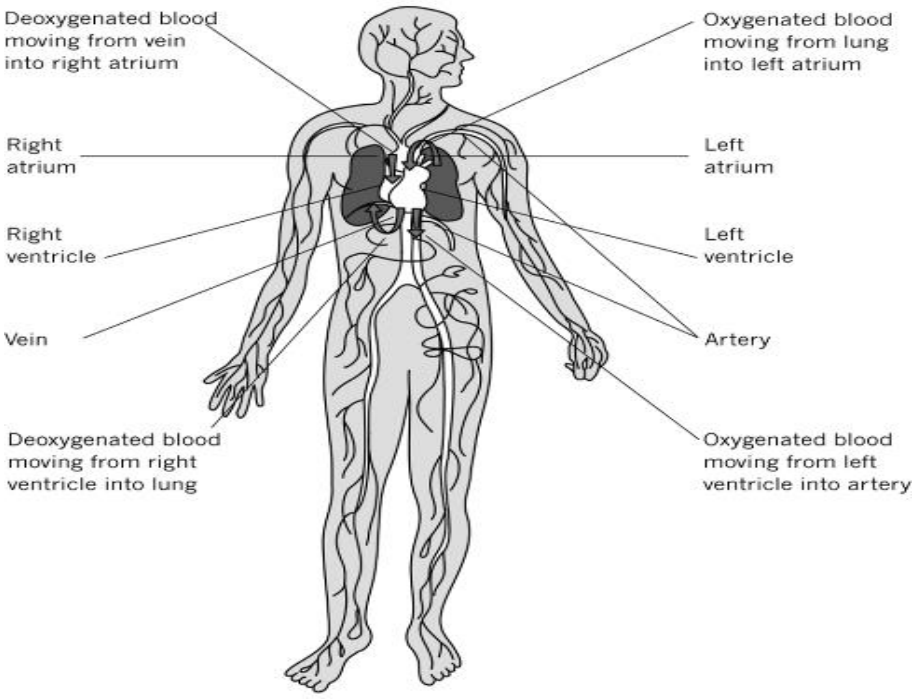
Groups of tissues form organs. Organs are usually composed of more than one type of tissue. The stomach is a good example of an organ; its lining is epithelium, its wall is muscle tissue, and it has nerve cells that stimulate it to contract. Examples of organs include the kidneys, heart, liver, lungs and brain.

Systems

Systems are formed by groups of organs and tissues working together to perform specialised functions such as breathing, movement, digestion and reproduction. A system is a group of organs that work together to perform certain tasks.

Listed are all the systems within the body.

- The musculoskeletal system
- The integumentary system
- The respiratory system
- The cardiovascular system
- The gastrointestinal (digestive) system
- The endocrine system
- The lymphatic system
- The urogenital system (urinary and reproductive systems)
- The nervous system
- The special sense organs



Cardiovascular system

The cardiovascular system includes:

- The heart
- Arteries
- Veins
- Capillaries

The main functions are:

- Distribution of blood
- Return of blood to the heart
- Exchange of materials in the tissues

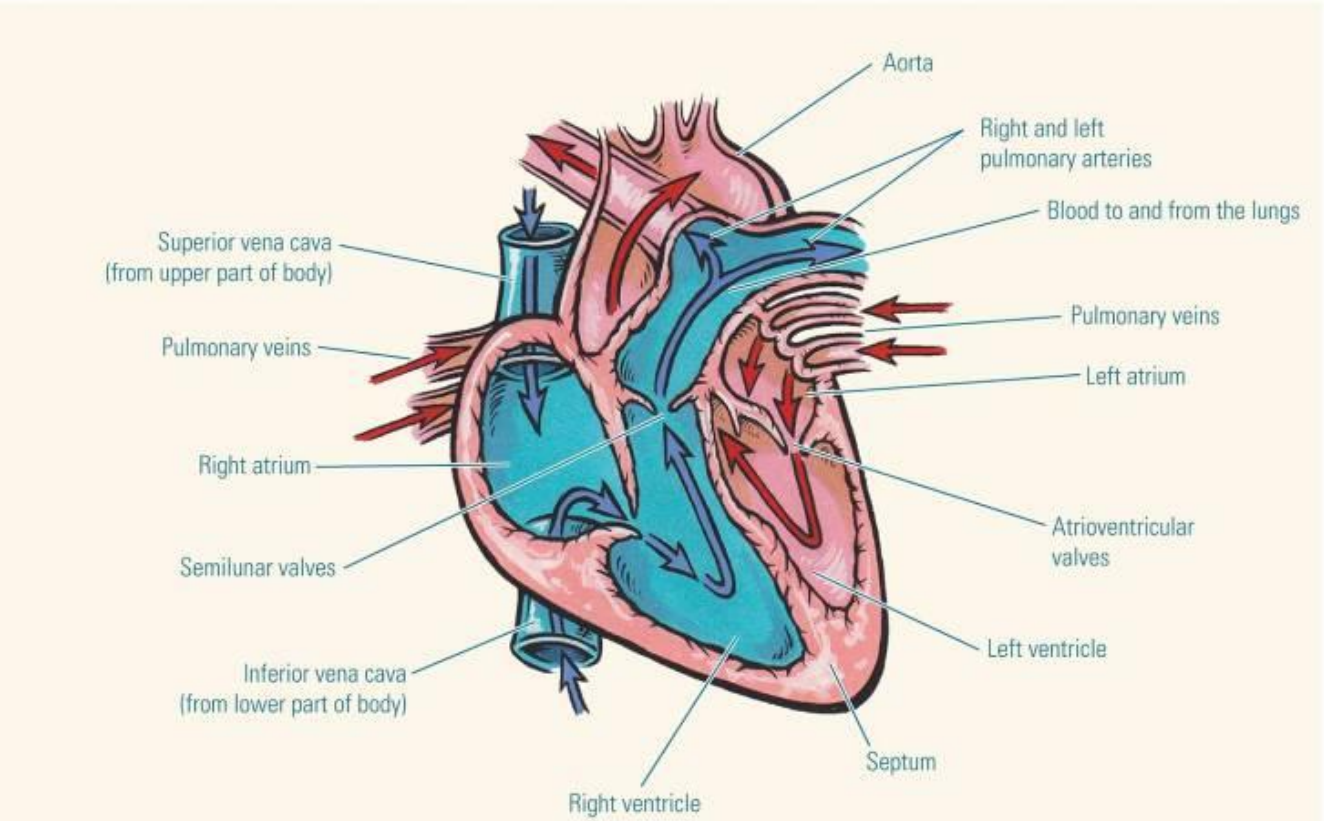
The heart and blood circulation

The heart:

- Is a hollow muscular organ
- Pumps blood around the body
- Is a one-way circulatory system carries blood to all parts of your body.

The veins and arteries:

- Arteries carry oxygen-rich blood away from your heart
- Veins carry oxygen-poor blood back to your heart.
- Capillaries exchange materials



The arrows indicate the circulation of blood through the heart.

Ageing and cardiovascular changes

As we grow older there are changes in the size and walls of the blood vessels which results in decreased blood flow to vital organs.

The effectiveness of the pumping action of the heart is reduced. Under resting or non-stressful situations this is not a problem. However, the time it takes for the heart to return to normal after strain or stress increases. These changes produce an increase in blood pressure.

There also may be a decrease in the quantity or quality of red blood cells.

The older person therefore may have a tendency to:

- Heart disease
- High blood pressure
- Anaemia
- Arteriosclerosis
- Oedema
- Hypotension, dizziness, fainting, blackouts and falls

Support routines: cardiovascular changes

The support worker and other members of the care team can support the resident with cardiovascular problems, by care routines which may include:

- Regular but gentle exercise
- Good fluid intake and good temperature regulation
- Diet that is not too high in cholesterol and fat
- Identifying smoking as a heart attack risk for any resident or client who smokes
- Ensuring medication is taken as prescribed e.g. diuretics, heart medication
- Avoiding sudden movement, particularly after lying down or hot baths
- Awareness of the variety of symptoms that may indicate heart problems e.g. extreme tiredness, confusion
- Awareness of warning signs of a heart attack; discomfort/pain in the centre of the chest – this may feel like a tightness or pressure; discomfort in the upper body – this may be in the arms, shoulders, neck, jaw and back; Feeling short of breath, Feeling nauseous,
- Having a cold sweat, Feeling dizzy or light-headed.

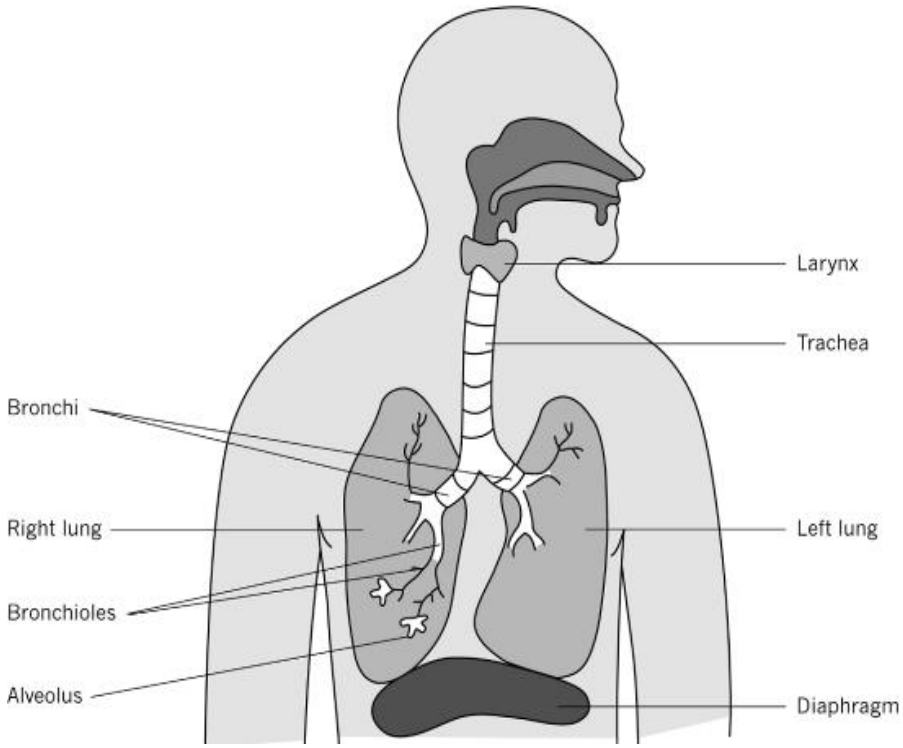
i	**Additional resources – Heart Anatomy** https://www.youtube.com/watch?v=H04d3rJCLCE&feature=youtu.be

Respiratory system

The respiratory system contains the passages and organs concerned with breathing that function to take oxygen from the air into the blood and carry it to the tissues. The waste product, carbon dioxide, is carried by the blood from the body tissues to the lungs and breathed out in the expired air.

The system consists of:

- Nose
- Pharynx (throat)
- Larynx (voice box)
- Trachea (windpipe)
- Bronchi
- Lungs



The sinuses, diaphragm and intercostal muscles between the ribs also assist in breathing and are called auxiliary structures.

Function of the respiratory system

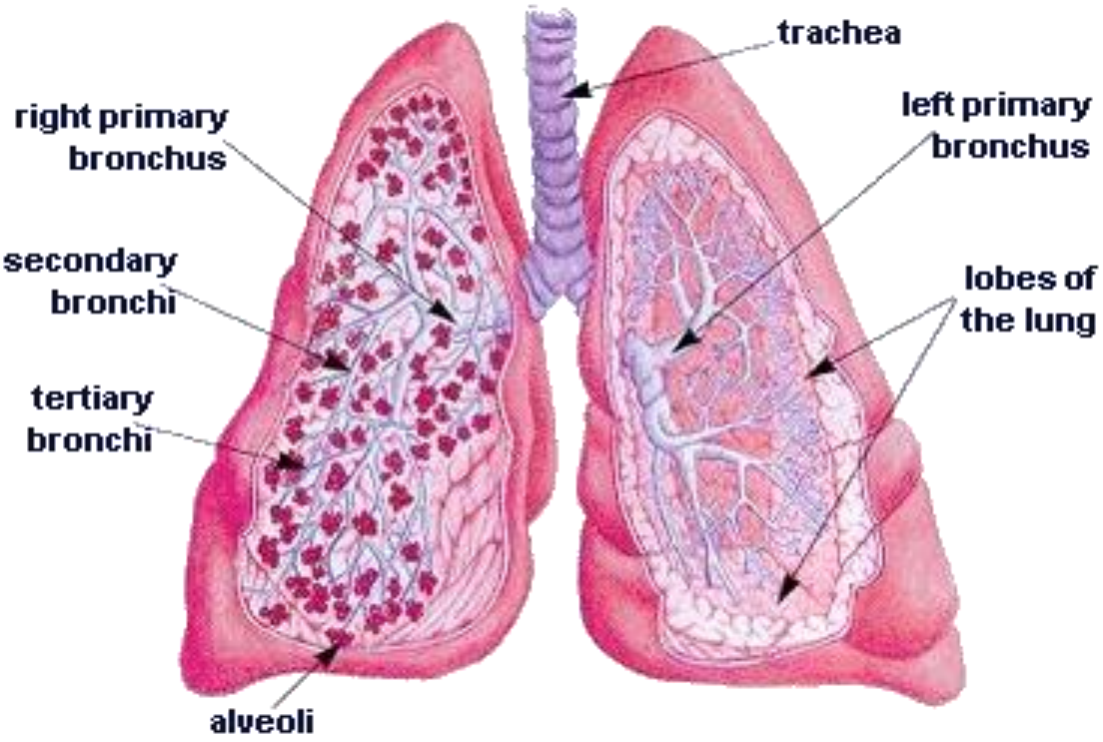
Primary function

To supply the blood with oxygen in order for the blood to deliver oxygen to all parts of the body.
The respiratory system does this through breathing:

When we breathe, we inhale oxygen and exhale carbon dioxide. This exchange of gases is the respiratory system's means of getting oxygen to the blood. Respiration is achieved through the mouth, nose, trachea, lungs and diaphragm.

Breathing

Oxygen enters the respiratory system through the mouth and nose passes through the larynx and trachea into the bronchi and bronchial tubes.
The bronchial tubes lead directly into the lungs connecting to tiny spongy, air-filled sacs called alveoli.
The inhaled oxygen passes into the alveoli and then diffuses through capillaries into the arterial blood.
Blood from the vein's releases carbon dioxide into the alveoli which follows the same path out of the lungs.
The diaphragm helps pull the oxygen into the lungs and pump the carbon dioxide out of the lungs.



Ageing and respiratory changes

Changes in the lungs and chest wall include reduced mobility in the rib cage, loss of elasticity and decreased blood flow to the lungs. The lungs become more rigid and the amount of air that can be expelled after full expiration is reduced and they are less efficient.

Because of this and a reduced cough reflex, the elderly can't cough up mucous easily so have a high risk of chest infections and respiratory complications. Older people therefore may have a tendency to:

- Increased risk of the complications of flu and of pneumonia
- Increased shortness of breath when mobile

Support routines: respiratory changes

The support worker and other members of the care team can support the resident with respiratory problems, by care routines which may include:

- Encouraging residents not to smoke
- Maintaining posture - you should check to see if your resident is positioned appropriately in bed or in their recliner
- Participation in active and passive exercises as appropriate: however, you should not allow residents with diminished respiratory capacity to become fatigued. Encourage the resident to exercise – but let them take their time. Always be aware of the physiotherapist's directions as recorded in the Care Plan.
- Wearing adequate clothing
- Getting flu shots when available
- Having oxygen available if required - but its use must be in accordance with facility or service guidelines

For bedfast clients it is important that they are transferred from their bed and placed in a recliner at least several times a week. In addition, regular turning assists in keeping the chest clear.

Additional resources – Lungs
https://www.nhlbi.nih.gov/health/health-topics/topics/hlw/

Muscular-skeletal system

The musculoskeletal system concerns the movements of the body.

It comprises:

- The skeletal system – bones, cartilages and membranes
- The articulatory system – joints or articulations
- The muscular system – muscles, fascia, tendons

The skeleton

The skeleton is the bony framework of the body that provides protection for organs within the body and provides articulation for movement

Major parts of the skeleton are:

- The skull
- The thorax
- The vertebral column
- The lower limbs
- The upper limbs

The human skeleton consists of bone tissue, cartilage and bone marrow. The adult skeleton normally consists of 206 bones and strong connective tissues which form ligaments, tendons and cartilage. The connective tissue is attached to the bones forming joints and there are approximately 100 joints within the human skeleton.

The functions of the skeleton:

- Provides a strong framework for the body.
- Provides points of attachment for the muscles and assists in movement.
- Stores fats and minerals which are important in muscle contraction and nerve activity.
- Produces the bulk of the red blood cells in the bone marrow.
- Gives protection to many of the internal organs.

Joints

A joint is the union of any two or more bones. There are three main classes:

- Fibrous – immovable or fixed joint (skull bones)
- Cartilaginous – slightly movable (intervertebral)
- Synovial – freely moveable (six types)
  - Gliding joint (e.g. carpals and tarsals)
  - Ball and socket (e.g. hip and shoulder)
  - Hinge joint (e.g. elbow)
  - Condyloid Joint (e.g. wrist)
  - Pivot Joint (e.g. head)
  - Saddle Joint (e.g. thumb)

Muscles

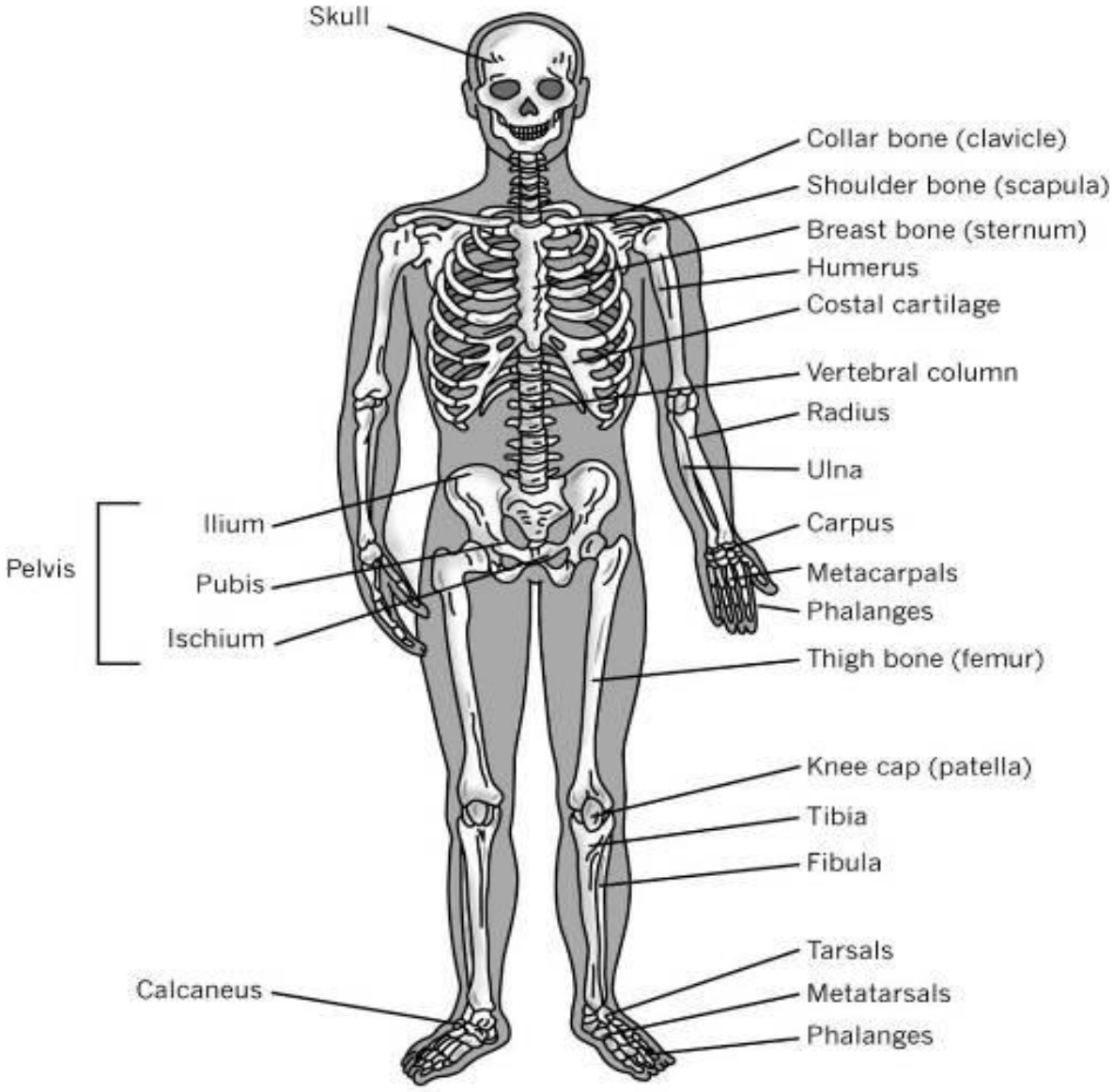
Muscles are attached to bone, cartilage, ligaments and to the skin:

- Under the skin = flat muscles
- Around the trunk = broad and flat muscles
- Around the limbs = long muscles

Muscles are generally attached to two parts of the skeleton and act in groups to perform movements of the different parts of the skeleton

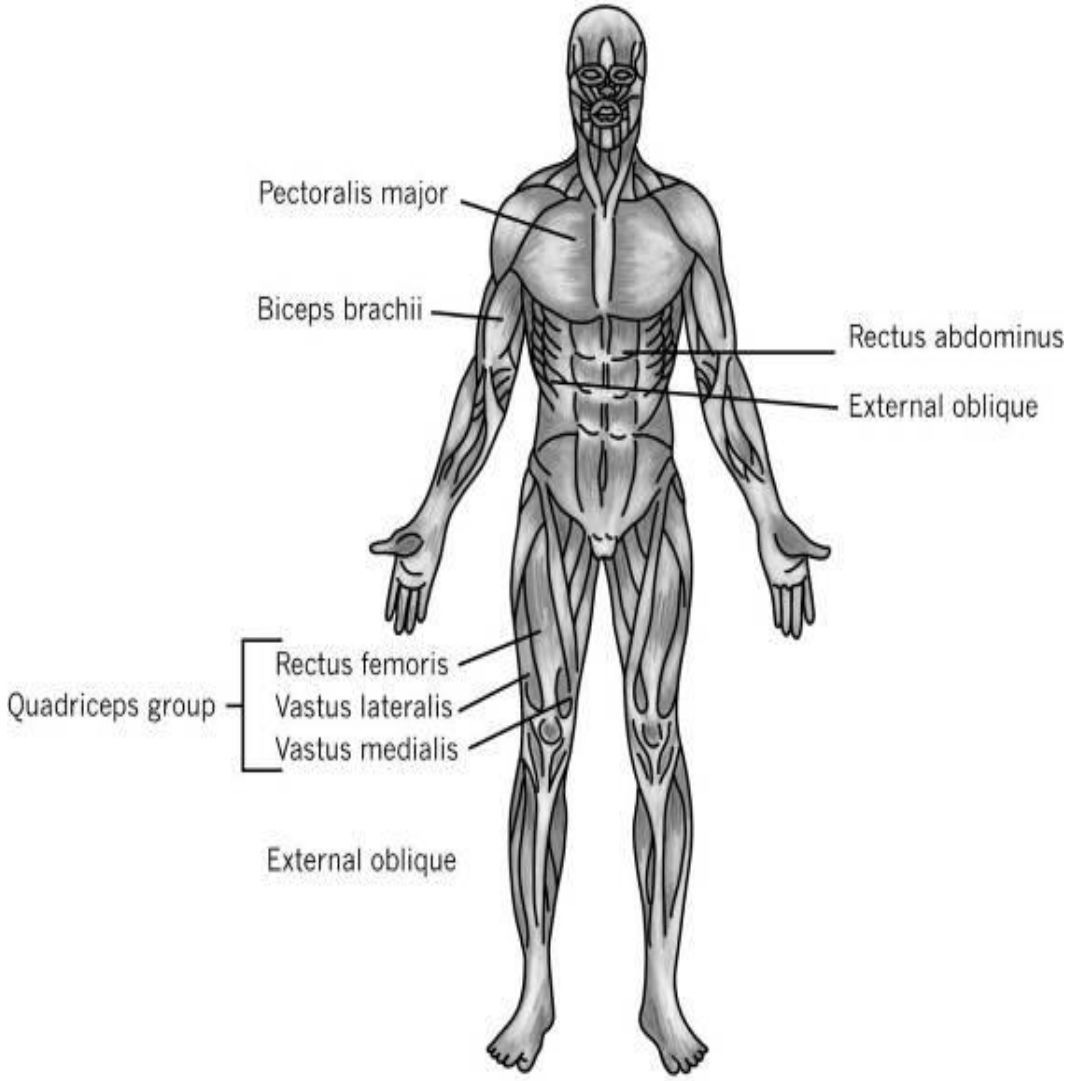
Tendons bind muscles to the bone

Pectoral Muscles - The pectoral is a term relating to the chest. The "pectoralis major" is a large, fan-shaped muscle that covers much of the front upper chest. Its main use is in moving the arm across the body. The "pectoralis minor" is a smaller, triangular muscle beneath the pectoralis major. It stems from the third to fifth ribs and converges at the shoulder blade (scapula), which it moves up and down.



Abductor Muscles - Abduction refers to movement of a limb away from the central line of the body or of a digit away from the axis of a limb. Muscles, then, that carry out this type of movement are called "abductor muscles."

Adductor Longus - The adductor longus is a long, triangular muscle that runs from the pubic bone to the femur. It functions to adduct, or move the thigh inward, and assists in flexing and rotating it to the side.



Biceps Brachii - Some muscles have more than one origin (immovable end) or insertion (movable end). The "biceps brachii" in the upper arm, for example, has two origins. This is shown in its name, "biceps," which means "two heads." It is attached to the scapula (shoulder blade) in two places and extends along the front surface of the humerus (upper arm bone). It is inserted by means of a tendon on the largest part of the radius (lower arm bone). When it contracts, the movable end is pulled toward the origin, and the arm bends at the elbow.

Brachialis - The brachialis is a large muscle beneath the biceps brachii. It connects the shaft of the humerus (upper arm bone) to the ulna (longest) forearm bone) and is the strongest flexor of the elbow.

Brachioradialis Muscle - The brachioradialis connects the humerus (upper arm bone) to the radius (shortest lower arm bone) and aids in flexing the elbow.

Sternocleidomastoid Muscle - The sternocleidomastoid is a long muscle in the side of the neck that extends up from the thorax to the base of the skull behind the ear. When the sternocleidomastoid on one side contracts, the face is turned to the opposite side. When both muscles contract, the head is bent toward the chest. If the immovable end is fixed in position by other muscles, it can raise the sternum (breastbone) - an action which aids in forceful inhalation of air.

Ageing and musculoskeletal changes

With increasing age, changes in muscle mass and bony structures alter posture, gait, height and weight.
Curvature of the spine, enlarged joints and decreased height occur in the elderly.
Bones become thinner, and the amount of bone mineral is reduced. Osteoporosis is an increasing porosity and fragility of the bones and for hormonal reasons is more common in older women.

Muscle wasting causes the older person to be weaker than a younger person and joints tend to become stiff, so flexibility is not as good.

The older person may therefore have a tendency to:

- Slower and more shaky movement
- Slower reaction times
- Poorer balance so falls are more common
- Less precision in fine movements – writing may be harder to read
- A shuffling gait and a hunching of the shoulders
- Break bones more easily

Additional resources – Skeletal system
http://www.innerbody.com/image/skelfov.html

Support routines: musculoskeletal changes

The support worker and other members of the care team can support the resident with musculoskeletal problems, by care routines which may include:

Ensuring clients retain as much mobility as possible: ongoing review of a client's mobility capacities by a physiotherapist is important in assisting individual clients to retain maximum mobility.

Assisting residents to undertake appropriate exercise: Exercise regimes are commonly part of residential programs – particularly in hostels. However, even for clients who are bedfast, passive exercise assists these residents to maintain muscle tone and condition.

Allowing sufficient time for activities of daily living so that clients are not hurried.

Provision of a safe environment where the risk of falling is as low as possible. We know that falls prevention is a major focus of frail aged care. One of the most effective methods for preventing serious injury associated with falls, is the use of hip protectors. These are a specially designed pair of underwear pants with inserts for light weight protector pads.

Endocrine system

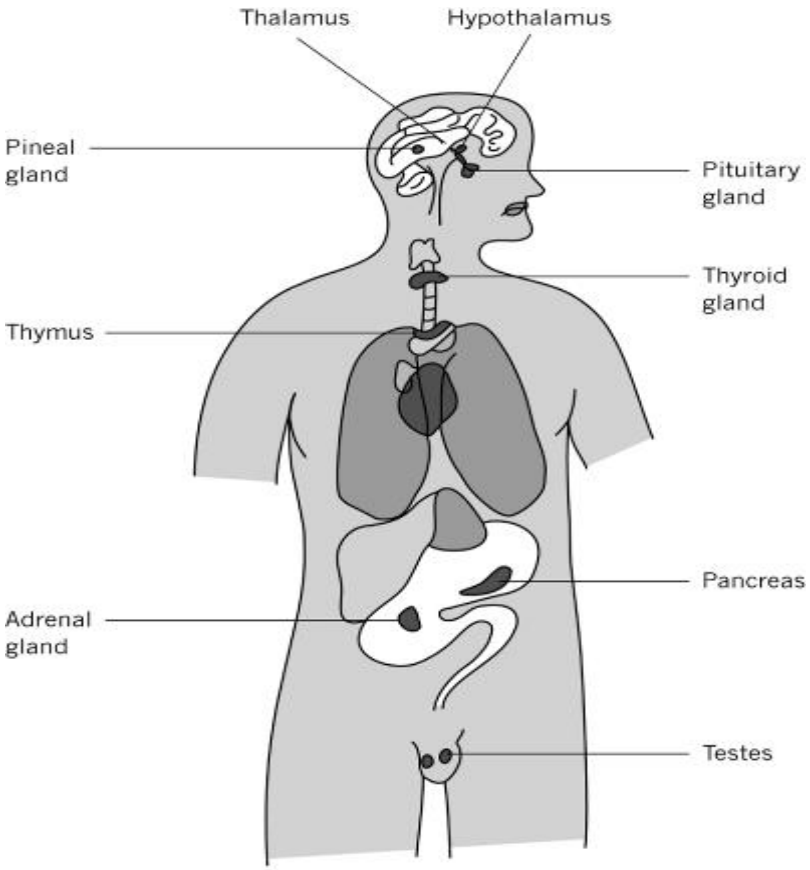
The endocrine system is a system of glands, each of which secretes a hormone to regulate the body.

The pancreas has a role in hormone production as well as in digestion.

Hormones regulate many functions of an organism, including mood, growth and development, tissue function, and metabolism.

The major glands are:

- The hypothalamus,
- Pituitary,
- Thyroid,
- Para thyroid's,
- Adrenals,
- Pineal body and the reproductive
- Organs (ovaries and testes).



Glands of the endocrine system

Hypothalamus
Is linked to metabolism and body temperature.

Pituitary

- Controls many functions of other endocrine glands.
- Is located in the centre of the skull just behind the bridge of the nose
- Is the size of a pea
- Is an important link between the nervous system and the endocrine system and releases many hormones
- Which affect growth, sexual development, metabolism and the system of reproduction.

Thyroid
Regulates the body's metabolism and helps maintain normal blood pressure, heart rate, digestion, muscle tone, and reproduction.

The adrenals

- The outer part (adrenal cortex) regulates metabolism, the balance of salt and water, the immune system, and
- Sexual function.
- The inner part (adrenal medulla) help the body cope with physical /emotional stress by increasing the heart
- Rate and blood pressure.
- Sit on each side of the kidney
- The adrenal gland receives the hormones produced by the pituitary and produces more of its own in response
- To growth and development requirements as well as the "fight or flight" responses.

Parathyroids
Are four small oval bodies located on either side of and on the dorsal aspect of the thyroid gland play a role in regulating calcium levels in the blood and bone metabolism

Pineal body
The pineal gland may help regulate the wake-sleep cycle of the body

Endocrine pancreas
Secretes hormones of insulin and glucagon (these hormones regulate the level of glucose (sugar) in the blood).

Reproductive organs
Ovaries and testes are the main source of sex hormones.

Thymus

- Forms part of the immune system
- Is located in the upper part of the chest, behind the breastbone
- Is made up of two lobes that join in from of the trachea
- Its function is to transform lymphocytes (white bloods cells developed in the bone marrow) into T-cells (which are developed in the thymus)
- These cells are then transported to various lymph glands why they plan in important part in fighting infections and disease.

Ageing and changes in the endocrine system

The older person may have a tendency to:

- Susceptibility to diabetes melitis, particularly if the person is overweight
- Susceptibility to decreased blood pressure
- Tiredness and difficulty regulating temperature
- Alterations in the secretion, circulating levels, metabolism, and biologic activity of hormones
- A decrease in the secretion of the growth hormone causes a decrease in the muscle mass and an increase in the storage of fat
- A decline in hormone production reduces the anti-inflammatory and immunosuppressive qualities. This means that the elderly is more prone to pain and infections

Support routines: endocrine changes

Care routines which may include:

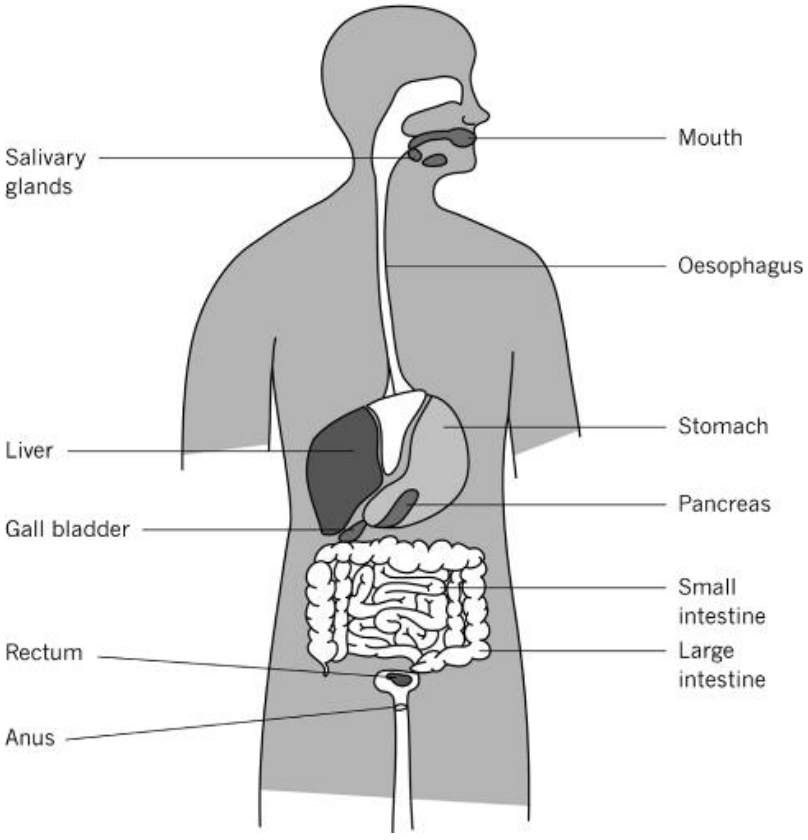
- Assistance in regulation of diabetes
- Assistance in temperature regulation
- Measuring of blood pressure

Digestive system

The primary purpose of the gastrointestinal tract is to break down food into nutrients, which can be absorbed into the body to provide energy

The gastrointestinal system consists of:

- Oral cavity
- Salivary glands
- Oesophagus
- Stomach
- Small intestine
- Large intestine
- Liver
- Gall bladder
- Pancreas



Each of the organs within the gastrointestinal system are listed below:

oral cavity

- The tongue, a strong muscular organ, manipulates the food bolus to come in contact with the teeth. It has specialised sensors known as papillae for touch, temperature and taste.

Salivary glands

Each pair of salivary glands secretes saliva with slightly different compositions. Salivation occurs in response to the taste, smell or even appearance of food.

Oesophagus

The oesophagus extends from the pharynx to the stomach and functions primarily as a transport medium.

Most of these functions are achieved by the secretion of gastric juices by gastric glands.

Functions of the stomach

- The short-term storage of ingested food
- Mechanical breakdown of food by churning and mixing motions
- Chemical digestion of proteins by acids and enzymes
- Stomach acid kills bugs and germs
- Some absorption of substances such as alcohol

The small intestine

- Consists of the duodenum, jejunum, and ileum
- Is compressed into numerous folds and occupies a large proportion of the abdominal cavity
- Performs most of the digestion and absorption of nutrients
- Digested food from the stomach is further broken down by enzymes from the pancreas and bile salts from the Liver and gallbladder.

The large intestine

Consists of the appendix, caecum, colon, and rectum.

The functions of the large intestine include:

- The accumulation of unabsorbed material to form feces
- Some digestion by bacteria. the bacteria are responsible for the formation of intestinal gas
- Re-absorption of water, salts, sugar and vitamins

The liver

The liver has several important functions:

- Acts as a mechanical filter by filtering blood that travels from the intestinal system.
- Produces albumin and blood clotting factors.
- Produces bile and metabolises nutrients.

Gall bladder

Main function - storage and concentration of bile – a fluid that contains enzymes to help dissolve fat in the intestines.

Pancreas

- The pancreas has both exocrine and endocrine functions
- Endocrine refers to production of hormones which occurs in the Islets of Langerhans
- The Islets produce insulin, these are the areas damaged in diabetes mellitus
- The exocrine (secretory) portion makes up 80-85% of the pancreas and is the area relevant to the Gastrointestinal tract.

Ageing and gastro-intestinal (digestive system) changes

The older person can suffer considerable discomfort and loss of lifestyle quality due to the effects of ageing on the gastro-intestinal system.

Typically, with age, ingestion is less efficient with decreased and thicker saliva; and sometimes with teeth and mouth problems.

The stomach functions less efficiently and there is a decrease in gastric juice and digestive enzymes. Also, there is usually a reduced blood flow to the intestines which reduces absorption of nutrients.

Slower peristaltic action of the intestines due to the decreased muscle tone makes them sluggish. This can result in constipation.

Many older people have a poorer tolerance to certain foods, particularly lactose in milk and milk products. Fat absorption and absorption of fat-soluble vitamins decreases and other minerals, such as calcium, may be used less efficiently.

The older person, therefore, may have a tendency to:

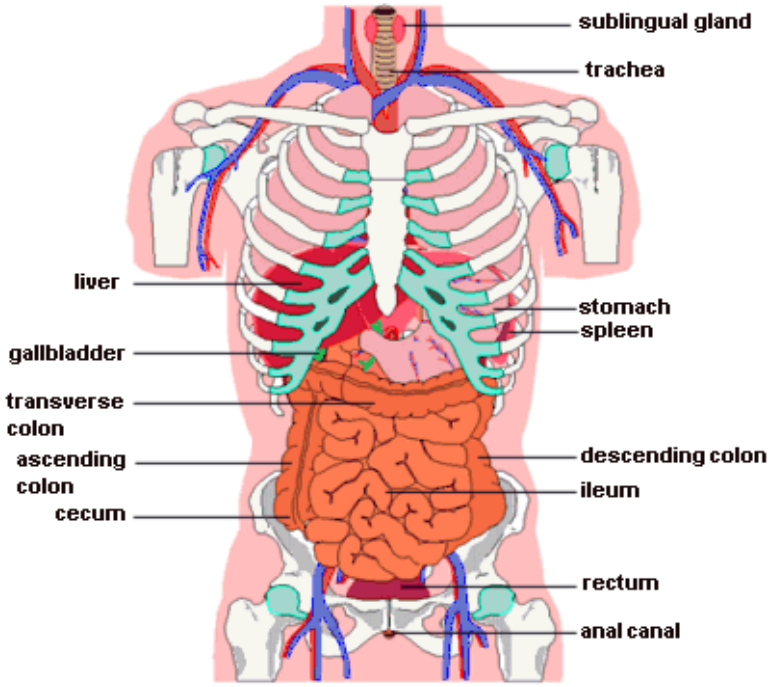
- Constipation
- Poor digestion
- Lack of vitamins/minerals
- Declining appetite
- Oral problems
- Bloating and wind
- Nausea

Support routines: gastrointestinal changes

The support worker and other members of the care team can support the resident with gastro-intestinal problems, by care routines which may include:

- An adequate and varied diet
- Provision of appetising food with adequate roughage
- Good oral hygiene
- Care of teeth/false teeth
- Medication for indigestion and constipation is taken as necessary
- Vitamins/minerals are administered as recommended by the doctor or clinical nurse
- Raising the bed head for sleeping, if gastric reflux is a problem

If the client is bedfast or has swallowing difficulties, you need to ensure that the client is upright (a) during the meal; and (b) after the meal for the period of time designated in the Care Plan.



In chronic conditions, swallowing difficulties may be experienced. A speech pathologist will usually be consulted, and care strategies considered such a vitamising food, use of food/fluid thickeners and specially designed mugs.

Urinary system

The structure of the urinary tract includes: the kidneys, two ureters, (tubes leading from the kidneys to the bladder,) and the urethra, a tube leading from the bladder to the exterior of the body. The urinary tract is a little like a plumbing system, with special pipes that allow water and salts to flow through them. The kidneys make up a filter system for the blood, reabsorbing almost 99%% of the fluid into the blood, and sending only two to four pints of waste (urine) into the bladder for storage until it can be disposed of.

The kidneys' main function is to produce urine. The urethras are muscular tubes that propel urine from the kidneys to the urinary bladder.

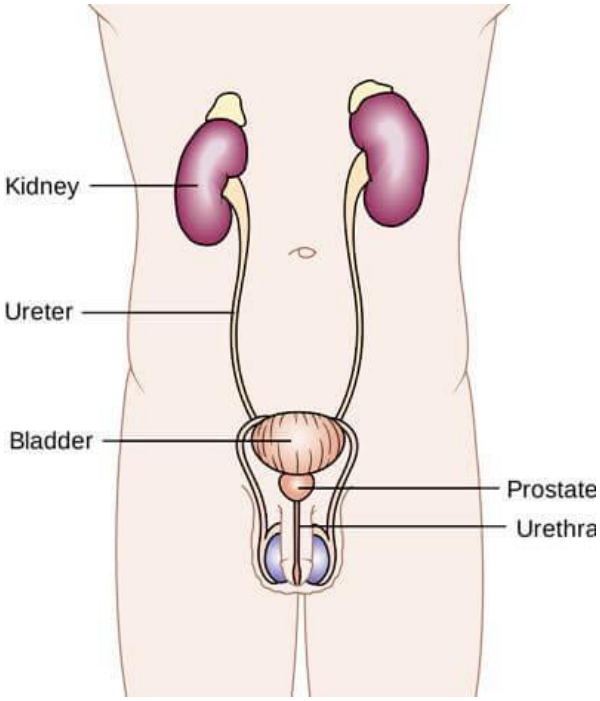
The urethra is a tube which connects the urinary bladder to the outside of the body:

- In males, the urethra carries semen/urine.
- The bladder is the organ that collects urine excreted by the kidneys prior to disposal by urination.
- Urine enters the bladder via the ureter and exits via the urethra.

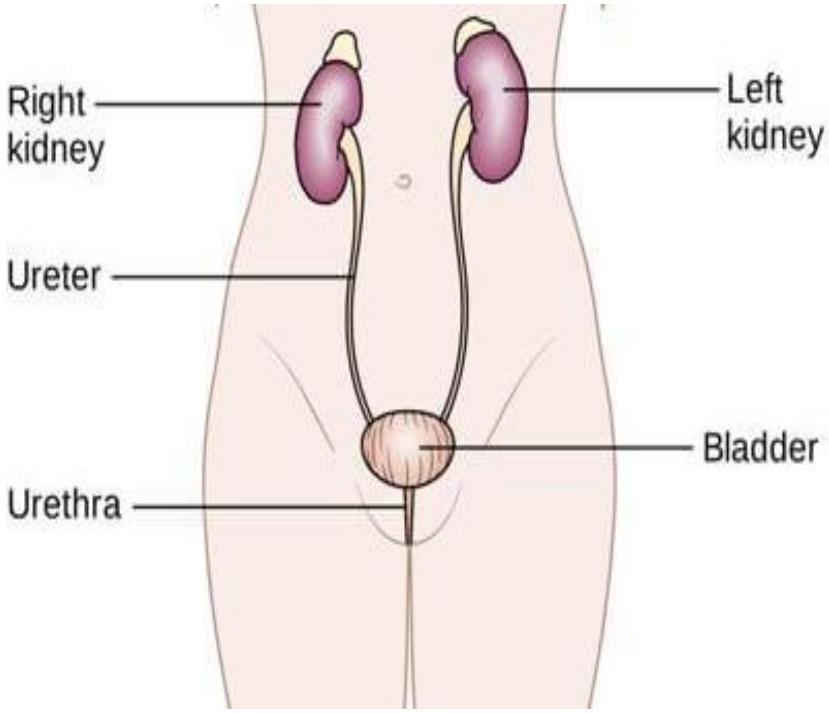
The urinary system includes:

- Kidneys
- Urethras
- Ureters
- Bladder

The Male urinary system



The Female urinary system



i	**Additional resources – Digestive System** http://www.innerbody.com/image/urinov.html

Ageing and urogenital system changes

Age related changes here include:

- Decreased function and efficiency of the kidneys. The kidneys decrease in size, scars replace renal cells and renal concentration is poorer with nocturia.
- Loss of urinary bladder muscle tone. The bladder capacity decreases and the bladder wall becomes increasingly irritable. Bladder emptying becomes less efficient and filtration ability is reduced which gives a susceptibility to urinary infections.
- enlarging of the prostate in men

The older person therefore may have a tendency to:

- decline in bladder capacity
- have incontinence
- have stress incontinence (leakage of urine) especially in women
- have an enlarged prostate and bladder dysfunction in men
- have kidney and urinary infections

Support routines: urogenital system changes

Care routines which may include:

- Establishment of toileting schedules
- Control of fluid intake
- Encouragement to increase fluid intake
- Provision of appropriate aids for incontinence
- Exercise as appropriate
- Emptying urine bags in line with the facility's infection control procedures
- Care of catheter lines and bags when transferring or turning residents

Reproductive system

The reproductive system is a collection of internal and external organs — in both males and females — that work together for the purpose of procreating.

The male reproductive system includes;

- Testes
- Penis
- Urethra
- Sperm ducts

Additional resources – Anatomy of the male reproductive system
http://www.innerbody.com/image/repmov.html

The penis and urethra belong to both the urinary and reproductive systems in males.

The female reproductive systems have internal and external sections which includes;

- Clitoris
- Labia minora
- Labia majora
- Bartholin's glands
- Vagina
- Uterus
- Ovaries
- Cervix
- Fallopian tubes

Additional resources – Anatomy of the female reproductive system
http://www.innerbody.com/image/repfov.html

Diseases of the female and male reproductive system

Many parts of the male and female reproductive systems can be affected by cancer. In females, cancer can attack the uterus, ovaries, breast and cervix, among other organs. Of male-specific diseases of the reproductive system, prostate cancer is the most common, but men can also suffer from testicular and penile cancer

Both genders can develop sexually transmitted diseases, including genital herpes, gonorrhoea and syphilis, according to the National Institutes of Health (NIH). HIV/AIDS, a disease of the immune system, is not exclusively transmitted through sexual contact; sexual activity is one of the ways that the HIV virus is spread.

Age related changes here include;

For men:

- Change in fertility called andropause
- Erectile dysfunction

For women:

- Menopause
- Prolapse

Additional resources
Aging changes in the male reproductive system, visit; https://medlineplus.gov/ency/article/004017.htm
Aging changes in the female reproductive system, visit; https://medlineplus.gov/ency/article/004016.htm

See also; Male reproductive system:
www.youtube.com/watch?v=qCXG_ZfqAks
https://swsi.moodle.tafensw.edu.au/mod/book/view.php?id=457911&chapterid=95068

Female reproductive system:
https://www.youtube.com/watch?v=SkcddD0LGlM&feature=related
https://www.youtube.com/watch?v=ptCW_W07pzk

Integumentary system

The integumentary system includes:

- Skin
- Hair
- Nails
- Sweat glands
- Oil glands

Skin is the outside covering of body tissue, which protects inner cells and organs from the outside environment. The skin is the largest organ of the body, and its cells are continuously replaced as they are lost to normal wear and tear. The skin totals between twelve and twenty square feet in area and accounts for 12% of body weight.

The skin

- Protects the body from external factors
- Regulates temperature, protects the body from dehydration
- Waterproofs, cushions and protects the deeper tissues
- Excretes waste through perspiration

The skin has two principle layers:

- **Epidermis**: the thin inner layer
- **Dermis**: the thicker outer layer

The thickness of the epidermis and the dermis varies over different parts of the body. It is thickest on the palms of the hands and feet, where friction is needed for gripping, and it is thinnest on the eyelids, which must be light and flexible. The epidermis also grows into fingernails, toenails and hair. The dermis, or true skin, is thick, sturdy, rich in nerves and blood vessels and in sweat glands. It shields and repairs injured tissue. This layer consists mostly of collagen, which originates from cells called fibroblasts and is one of the strongest proteins found in nature. It gives skin durability and resilience.

Ageing and the integumentary system

- The epidermis and dermis thin and the elastic fibers decrease in size.
- The skin becomes weaker and starts to sag, forming wrinkles.
- Melanocytes decrease production of melanin, and the skin becomes pale and hair turns grey/white.
- Sweat decreases causing the skin to become drier.
- Blood supply to the skin is reduced and body temperature cannot be regulated as well.

In general, the elderly have special skin care needs because aging skin is so thin and dry. If it becomes too dry, it is prone to cracking and dermatitis, which allows for penetration of bacteria that can result in infection. The elderly should: Avoid hot baths and frequent showers.

i	**Additional resources – Preventing serious skin conditions** http://www.parentgiving.com/elder-care/seniors-and-skin-health/ https://www.youtube.com/watch?v=yKAzVC0WcmI&feature=related

Lymphatic system

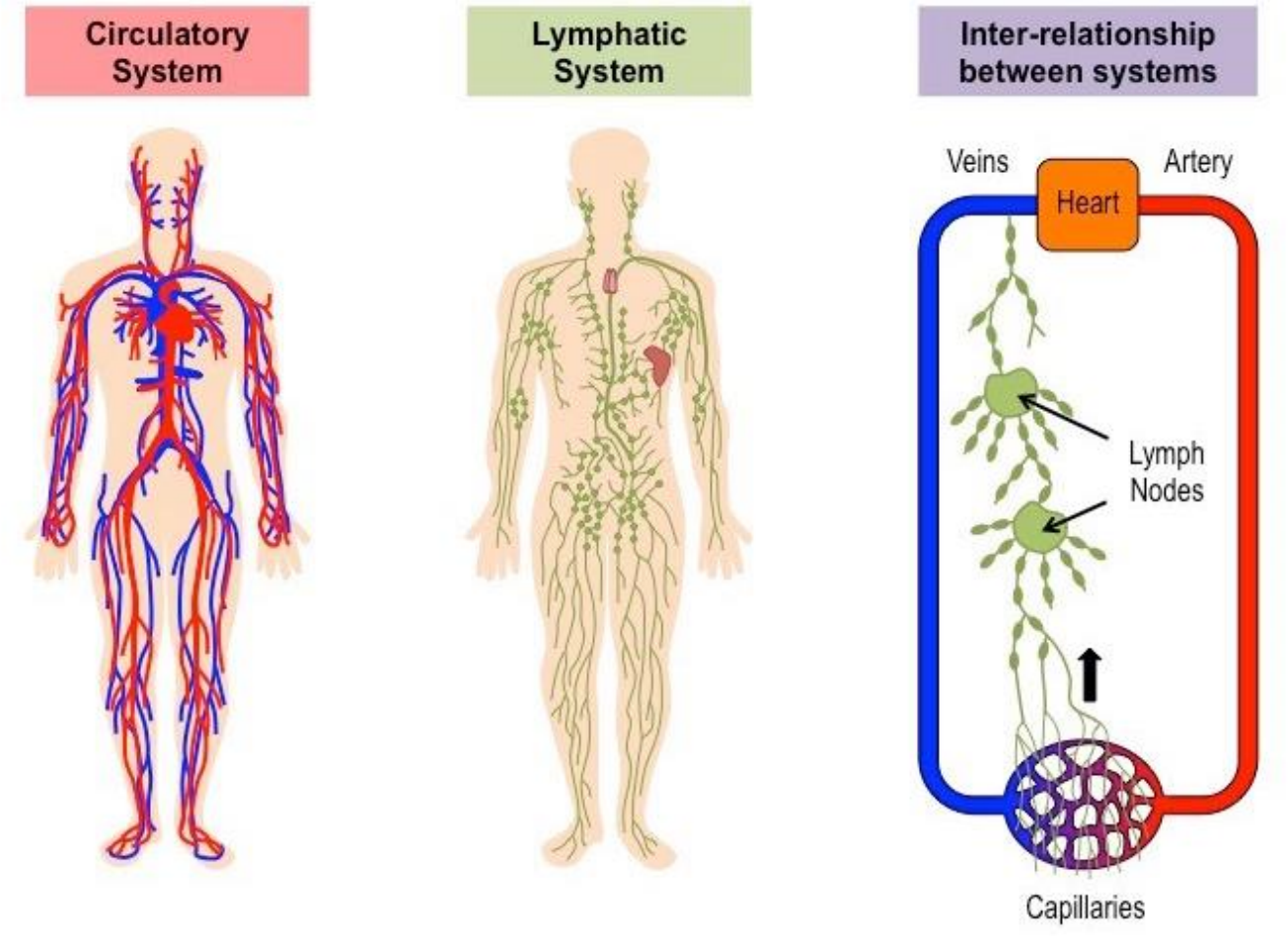
The lymphatic system and the cardiovascular system are closely related structures that are joined by a capillary system. The purpose of the lymphatic system is to protect the body from disease and drain fluids from body tissue back into the blood circulation.

Key structures of the lymphatic system are:

- The spleen
- Lymph nodes and lymph ducts
- The thymus
- Tonsils
- Red bone marrow

Ageing and the lymphatic system

- Increased susceptibility to diseases
- Increased susceptibility to infections
- Increased fluid retention

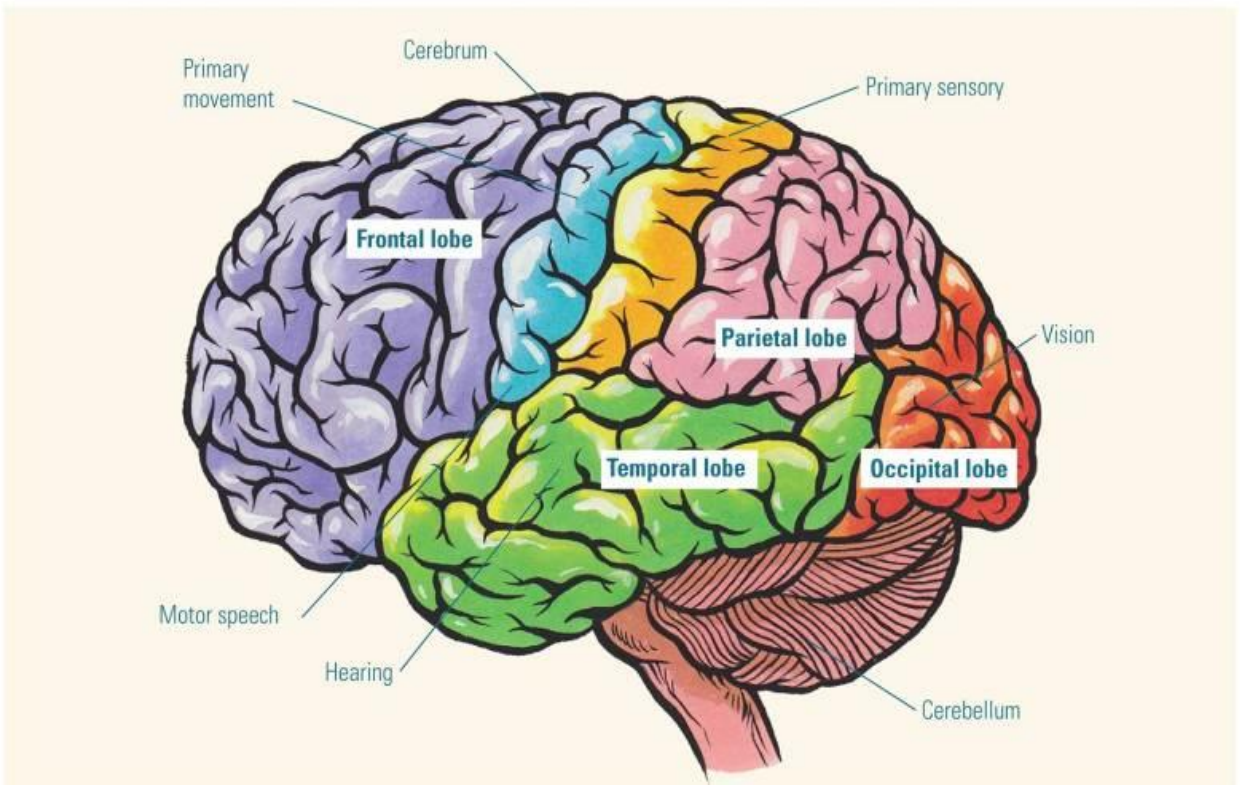


i	**Additional resources – Lymphatic system** http://www.innerbody.com/image/lympov.html

Nervous system, including sensory systems – eye and ear

The nervous system consists of:

- The central nervous system: the brain and spinal cord
- The peripheral nervous system: sensory neurons, clusters of neurons called ganglia, and nerves connecting them to each other and to the central nervous system



The Brain

Helps to control all of the body systems and organs
Is composed of three parts:

1. **The cerebrum** is divided into left and right hemispheres, responsible for perception, imagination, thought, judgment, and decisions
2. **The cerebellum** – muscle coordination, maintains normal muscle tone, posture and balance
3. **The medulla oblongata** - regulation of heartbeat, breathing, vasoconstriction (blood pressure), and reflex centers for vomiting, coughing, sneezing, swallowing

i	**Additional resources – Inside the brain** http://www.alz.org/alzheimers_disease_4719.asp

The spinal cord

Connects to the brain and has nerves that branch off from the spinal cord into the arms, legs, and torso. It is ssurrounded by cerebral spinal fluid which acts as a cushion.

There are two types of nerves within the spinal cord:

- Ascending tracts carry information from the body, upwards to the brain, such as touch, skin temperature, pain, joint position
- Descending tracts carry information from the brain downwards to initiate movement and control body functions

The peripheral nervous system

The peripheral nervous system:

- Acts as a connector to the central nervous system
- Is comprised of neurons that transmit information to and from the brain

The peripheral nervous system has two parts:

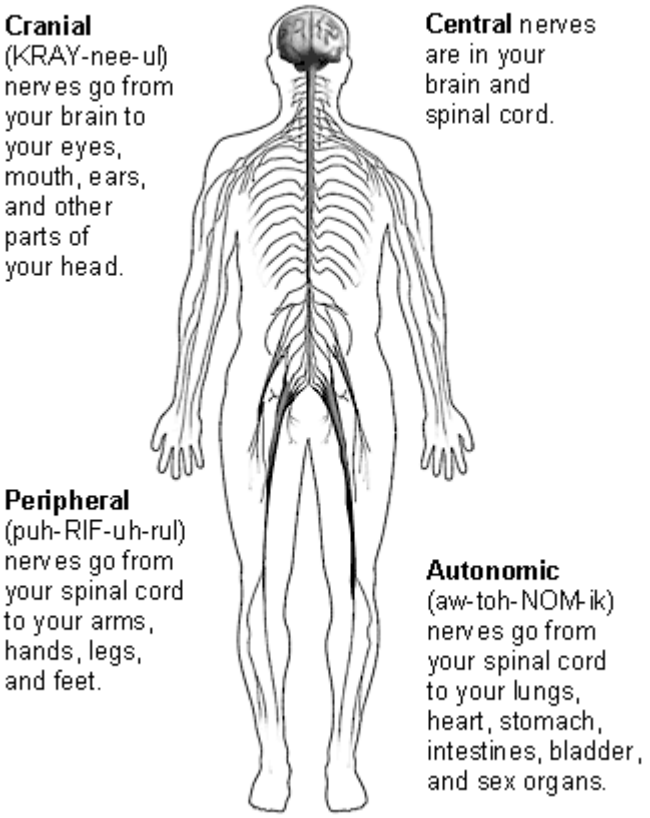
- The somatic nervous system
- The autonomic nervous system

The somatic nervous system

- Comprised of cranial nerves and spinal nerves.
- Supply the muscular system and external receptors – enables movement.
- Controls sense of touch, taste, sight, sound and smell.
- Causes the body to feel heat, cold, and pain.
- Controls involuntary actions.

The autonomic nervous system

- Comprised of sympathetic and parasympathetic nervous systems.
- Controls and regulates the body internally.
- Conveys impulses to and from the sensory organs and brain.
- Is in control when the body is at rest.
- Regulates internal processes.



i	**Additional resources – Nervous system** http://www.innerbody.com/image/nervov.html

Ageing and changes to the nervous system

With increasing age, the blood flow to the brain decreases, some neurones are lost, and end organs degenerate. This tends to slow reaction times, as cerebral processing is slower. Although synthesis of information is slower, intelligence does not decrease. There may be some memory changes, particularly in short-term memory. These changes can really distress older people. Encouragement and cues to prompt their memory can help.

The older person has a tendency to:

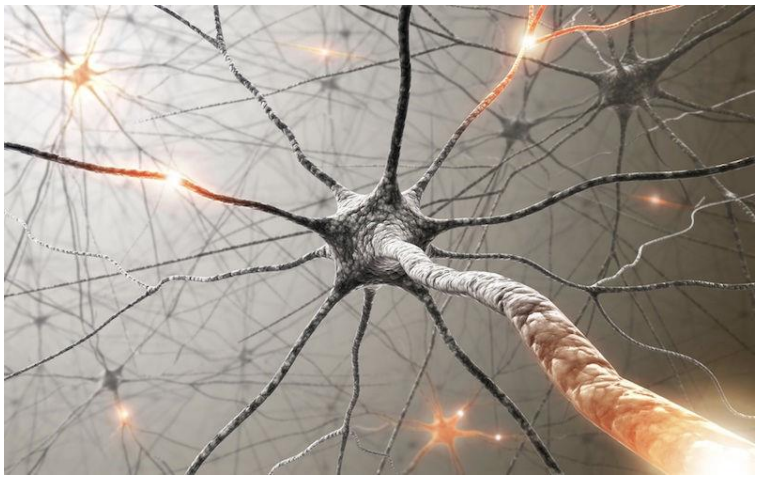
- Have some short-term memory difficulties and be more forgetful
- Become more preoccupied with the past
- Be less sensitive to pain
- Have slower reflexes and decreased sensory perception

Confusion and dementia are specific diseases of the Central Nervous System that can occur in the aged person, causing specific and urgent needs to be met.

Support routines: neurological changes

Clients may need:

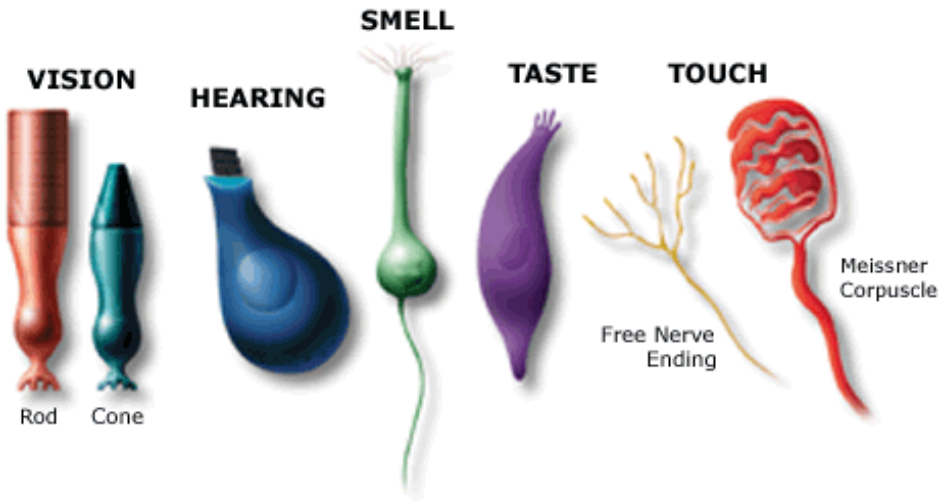
- Reminding clients of tasks, such as outings, appointments, taking medication, etc.
- Being patient when clients forget or repeat things
- Allowing and encouraging reminiscing



The special senses

The special sense organs include:

- Taste
- Smell
- Sight
- Hearing
- Touch

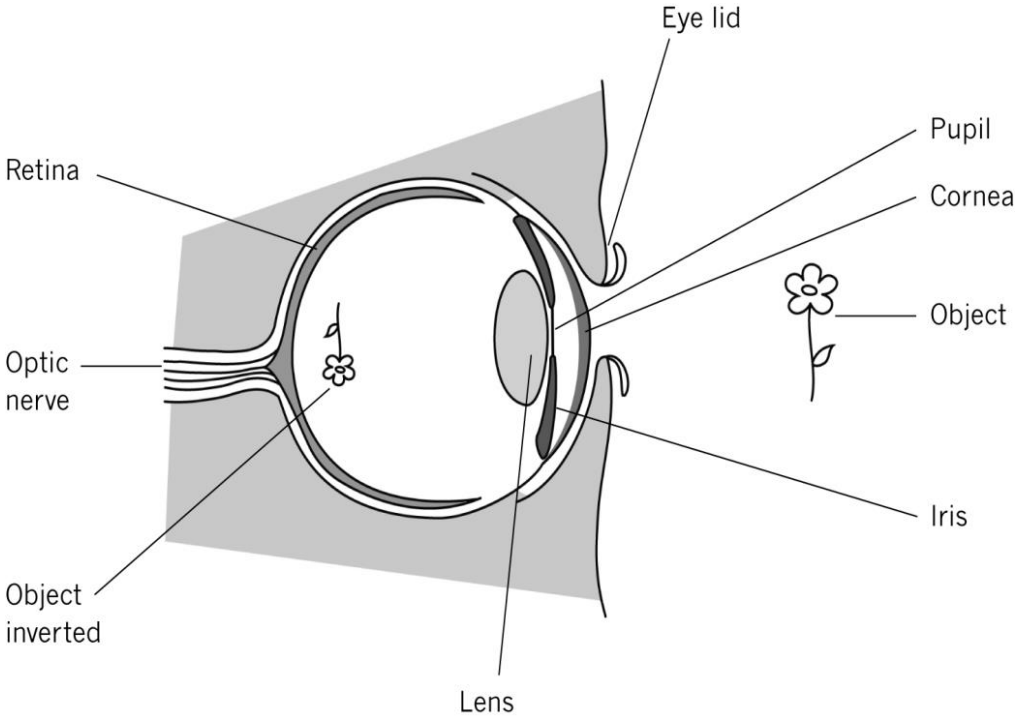


Our senses shape our view of the world and transmit those impulses to the brain which trigger an adaptive response.

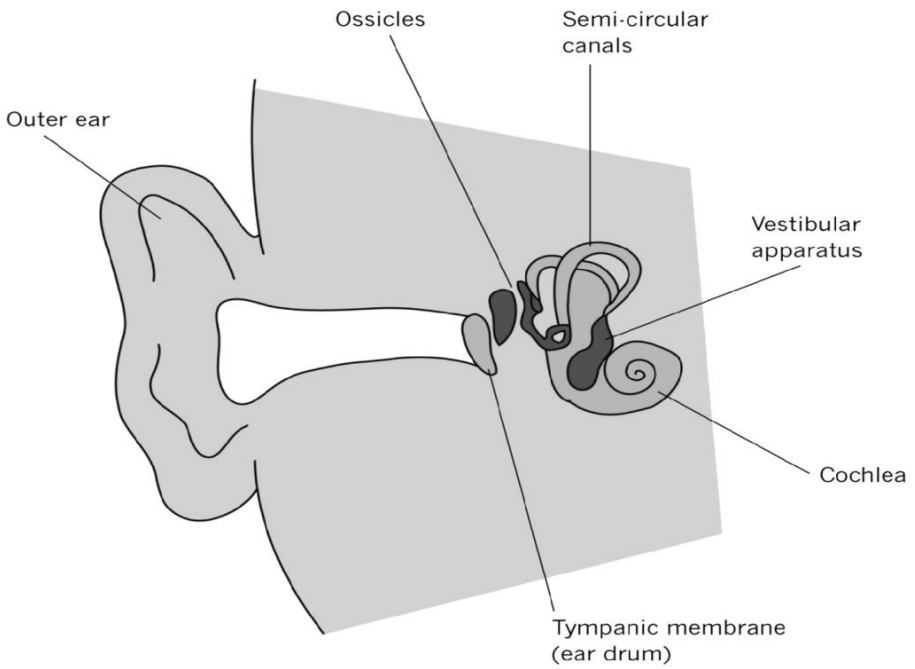
- Taste – tongue with numerous taste buds
- Smell – olfactory organs of the nose are stimulated
- Sight –the retina is stimulated by light rays and transmits them to visual centers of the brain via the optic nerve
- Hearing – the outer ear directs sound waves to the middle ear to the eardrum which vibrates, and the sound waves are carried by the auditory ossicles to the opening of the inner ear. The membrane of the inner ear causes fluid to move which stimulates the cochlea with sound sensations which are carried to the temporal lobe of the cerebrum. the inner ear also has three semi-circular canals associated with maintaining balance
- Touch – results from stimulation of nerve endings in the skin.

The purpose is to keep the body aware of external forces, so they can protect themselves.

The Eye



The Ear



Ageing and the special sense organs

- Ageing and changes in taste
- Taste buds atrophy over the years and lose efficiency in relaying flavour sensation.
- The taste buds at the front of the tongue are the first to go.
- Salt taste may be lost early followed by bitter and sour.
- Sweetness discernment may also be lost early.
- The reduced taste-bud sensitivity to sour, salt and bitter is further retarded by the reduction in saliva production.

Ageing and changes in smell

The decline starts about 60, though there is wide variability.

Ageing and changes in touch

- Touch is diminished.
- There is a thinning of the epidermal skin layer and a loss of elasticity and a loss of subcutaneous cushioning fat.
- With this and a reduction in the numbers of sensory receptors under the hardening, thinning skin leads to a general loss of acuity in the sense of touch.
- This leaves the older person open to lack of sensitivities of all kinds, including temperature changes, textures, dryness and wetness.
- Bruising, cuts and scratches may occur without them noticing and there is a danger of over exposure to sun.

Ageing and changes in vision

- Major changes in vision include decreased visual acuity, decreased tolerance to light, plus decreased ability to adapt to dark and light, and decreased peripheral vision.
- Elderly people have a poor discrimination of the 'cooler' colours – the blues and greens. 'Warmer' colours – the reds, yellows and oranges – can help older people cope better with their environment. The elimination of glare is also important.

Ageing and changes in hearing

Major changes in hearing include the progressive loss of hearing with ageing – high frequency sounds may be lost, which causes speech to sound distorted. This is frustrating for the elderly and can cause social problems of withdrawal and depression and can cause the appearance of confusion.

Ageing and changes in the special senses

There may be a tendency in the older person to:

- Be unable to focus on near objects
- Be sensitive to bright light
- Hear conversation less well, affecting communication and socialisation
- Have difficulty regulating temperature
- Be less aware of pain, resulting in bruising or burning easily
- Be less enthusiastic with eating as taste and smell diminishes

Support routines: neurological and special sense changes

The support worker and other members of the care team can support the resident with neurological and special sense organ problems, by care routines which may include:

- Ensuring clients have appropriate glasses, and that they carry them with them and use them or have access to magnifiers
- Ensuring that clients glasses are clean
- Checking that clients are not bothered by glare in their rooms or in the living areas
- Provision of a bright and cheery environment
- Provision of comfortable seating
- Ensuring clients wear and maintain hearing aids
- Communication is clear and allows for sufficient time for clients to process what is being said
- Checking that withdrawn behaviour is not due to hearing difficulties
- Provision of an appropriate diet with food that is well prepared and tasty
- Taking care of nails and hand/foot care.

- Fingernails and toenails in particular can be the site of infection.
- They need to be kept clean and appropriately clipped.
- A podiatrist is usually a member of the care team –both in residential and HACC service delivery.
- The podiatrist should determine the care strategies for nail and foot care.
- Skin and treating cuts and bruises: this raises the important issue in aged care of maintaining skin integrity and overcoming pressure sores

Immune system

The immune system is the body's defence against infectious organisms and other invaders. The body employs many different types of immunity to protect itself from infection from a seemingly endless supply of pathogens. Through a series of steps called the immune response, the immune system attacks organisms and substances that invade body systems and cause disease.

These defences may be external and prevent pathogens from entering the body. Conversely, internal defences fight pathogens that have already entered the body. Among the internal defences, some are specific to only one pathogen or may be innate and defend against many pathogens. Some of these specific defences can be acquired to pre-emptively prevent an infection before a pathogen enters the body.

External defences:

- Coverings and linings of the body preventing infections before entering the body
- Secretions like sebum, cerumen, mucus, tears and saliva are used to trap, move and sometime skill bacteria
- Stomach acids act as a chemical barrier to kill microbes found on food entering the body
- Urine and acidic vaginal secretions kill and remove pathogens that attempt to enter the body
- Natural beneficial bacteria that live on our bodies provide protection

Internal defences

Fever

In response to an infection, the body may start a fever by raising its internal temperature out of its normal homeostatic range. Fevers help to speed up the body's response system to an infection while at the same time slowing the reproduction of the pathogen.

Inflammation

The body may also start an inflammation in a region of the body to stop the spread of the infection. Inflammations are the result of a localised vasodilation that allows extra blood to flow into the infected region. The extra blood flow speeds the arrival of leukocytes to fight the infection. The enlarged blood vessel allows fluid and cells to leak out of the blood vessel to cause swelling and the movement of leukocytes into the tissue to fight the infection.

Natural Killer Cells

Natural killer (NK) cells are special lymphocytes that are able to recognise and kill virus-infected cells and tumour cells. NK cells check the surface markers on the surface of the body's cells, looking for cells that are lacking the correct number of markers due to disease. The NK cells then kill these cells before they can spread infection or cancer.

Phagocytes

The term phagocyte means "eating cell" and refers to a group of cell types including neutrophils and macrophages. A phagocyte engulfs pathogens with its cell membrane before using digestive enzymes to kill and dissolve the cell into its chemical parts. Phagocytes are able to recognise and consume many different types of cells, including dead or damaged body cells.

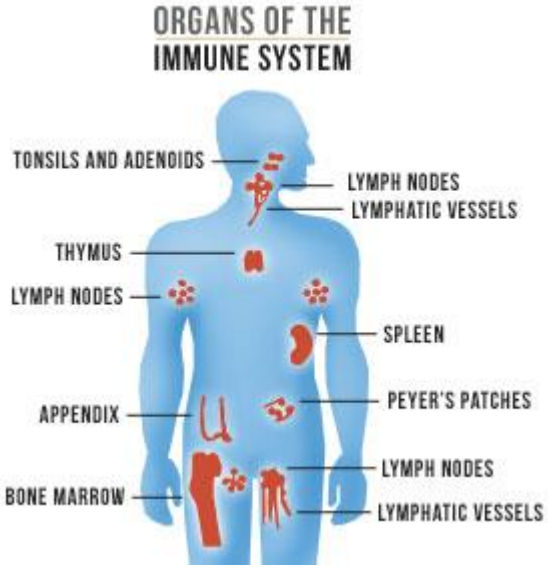
Cell-mediated Specific Immunity

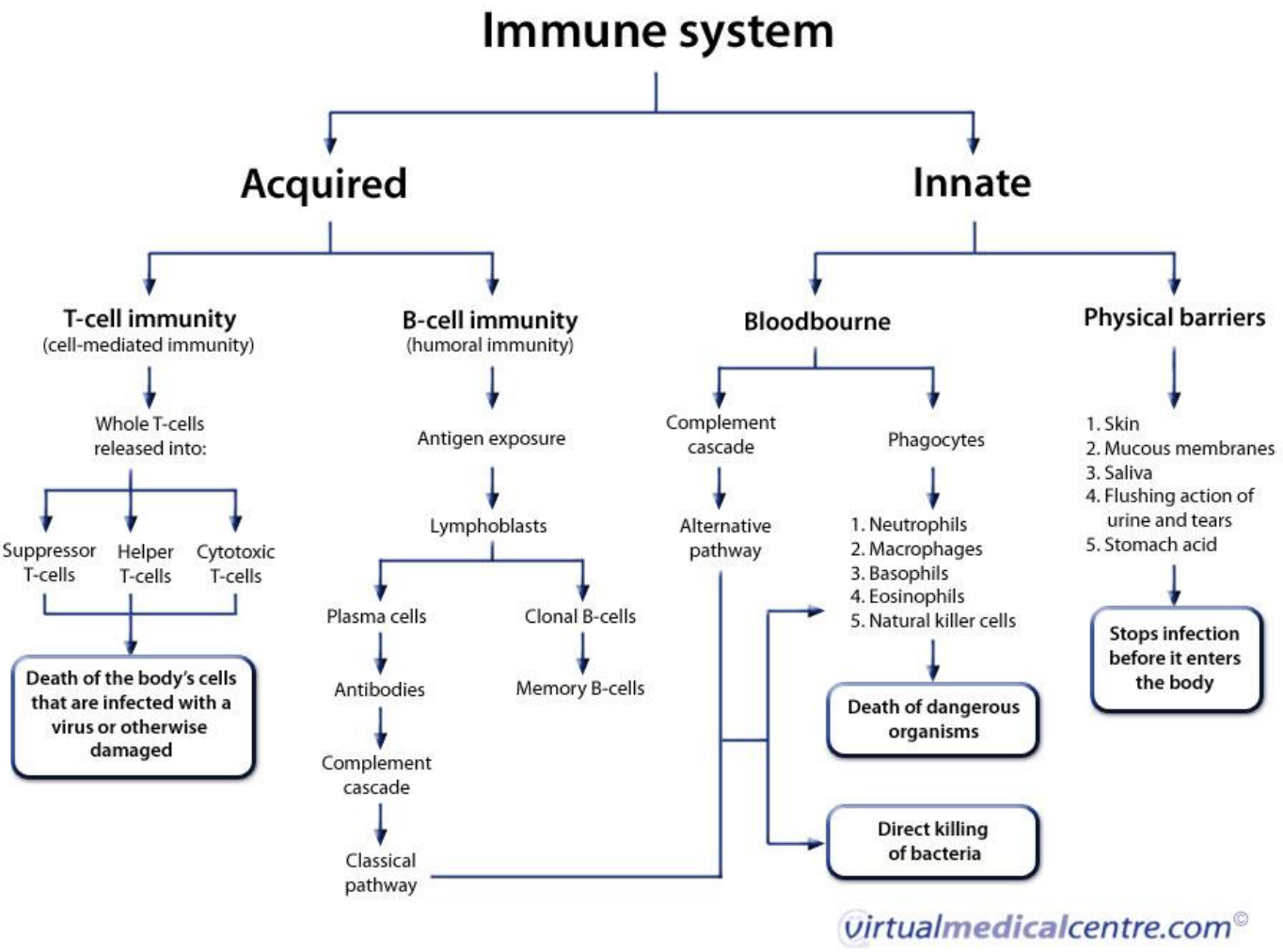
When a pathogen infects the body, it often encounters macrophages and dendritic cells of the innate immune system. These cells can become antigen-presenting cells (APCs) by consuming and processing pathogenic antigens. The APCs travel into the lymphatic system carrying these antigens to be presented to the T cells and B cells of the specific immune system

To help the immune system stay healthy, ensure clients:

- Have 7 – 8 hours' sleep
- Eat healthy and drink water
- Get fresh air and exercise
- Are free from bacteria

If clients have a low level of immunity, make sure that they are not exposed to allergens or people with infectious diseases.
Check if clients' skin is damaged in any way, recognise and report this. Make sure hands are washed and if water is not available a suitable hand sanitising gel should be made available.





Interrelationships between body systems

Each of the body systems and the organs and structures that make up these systems, are designed to perform specific complex functions. All of the systems work together to ensure the healthy survival of the human body, and the immune system protects the body from disease, infection and illness. The interrelationship between body systems becomes more obvious when a disease or illness affects one body system and other systems are also affected. While you are not expected to have a full understanding of how the body systems work together, it is important to have some knowledge of the interrelationships of the systems.

For example; The cardiovascular system is responsible for transporting blood throughout the body. It works in conjunction with the respiratory system to help move oxygen throughout the body

Interactions the cardiovascular systems have with other body systems

Respiratory – The cardiovascular system helps the respiratory system transport gases.
Musculoskeletal – The cardiovascular system delivers and removes material to and from the musculoskeletal system.
Endocrine – The cardiovascular system transports hormones for the endocrine system.
Nervous – The cardiovascular system delivers oxygen and hormones to and from the brain and spinal cord.
Digestive – The cardiovascular system transports nutrients for the digestive system.
Urinary – The cardiovascular system helps maintain kidney function.
Reproductive – The cardiovascular system helps with the blood flow needed to maintain and sustain an erection.
Integumentary – The cardiovascular system controls sweat production.
Lymphatic – The cardiovascular system provides the lymphocytes for the lymphatic system

Secondly the respiratory systems are responsible for ensuring the body has sufficient oxygen intake to oxygenate the blood and that it expels carbon dioxide. The respiratory interacts with the body by providing oxygen to the entire body and moves carbon dioxide from cells.

Element 2: Recognise and promote ways to support healthy functioning of the body

Support workers are often involved in helping clients carry out activities of daily living (ADLs). These activities include assisting the people with general mobility, such as moving in bed or moving from bed to chair, to helping with grooming, showering, dressing or eating. Undertaking these activities means that a support worker is in very close contact with the people they care for. As a result, they will be able to notice changes in things such as skin condition, respiration, swallowing, temperature, weight and behaviour.

Support workers need to understand how the body systems function, so they can recognise and report signs that suggest there may be a problem. Support workers also need to know about the factors that help people maintain a healthy body, so they can help older people, and those in need of care, to maintain their health.

Factors that contribute to maintenance of a healthy body

Leading a healthy lifestyle is a complex task, as there are many factors contributing to overall health. Achieving and maintaining your health requires you to not only make sure you do certain things, but also avoid making unhealthy decisions.

Common decisions that contribute to unhealthy lifestyles include;

- Smoking
- Getting little sleep
- Poor eating habits
- Drinking too much alcohol
- Having too much stress
- Low physical activity

i	**Additional resources – Unhealthy lifestyle practices** http://keeplog.net/common-unhealthy-lifestyle-practices/

There are five key factors to a healthy lifestyle. These factors greatly influence the health of physiology in terms of both the mind and body.

1. Diet
2. Physical activity
3. Sleep
4. Fun
5. Keep mentally active

Keeping a balanced diet

To maintain a balanced diet, you should try to eat a variety of foods from different groups. This means trying to eat:

- Fruit and vegetables – two serves of fruit and five serves of vegetables every day
- Foods such as bread, cereal, rice, potatoes, pasta and other starchy foods, preferably wholegrain or wholemeal
- Milk and dairy foods – use low fat milk and yoghurt and hard cheeses
- Meat, fish, eggs, beans such as broad beans, soybeans and lentils and other non-dairy sources of protein
- Fish – at least two portions a week, including one portion of oily fish such as trout, salmon and sardines
- Smaller amounts of food and drink that are high in fat or sugar.

Physical activity

Physical activity is defined as any bodily movement produced by skeletal muscles that requires energy expenditure. Physical inactivity has been identified as the fourth leading risk factor for global mortality causing an estimated 3.2 million deaths globally.

Regular moderate intensity physical activity – such as walking, cycling, or participating in sports – has significant benefits for health. For instance, it can reduce the risk of cardiovascular diseases, diabetes, colon and breast cancer, and depression. Moreover, adequate levels of physical activity will decrease the risk of a hip or vertebral fracture and help control weight.

There are two types of physical activity; passive and active. During active exercise, a person contracts and relaxes muscles directly while during passive exercise the muscles are moved by an outside force, such as another body part, a machine or another person. Passive exercise is useful for maintaining and increasing range of motion as part of a rehabilitation program.

Active exercises require exertion to move the muscles. This includes stretching to improve range of motion, resistance training to build muscle mass, and aerobic exercises in which the muscles move the body to increase the heart rate. Active exercises are also useful in rehabilitation to develop nerve pathways and make it easier to control action. Active exercises provide more benefits than passive exercises and are preferred in the rehabilitation process when not contraindicated by health conditions or ability.

Passive exercises require no effort on the part of the person exercising. A helper or machine moves the body to work the muscle. In rehabilitation programs, the goal of passive exercises is increasing range of motion and joint function while preventing muscle stiffness and loss of tissue. Regular passive exercise also reduces muscle spasms in some patients with neurological damage. Passive exercises are part of the rehabilitation process for many patients following joint replacement surgery or while recovering from stroke or paralysis.

i	**Additional resources – Physical activities** http://www.who.int/topics/physical_activity/en/ http://health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-food-index.htm http://health.gov.au/internet/main/publishing.nsf/Content/ECBF57CB49827C0BCA2575820004650C/$File/pa-guidelines.pdf

Stay Mentally active

Forgetfulness and problems with remembering things are a normal part of growing older. The mind does slow down as a result of ageing, but this isn't the case for everyone. Some people notice a decline in their fifties, but others remain mentally sharp into their nineties.

Older people still have the ability to learn new things and acquire knowledge when older, but it may take a little longer to do so. For instance, look at the number of older people who use the Internet or a mobile phone. It may take them a bit longer to learn how to do so but they get there in the end.

Activities like this and others, such as crosswords and quizzes can all give the brain a 'mental workout'.

i	**Additional resources – Healthy lifestyle** http://www.medic8.com/healthguide/elderly-care/healthy-lifestyle.html

Protection from infection

What is infection control?

Infection control is the prevention of the spread of micro-organisms. Infections can spread through contact with body fluids that are airborne, ingested, on the skin, or on other surfaces.

According to the World Healthcare Organisation (WHO), at any given time 1.4 million people are suffering from an infection acquired in a hospital and care facilities are not excluded.

Infection control is an important risk management consideration for all aged and community care services. The spread of infection can have seriously negative consequences for the health of clients and workers, as well as on the ability of the organisation to deliver services.

Residential and community care services are required to have effective infection control programs in place, including policies and practices that cover:

- Implementation of 'standard precautions' where applicable
- Appropriate PPE e.g. gowns, gloves, masks
- Safe handling, use and disposal of sharps
- Hand washing and hand care
- Monitoring and instituting health surveillance where appropriate
- Keeping accurate health and immunisation records (where appropriate) for each member of staff
- Identifying and assessing the risks to staff and patients of microbiological and chemical hazards
- Appropriate control measures to avoid transmission of infection, including a suitable immunisation policy and post exposure protocols
- Ensuring staff are informed and trained with regard to safe working procedure
- Safe preparation, transportation and service of food
- Planning for the management of infection control incidents

Infectious agents

The presence of infectious agents creates an infection. Infectious agents may be:

- Bacteria – e.g. Escherichia coli (E coli), a common cause of Gastroenteritis;
- Virus
- Fungi – e.g. Candida species which can lead to Thrush; or
- Parasites

Factors that reduce resistance to infection

There are factors that increase the risk of a person contracting an infection. Some of these are:

- Poor nutritional state
- Age (very young and elderly)
- Stress
- Hereditary conditions
- Living conditions
- Lifestyle factors, past and present

The clients you work with will often present with one or more of these risk factors, so infection control is very important.

If clients have a low level of immunity, make sure that they are not exposed to allergens or people with infectious diseases.

Standard Precautions

A set of standards known as Standard Precautions have been developed to reduce the possible transmission of infection from one place or person to another place or person. It is important for care workers to treat all client body substances (e.g. blood, semen, tears, saliva, urine, faeces) as potentially infectious, regardless of the client's perceived infectious state.

Standard precautions include:

- Aseptic technique
- Personal hygiene practices especially washing and drying hands (e.g. before and after client contact)
- Use of personal protective equipment
- Techniques to limit contamination
- Surface cleaning and management of blood and body fluid spills
- Safe handling of sharps
- Safe disposal of sharps and other clinical waste
- Appropriate reprocessing and storage of reusable instruments

Additional precautions are designed to interrupt transmission of infection by these routes and should be used in addition to standard precautions. Additional precautions should be tailored to the particular infectious agent involved and the mode of transmission and may include:

- Allocation of a single room
- A dedicated toilet
- Additional use of PPE (personal protective equipment)
- Dedicated client equipment (e.g. to each client or as appropriate to work function)
- Special ventilation requirements
- Restricted movement of clients and health care workers

Safe Disposal of Contaminated Items

It is your responsibility to find out the correct procedures to dispose of contaminated items safely. This is part of your preparation for your workplace assessment. Read the relevant documents in your organisation's policy and procedure manuals. Ask your supervisor for guidance.

Examples of contaminated items that may need to be disposed of include:

- Body fluids and waste
- Continence pads
- Soiled linen
- Sharps

Maintaining a Clean and Tidy Environment

Maintaining a clean and tidy environment is critical to infection control. It is important to both the residential and home care setting.

Personal Health and Hygiene

Maintaining our own personal health and hygiene is important for three reasons:

1. It reduces the likelihood that you will pick up an infection from someone else or an object;
2. It reduces the likelihood that others will pick up an infection you may have; and
3. It reduces the likelihood that you may infect or re-infect yourself or clients from one body site to another.

Hand Care

- Intact skin is a natural defence against infection.
- Cuts and abrasions must be covered with a waterproof dressing.
- Care workers with dermatitis on their hands must seek medical advice.
- Hand lotion is to be used to prevent dryness, small tubes for individual use or a pump dispenser (not to be refilled) should be used.

Hand washing is the single most important procedure for preventing health care associated infections. It is prudent to encourage hand washing when health care workers are in doubt about the need to do so. Health care workers should be able to easily access hand washing facilities. When clean running water is inaccessible, non-water cleansers or antiseptics, such as alcohol-based hand rubs or foam provide an appropriate alternative. However, hands should be washed with soap and water if visibly soiled.

Hand Washing Policy & Procedure

Purpose:

To ensure all clients, staff and visitors are protected from infections that may be spread by touch.

Policy:

Management are to ensure that all staff are aware of the correct procedures for routine hand washing. Hand washing posters are to be displayed near all hand washing facilities. Gloves are not a substitute for hand washing.

All staff are to wash hands:

- Prior to and after touching a client
- If hands are soiled in any way
- Prior to starting work
- Before and after meal/recreation breaks
- Prior to handling food or drinks
- After handling anybody substance
- Prior to handling any medical equipment
- After treating a client
- Prior to and after handling individual client medications
- After removing gloves
- After going to the toilet or touching anything to do with the toilet
- After smoking

Procedure:

Routine Hand Washing

Hands need to be cleaned thoroughly with soap to remove dirt and micro-organisms.

Solution: Liquid soap (neutral Ph soap with no added substances which may cause irritation should be used) preferably containing an anti-microbial solution.

Time: at least 10 - 15 seconds

Area: Hands and wrists

1. Remove any rings or watch
2. Turn on the taps, warm water
3. Wet hands under running water then apply sufficient soap to lather
4. Follow set hand washing procedure as displayed on posters
5. Rinse all soap off hands under running water
6. Turn off tap with elbow or paper towel
7. Pat hands dry with paper towel

Evaluate how the relationships between different body systems affect and support healthy functioning

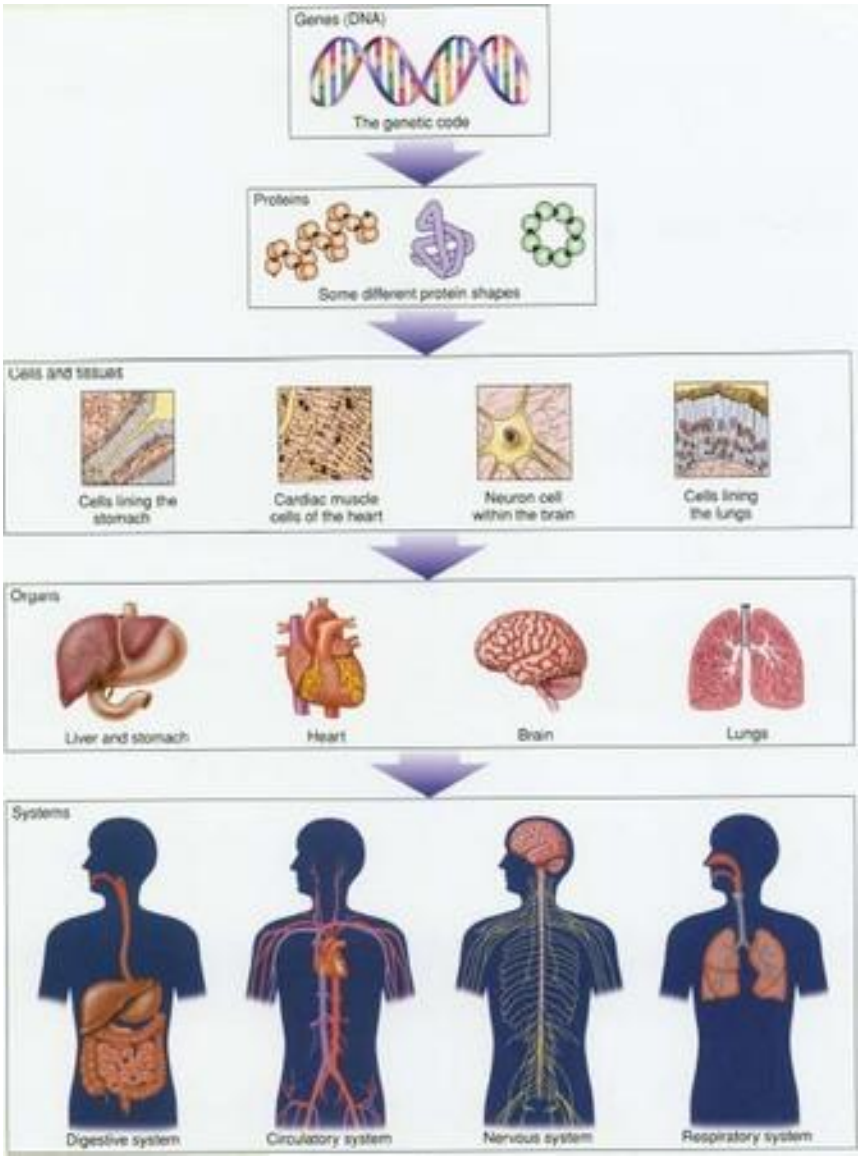
A system is a collection of parts that interact together for a common purpose. But a system is not just any old collection of parts. The parts are related in such a way that each depends on the others to do whatever job there is to be done. No single part can do the job alone, and any malfunction or delay is likely to affect the whole system.

A body system is a set of body parts that do a particular task. The human body itself is an example of a complex system—many sets of interacting parts that work to keep the human machine running. On any single day, we can estimate that your heart beats 103,689 times, your blood travels 168,000,000 miles, your digestive system processes 7.8 pounds of waste, and your lungs take in 438 cubic feet of air. These are only a few of the multitude of functions the human body performs.

As we have already discovered, the body systems interrelate with each other to ensure an organism functions normally. The brain receives information from other body systems to ensure proper functioning of the body. Examples of body systems include the circulatory system, digestive system, endocrine system, integumentary system, muscular system, nervous system, reproductive system, respiratory system, skeletal system and urinary/excretory system. Each system depends on others, either directly or indirectly.

In addition, there are processes and resources required by the body to support healthy functioning and body regulation. These include;

- Maintenance of body temperature
- Elimination of waste
- Fluid and Electrolyte (including PH) balance
- Blood pressure



Processes, conditions and resources required by the body to support healthy functioning body regulation

Maintenance of body temperature

Regulation of your body temperature is called thermoregulation. The hypothalamus is the processing centre in the brain that controls body temperature. It does this by triggering changes to effectors, such as sweat glands and muscles controlling body hair. Heat stroke can happen when the body becomes too hot; and hypothermia when the body becomes too cold.

In a neutral climate, at rest, your body regulates its temperature to around 37°C. This is by no means an exactly fixed temperature for all humans. When measured in the morning after bed rest, the average temperature of a large group of people will be around 36.7ºC, but individual values of healthy people will range from 36 to 38ºC. During the day, your temperature will increase, typically by about 0.8°C, peaking in the late evening. It will drop again until early morning due to the circadian rhythm (changes in bodily functions over the course of the day and night). Also, exercise will cause an increase in body temperature, with temperatures around 38°C typical for moderate work and values up to 39°C and occasionally above 40°C.

Heat is produced in your body by metabolic (chemical) processes, such as absorbing nutrients and performing muscular work. When at rest, your body needs all this heat to enable its basic functions to work properly. For example, to provide your body cells with oxygen and nutrients during breathing and digestion. When working however, the active muscles need more oxygen and nutrients, and your metabolic activity, and heat production increases.

In the cold, automatic closing down (constriction) of the blood vessels is not enough to maintain your temperature. Shivering produces additional heat. Opposing muscle groups are made to work against one another. This increase in activity increases the metabolic heat to between 2 and 4 times what it is at rest. Shivering is not enough to heat you up - it can only stop you from cooling down. The better physical condition you are in, the better you are at maintaining shivering without tiring, and therefore the better you would be at surviving cold stress.

Your body also needs to get rid of any excess heat it produces otherwise it will warm up to lethal levels. For example, if no cooling was possible, and you worked at moderate levels, your body temperature would increase by around 1°C every 10 minutes.

Healthy young adults adapt to temperature changes through various processes aimed at core body temperature maintenance. Sweating cools the body and shivering warms the body. Although there is variation among individuals, the elderly loses these thermoregulation functions, with reduced ability to sweat and shiver. Blood circulation problems increases thermodys regulation responses. Decreased thirst awareness affects body temperature in the elderly, as dehydration further reduces the body's ability to maintain a steady temperature.

Measures to prevent dangerous body temperatures when the weather is hot include drinking water, avoiding alcohol and caffeine, taking cool baths or showers, staying indoors during the heat of the day, using cooling fans or air conditioners and avoiding excessive exercise. Special care should be taken to keep the elderly warm in cold environments, including operating rooms.

If a person is unable to maintain their correct body temperature this can lead to complications such as organ/systems failure and/or damage.

You can help the client avoid high body temperatures by:

- Giving them plenty of water
- Getting them to wear appropriate clothes
- Giving them a cold shower or bath
- Getting them to stay inside
- Getting them to perform light exercise

Maintaining body fluids

The body systems that play a major role in maintaining body fluid are:

- The cardiovascular,
- Digestive and integumentary systems,
- The urinary system.

To maintain clients' body fluids their fluid intake must be adequate, applying a topical cream can also help improve skin moisture.

Fluid and electrolyte (including PH) balance

The kidneys are essential for regulating the volume and composition of bodily fluids. Water balance is achieved in the body by ensuring that the amount of water consumed in food and drink (and generated by metabolism) equals the amount of water excreted. The consumption side is regulated by behavioural mechanisms, including thirst and salt cravings. While almost a litre of water per day is lost through the skin, lungs, and faeces, the kidneys are the major site of regulated excretion of water.

Electrolytes are ions that form when salts dissolve in water or fluids. These ions have an electric charge. Positively charged ions are called cations. Negatively charged ions are called anions. Electrolytes are not evenly distributed within the body, and their uneven distribution allows many important metabolic reactions to occur. Sodium (Na^+), Potassium (K^+), Calcium (Ca^{2+}), Magnesium (Mg^{2+}), chloride (Cl^-), phosphate (HPO_4^{2-}), bicarbonate (HCO_3^-), and Sulfate (SO_4^-) are important electrolytes in humans.

Electrolytes play a critical role in almost every metabolic reaction in the body. For example, they:

- Help control water balance and fluid distribution in the body
- Create an electrical gradient across cell membranes that is necessary for muscle contraction and nerve transmission
- Regulate the acidity (pH) of the blood
- Help regulate the level of oxygen in the blood
- Are involved in moving nutrients into cells and waste products out of cells

Water is essential to life. Dehydration occurs when more water is lost from the body than is replaced. A loss of 20% of the body's water can be fatal. Water balance and electrolyte concentrations are closely intertwined. Dehydration is a major cause of electrolyte imbalances

Electrolytes, proteins, nutrients, waste products, and gasses are dissolved in fluid in the body. This fluid is not distributed evenly. About two-thirds of it is found inside cells (intracellular fluid). The rest is found in the spaces between cells (interstitial fluid), in the circulatory system, and in small amounts in other places such as the stomach. Changes in the concentration of electrolytes results in changes to the distribution of water throughout the body as water moves into or out of cells.

The components of body fluid—electrolytes, proteins, and so forth—are not evenly distributed either. Different types of cells have membranes that allow some electrolytes (and other components of the fluid) to pass across them while blocking others. This difference in the distribution of electrolytes (and thus electric charges) on either side of cell membranes makes it possible for many metabolic reactions to take place

Water passes easily across cell membranes. When fluid with two different concentrations of electrolytes is separated by a cell membrane, there is pressure (called osmotic pressure) for water to flow across the membrane from fluid that contains fewer electrolytes (less concentrated) into fluid that contains more electrolytes (more concentrated). The cell uses energy to resist osmotic pressure and maintain different concentrations of electrolytes on either side of the membrane because even small changes in the concentrations and distribution of electrolytes can result in large movements of water in and out of cells. Maintaining this difference, or gradient, across cell membranes is a major part of the complex regulatory events called homeostasis that keep conditions within the body stable within very narrow limits. When there is an imbalance in electrolytes many systems in the body are affected and serious, even fatal, health problems can result.

An electrolyte imbalance occurs when the concentration of a specific electrolyte is either too high or too low. The concentration of electrolytes is strongly affected by the amount of fluid in the body. Fluid balance is largely controlled by hormones that act on the kidneys and regulate how much urine the kidneys produce. The average male adult loses about 1.5-2.5 L of water daily through urine production, sweating, breathing out water vapor, and bowel movements depending on exercise levels and environmental temperature. The United States Institute of Medicine recommends that adult men drink a minimum of 3 L of liquids a day, and that women drink a minimum of 2.2 L to replace lost water

Dehydration is a major cause of electrolyte imbalance. It occurs whenever water is lost from the body and not replaced fairly quickly. When fluids are lost, electrolytes in those fluids are lost too, increasing the risk of electrolyte imbalance. Dehydration can be caused in many ways. These include:

- Heavy exercise, especially in hot weather. Sodium and water are both lost through the skin with heavy sweating
- Limited fluid intake. This is a particular problem with the elderly, especially those who are unable to walk or are bedridden
- Severe vomiting and diarrhea. Large amounts of water and many electrolytes that would normally be absorbed in the intestines are lost with diarrhea and vomiting. Small children with diarrhea can become seriously dehydrated in less than one day. Infants can become dehydrated within hours
- Severe burns. More water is lost from the surface of the body when the skin is not there to prevent evaporation, and damaged cells release their electrolytes into interstitial fluid, upsetting the electrolyte balance
- Electrolyte imbalances can have other causes unrelated to dehydration. These include:
- Kidney damage or kidney failure. This is a common cause of electrolyte imbalances in the elderly and can be fatal
- Anorexia nervosa (self-starvation) or bulimia nervosa (binge and purge eating)
- Excessive intake of water. Called water intoxication, this can result in swelling in the brain. In 2007, a Sacramento, California, woman died when she participated in a radio station contest that involved drinking large amounts of water in a short period of time
- Some drugs, herbal supplements, and chemotherapy. Some medications/treatments selectively increase the excretion of certain electrolytes, cause the body to retain excess water, or stimulate the kidneys to produce excess urine
- Hormonal imbalances in the production of hormones that regulate the kidneys. This causes too little or too much urine to be produced
- Cancer. Some tumours produce chemicals that upset electrolyte balance
- Abuse of electrolyte supplements

Elderly dehydration is especially common for a number of reasons:

Medications

It's not uncommon for seniors to be on several medications at any given time. Some of these may be diuretic, while others may cause patients to sweat more.

Decreased Thirst

A person's sense of thirst becomes less acute as they age. In addition, frail seniors may have a harder time getting up to get a drink when they're thirsty, or they may rely on caregivers who can't sense that they need fluids.

Decreased Kidney Function

As we age our bodies lose kidney function and are less able to conserve fluid (this is progressive from around the age of 50 but becomes more acute and noticeable over the age of 70).

Additional resources – Fluid, electrolyte and PH balance

http://www.wou.edu/~lemastm/Teaching/BI336/Unit%204%20-%20Water%20Balance%20(2).pdf
http://www.aplaceformom.com/senior-care-resources/articles/elderly-dehydration

Elimination of wastes from the body

When the Food is broken down or burned inside the Body, like every other kind of burning, produces two kinds of Wastes – "Smoke" and "Ashes."

The carbon dioxide "smoke", is carried in the Blood to the Lungs, where it passes off in the Breath.

The solid part of our Body Waste, or the "Ashes", is of two kinds

1. That which can be melted in water, i.e. Soluble Part
2. And that which cannot be melted in water or Insoluble Part.

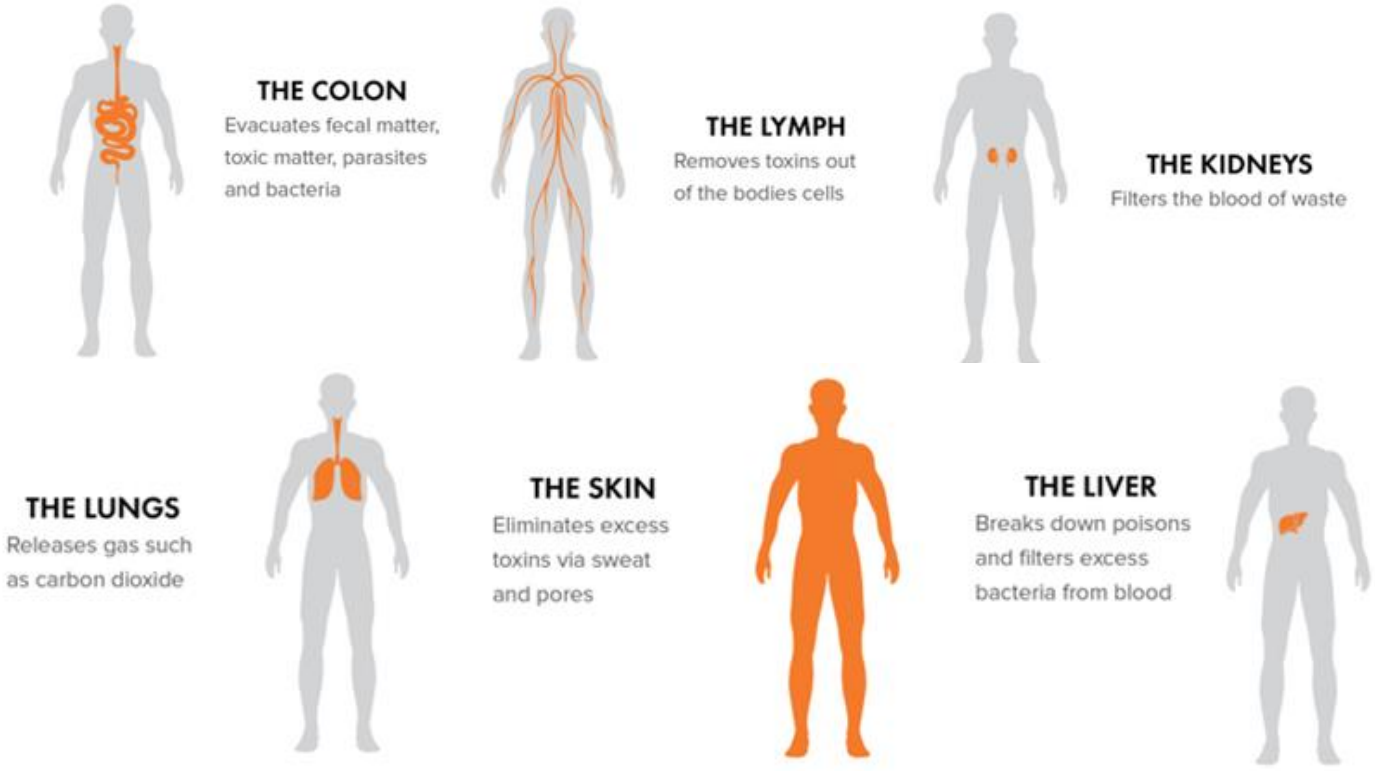
The Insoluble Part of our solid body waste goes into the faeces and is thus disposed of.

The soluble part of the body waste goes by a somewhat more roundabout route. With the Carbon Dioxide, it is poured by the Body cells into the veins, carried to the Heart, and pumped to the Lungs, where the Carbon Dioxide is thrown off. Going back to the Heart it is pumped all over the body, part of it going through a very large artery to the Liver, part through two large arteries to the Kidneys, part to the Skin, and the rest all over the remainder of the Body. The blood goes completely round the body-circuit from the Heart to the Fingers and Toes, and back again to the Heart, in less than 45 seconds.

The lungs, liver, and skin are the main non-renal system organs involved in waste excretion.

Main points of waste management systems include;

- The liver is a vital organ with a wide range of functions, including detoxification, protein synthesis, and the production of the biochemicals necessary for digestion.
- The liver converts waste into other substances, but does not remove it from the body directly.
- The skin has sweat glands that secrete a fluid waste called perspiration, or sweat, which is a pathway for water and ion removal from the body, among other things.
- The lungs diffuse gaseous wastes, such as carbon dioxide, from the bloodstream as a normal part of respiration



Additional resources – Body Waste

For more information, visit; https://www.boundless.com/physiology/textbooks/boundless-anatomy-and-physiology-textbook/urinary-system-25/urine-transport-storage-and-elimination-242/waste-management-in-other-body-systems-1187-5109/
information on what the body waste tells us about our health visit;
http://www.foxnews.com/health/2012/10/12/5-things-poo-tells-about-your-health.html
For information relating to thirst and temperature throughout palliative care, visit;
http://palliativecare.org.au/resources/the-dying-process/

Maintenance of blood pressure

Blood pressure (BP) is the pressure of circulating blood on the walls of blood vessels. When used without further specification, "blood pressure" usually refers to the pressure in large arteries of the systemic circulation. Blood pressure is usually expressed in terms of the systolic (maximum during one heartbeat) pressure over diastolic (minimum in between two heart beats) pressure and is measured in millimetres of mercury (mmHg), above the surrounding atmospheric pressure (considered to be zero for convenience).

Blood pressure is influenced by cardiac output, total peripheral resistance and arterial stiffness and varies depending on situation, emotional state, activity, and relative health/disease states. In the short term it is regulated by baroreceptors which act via the brain to influence nervous and endocrine systems.

Your blood pressure varies from day to day, even moment to moment. Most doctors would say that a healthy blood pressure is higher than 90/60 mm/Hg but lower than about 140/90. Optimal blood pressure is 120/80.

High blood pressure can pose serious health issues to clients. People with low blood pressure experience dizziness and confusion and are at risk of falls. People with high blood pressure are at risk of stroke, heart attack and kidney disease.

To help clients:

- Increase fluids
- Increase salts (low blood pressure)
- Encourage wearing of pressure stockings
- Elevate client's feet (low blood pressure)
- Encourage exercise and a healthy diet to maintain a healthy BMI
- Ensure medication is taken as prescribed

Additional resources – Lowering blood pressure

https://www.healthdirect.gov.au/what-is-a-healthy-blood-pressure

The human body is an incredibly complicated unit. The various systems work together to ensure the body has sufficient nutrition, sufficient oxygen, expels toxins and deals effectively with diseases and other pathogens that recognises and responds to pain.

If one or more of the systems is not functioning correctly, the other systems can be affected.

Processes, conditions and resources required by the body to support healthy functioning may include but are not limited to:

- Body regulation including
- maintenance of body temperature
- maintenance of body fluids (including e.g. absorption of water from digestive system, loss of water through skin, distribution of water by cardiovascular system)
- elimination of wastes from the body
- maintenance of blood pressure
- Protection from infection
- Physical activity - active and passive

Body regulation

Body regulation includes maintaining body temperature, body fluids and elimination of wastes.

The following are signs that the body is not regulating itself:

Changes in behaviour such as:

- Disorientation
- Feeling dizzy
- Change in temperature
- Increased heart rate
- Dry or hot skin
- Headache
- Unconsciousness
- Sweating

Poor regulation can lead to organ failure and death, if you suspect poor body regulation:

- Seek help – call nurse, doctor, supervisor, emergency services, depending on severity
- Follow workplace procedures and policies
- Document all actions
- Report all actions

Enhance quality of work activities by using and sharing information about healthy functioning of the body

The fundamentals of maintaining a healthy body include;

- Balanced nutrition
- Good hydration
- Physical activity/exercise
- Emotional and spiritual wellbeing
- Sleep and relaxation
- Avoid unhealthy substances
- Maintain a reasonable weight

To work in the sector, you need to have and apply a basic knowledge of the structure of the human body. To play a proactive role in assisting the elderly, people with disabilities and to improve their health and prevent illnesses you will need to have a good understanding of the structure, function and location of the major body systems, the terminology (words and phrases) used and the principles for maintaining a healthy body. This will also help you communicate effectively with other medical, allied health and welfare professionals involved in the care of the client. Understanding this information, using and sharing the information will assist you greatly in your role.

It is also important to understand how the body's systems work together to ensure that the body has sufficient nutrients, oxygen, expels toxins and deals effectively with disease and other pathogens. If you understand how the body works this will help you carry out arrange of tasks more effectively and efficiently as primary health care can help maintain the health of the body systems.

When we are young, we often are in a hurry to grow up because of the freedom to choose, which we like to think comes with being an adult. It may be hard to imagine that our bodies will ever be any different from what they are now. Yet just as the human organism grows from a single cell to a fully functioning person, over time it also begins to wear out or to malfunction—sometimes slowly, sometimes rapidly. Disability and disease are not a feature of the normal ageing process.

Some of the common changes that take place when ageing are:

- Change in appearance of skin and hair
- Reduced bone density
- Decrease in flexibility, damaged joints or decreased muscle strength
- Impaired taste, sensation, vision or hearing

These changes are caused by changes in the body systems; external factors also have an impact on the ageing process. For example, the behaviour of older people is often influenced by the attitudes of others; they may start to view themselves as less valuable and less worthy.

Physical changes can also result in psychological, psychosocial changes. For example, people that lose their hearing may avoid certain social settings, this decreases their interactions with the world. The connection between the mind and body should not be ignored; when delivering services to clients it is important to address factors that determine the quality of the client's life.

Working in the community services sector you can help provide holistic care by:

- Supporting them to participate in appropriate exercise
- Transporting them to social events
- Ensuring they have regular check ups
- Ensuring they eat a healthy range of foods
- Ensuring clients have and can use appropriate aids and equipment.

A number of simple strategies can be used to help clients maintain a healthy body, some of these are:

Having regular medical check-ups- can help improve quality of life, improve self-management of chronic disease, reduce anxiety and need to be hospitalised

Eating well – help clients overcome barriers such as low income, mouth or teeth issues, difficulty shopping so they can eat well. Suggest healthy meal choices, help with shopping, use support services, assist with meal preparation, assist with eating.

Exercising mentally and physically- work with client to identify exercise options, provide transport, exercise with clients, provide encouragement, provide clients with activities such as puzzles, crosswords, books, engage in conversation, encourage conversation with others.

Not smoking – refer clients to GP, link clients to organisations such as quit, support client to quit, provide educational material.

Drinking alcohol in moderation- recognise and report signs of alcohol abuse, provide referrals, support client.

Staying hydrated – provide fluids such as water, reduce alcohol and caffeine consumption, monitor/record fluids intake, seek medical help if client has diarrhea, vomiting or sweats excessively.

Maintaining a healthy weight, body mass index (BMI)- support the client so they eat healthy foods, encourage healthier choices, seek help, encourage exercise

Using aids safely – seek help from therapists or other health care professionals, help with maintenance.

Staying socially active and connected with others – create opportunities for clients to mete others, encourage this, organise activities, refer to psychologist if required

Sharing and using information about the healthy functioning of the body will enhance the quality of your work activities. Understanding the individual's current health status, will help ensure that they are receiving the care and support that meets their needs and you will be able to apply the correct care.

Providing support on how to maintain a healthy functioning body and mind, will provide opportunities for you to apply a positive perspective to the individual. For example; helping them maintain healthy body function by light exercise, encouraging social activities, enabling sleep and healthy eating will result in positive effects on the individual and therefore improve the quality of the individual's life.

Understanding the healthy function of the body, will also enable you to diagnose symptoms and situations quickly and accurately and provide information clearly and confidently to others which establishes trust and encourages open communication.

Further readings:

https://www.britannica.com/science/human-aging
http://www.wiley.com/legacy/Australia/PageProofs/SQ9_AC_VIC/c03SystemsWorkingTogether_WEB.pdf
http://www.humanillnesses.com/original/A-As/The-Human-Body-Systems-Working-Together.html
https://www.healthdirect.gov.au/anatomy
http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442454213
http://illawarratafe.libguides.com/indiv-support/topics/HLTAAP001
https://www.getbodysmart.com/

CHCCCS025 - Support relationships with carers and families

Welcome to the learning resource for the unit CHCCCS025 Support relationships with carers and families.

The focus of this unit is to apply the skills and knowledge required to work positively with the carers and families of people using the service based on an understanding of their support needs.

On completion of this unit you will have covered the requirements for:

1. Include carers and family members as part of the support team
2. Assess and respond to changes in the care relationship
3. Monitor and promote carer rights, health and well being

You will be able to demonstrate your ability to:

- Assessed and responded to the needs of at least 3 different people and their carers or family members
- Used strengths-based solutions to respond to both routine and unpredictable problems related to care relationships

You will gain knowledge about the:

- Context for caring in Australia:
    - Carer demographics
    - Carer support organisations and resources
    - Attitudes, stereotypes, false beliefs and myths associated with caring
    - Different pathways into service settings for the person and the implications for carers, families and friends
- Rights, roles and responsibilities of different people in the care relationship
    - The person
    - Family members
    - Friends
    - Support worker
- Impact of the caring role on family, carers and friends
- Different family patterns and structures and their impact on the person

Life cycle transitions:

- Types of transitions
- Positive and negative impacts

Current service delivery philosophy and models:

- Basic principles of person-centred practice, strengths-based practice and active support
- Strategies to work positively with families, carers and friends
- Organisation policies and procedures in relation to carers and families

Legal and ethical requirements for working with carers and families and how these are applied in an organisation and individual practice, including:

- Discrimination
- Privacy, confidentiality and disclosure
- Work role boundaries – responsibilities and limitations

A copy of the full unit of competency can be found at:
http://training.gov.au/Training/Details/CHCCCS025
This learning resource is designed to support your learning and act as a guide to further research. We encourage you to access other texts which include; standards and legislation and other resources relating to your industry that can be sourced throughout the internet or library.

Element 1: Include carers and family members as part of the support team

The fundamentals of a carers role

Working in community services means working with a wide range of different people. While a support workers primary focus in generally on the person with care needs, it is necessary to look more broadly at the client's situation to see who else is involved their care.

The carers role

A carer is defined as a family member, friend or neighbour who provides regular and sustained care and assistance to another person.

A carers role in society is crucial. Without the support of carers, many people with care needs would need a significant amount of extra support from external services which would place an impossible demand on the community and residential services available.

The roles that carers take in supporting the person they provide care for are quite varied. For some carers, the person may need help with things like getting from one place to another, doing their shopping, cleaning their house or preparing meals. For others, the person may need more intensive help with things like personal hygiene, mobility and medical procedures such as injecting medications, changing catheter or colostomy bags, or changing dressings.

The carers role is not an easy one and can include providing 24 hour care with high nursing needs.

Most carers give comfort encouragement and reassurance to the person they care for. Carers oversee the health and well-being, monitor the safety and help the one they care for stay as independent as possible.

Support workers and service providers must become aware of who the client describes as their main carer or carers and what the caring role consists of. Information about carers and their roles, will be gathered as part of the commencement assessment and will be recorded in the clients file or care plan.

Carer demographics

Carers provide support to a family member or friend who needs assistance. Some carers are eligible for government benefits, while others are employed or have a private income. There can be situations where carers are not paid at all.

Carers come from all walks of life, cultures and religions. Some may only be 20 while others may be 90. They may be spouses, parents, sons, daughters, siblings, friends, nieces, nephews or neighbours. Over 2.6 million Australians provide help and support to family members or friends.

Most carers (77 per cent) are female and are aged between 36 and 65 years. There are also around 300,000 young carers who are aged under 25 years.

People become carers in different ways. Sometimes it happens gradually, helping more and more as a person's health and independence gets worse over time. It may happen suddenly after a health crisis (for example a stroke or heart attack) or an accident. It is not uncommon for carers to feel like they don't have a choice. Many carers feel it is what they must do. Different cultures have different expectations.

The qualities of a good worker are many and varied. Everyone brings different strengths to their role, different values, beliefs and practical knowledge and skills. But there are some key skills areas that make workers more effective, for example:

- Ability to listen and understand
- Good communication skills
- Interest in helping people
- Willingness to collaborate and consult with others
- Ability to accept and respect the choices of other people
- Respect for different needs, values, beliefs, culture
- Commitment to increasing independence and capability in others
- Ability to share knowledge and skills but not to take over
- Having a positive attitude
- Being aware of realistic goals and limitations – making sure you understand each person and their strengths, needs, goals and support needs
- Consistency and ability to follow through
- Professional – human, friendly, but not needy or dependant

Attitudes, stereotypes, false beliefs and myths associated with caring

Lack of understanding around a carers role can be determinantal to the industry as well as impact the carers on an individual level. Misconceptions associated to being a carer include;

1. Carers being paid workers who go to someone else house to help them

A carer and a care support worker are sometimes confused with each other. A carer is someone who provides unpaid care to a family member or friend. A care support worker is someone who comes into your home to help.

2. You're only a carer if the person you care for is related to you

Many carers are friends and neighbours of people with care needs, helping them on a daily basis and offering support. All carers have the same rights to identification and support irrespective of their relationship to the person they care for.

3. You're only a carer if the things you do are activities i.e. shopping, pushing a wheelchair, helping people into bed

Although many carers undertake physical activities for the person they care for, for many (especially those caring or someone with a mental health problem) they provide a large amount of emotional support which can be as impactful on their wellbeing as those performing physical activities.

4. All carers choose to be carers

Most become carers without realising it: someone becomes ill, has an accident, develops or is born with a disability or becomes frail as they get older and other people step in to support them. Lots of carers don't recognise themselves as carers, many feel they are just fulfilling their "duty" so do not think they need to be recognised as such. Although legislation states it is important that carers have the choice about being a carer, it's often far more complex than that. However, it is important for carers to know they can make clear the tasks and responsibilities that they are not willing to undertake

5. They are in good health themselves

The majority of carers when consulted have stated they not only have their own health problems but that caring has adversely impacted their own physical and mental health.

Importance of a carer

A carer provides much value to both the client and a support worker. This includes strengthening the relationship you have with the person you are both providing support to.

The benefits of carers also include;

- They can provide valuable information (history, medical status, likes, dislikes, progress towards goals, achievements, setbacks just to name a few)
- Allowing individuals to remain at home and in familiar surroundings
- Assisting support staff with application of routines

Carers usually know the person with care needs better than the paid workers who provide support. It is important that support workers area aware of the roles of carers and their importance and that they take their support needs into account when planning and delivering services.

Supporting the relationship with the carer

As health professionals, we can help by acknowledging the carer as part of the care team and working in a manner that recognises and supports the carers relationship with knowledge about the client. In addition, we can identify the knowledge and skills of the carer that complements the role of the worker. By understanding the skills that the carer has and how they match the care and support needs of the client, a carer will be able to decide what tasks they need to complete themselves and what the carer is capable of achieving. It is every stakeholder's responsibility to ensure that the care plan is carried out safely and appropriately. Where needed an adjustment of the care plan can be completed to ensure that all needs are covered. If needed support, information or further education can be arranged for the carer so that they can develop the skills or knowledge needed to meet the various needs.

Where a support worker has identified that a carer has not performed a task correctly or it is seen that the task is too difficult, the support worker must address it (if this within the scope of their role) and ensure it is recorded on the clients care plan and discussed with supervisor.

Where a carer has skills to support the person they care for, these can complement the skills and knowledge of support workers. Good care planning will ensure that support is provided to a client and carer in a way that makes the most of the skills the carer has.

Example of working in partnership

Lin is a full-time carer for his wife Ruth who has dementia. Lin was recently diagnosed as having diabetes and is required to go into town to visit a specialist. Ruth doesn't like going into to town anymore and becomes quite distressed. Lin not wanting to leave her alone has engaged a local support agency and Belinda is scheduled to visit Ruth while Lin attends his appointments. Belinda has completed a university degree that focussed on dementia and Lin feels confident in her skills and knowledge and therefore being able to leave the farm to attend to his health needs.

We can also support the carer by;

Encouraging collaboration and participation in planning activities

Providing support in a manner that respects and includes the career as part of the team

Providing references and support to relevant organisation and government policy (Carers Victoria www.carersvic.org.au and other relevant organisations)

Further Reading:

http://www.dhs.vic.gov.au/pdfs/framework_action_plan0806.pdf

Carer support organisations and resources

There are a range of services available for carers to assist them in managing. These services can vary from area to area. There may be carer support groups, community health centres, food services, home help and maintenance services, home nursing, palliative care, and respite services.

Involving a carer and family in the design and delivery of the persons support services will provide an opportunity to include elements of support and resource options for the carer and family.

The rights and responsibilities of people in the care relationship

The person

The person receiving support have various rights and responsibilities which will be dictated in some respect by what their capabilities, age and specific needs might be.

Responsibilities will include (but not limited to):

- Providing a safe place of work for staff
- Keeping information up to date
- Informing service providers of any changes

Rights will include (but are not limited to):

- Access to fair and equitable services in line with legislation and meets standards and frameworks
- Direct their care plan as much as possible

Family members

Responsibilities will include (but not limited to):

- Sharing of relevant information
- Provide safe work environment
- Additional responsibilities may be included and outlined in a service agreement

Rights will include (but not limited to):

- To expect that services and supports are provided in a fair and equitable way
- The persons rights are upheld
- Information is provided where applicable (with consent of the person)

Friends

Friends often have a less formal role and different rights and responsibilities within a caring relationship. They are free to make their own choices and decisions about how much they commit to the relationship. Friends may be providing unpaid care to a person and so may then have the right to receive support as a carer. Friends offer social and recreation support and friendship, and this can be vital in maintaining the primary caregiver relationship. Friends have the same rights and responsibilities as other people under Australian law. The responsibilities also include providing information that is helpful to the carers and support workers along with treating people associated to the individual with respect.

Carers

Along with clients, friends and family members, carers have rights and responsibilities too. It is important for carers to be clear about their rights as well as their responsibilities. Understanding this will also help them to find a balance between caring and the other things in their life.

Carers have the right to:

- Dignity and privacy.
- Be treated with respect.
- Be asked to help - not expected to.
- Be acknowledged as the carer and included in any decision making about the support.
- needs of the person you care for.
- Choose the types of tasks you are comfortable helping with.
- e.g. preparing meals as opposed to showering.
- Ask other family members for assistance and support.
- Negotiate with the person you care for about using support services.
- Access support services to help with caring.
- Provide important or helpful information to GPs, health professionals and service providers.
- Offer suggestions and raise concerns when necessary.
- Reduce the level of support you offer or stop providing care, when and if you need to.

Support Workers

The support worker has a responsibility to carry out their work tasks to the best of their ability and in line with the requirements of their employer. They should follow lawful instructions given to them by their employer and ensure they comply with legislation, policies and procedures. They have a responsibility to document their work tasks, make reports, liaise with others and act on issues as required in their role.

They have the right to be able to work with the protection of relevant workplace laws such as anti-discrimination and work health and safety laws.

The importance of family

Today, 80 percent of aged Australians prefer to stay at home as they age. This means families are more directly involved than ever in their loved ones' care. So, it is more important than ever for families to be involved in the planning stage together, as no single individual can adequately handle the responsibilities of caregiving alone, certainly not on top of responsibilities at work and with their own families and community involvement.

When providing care, it is important to learn as much as possible about the person themselves, their family relationships and family dynamics. Family dynamics are significant.

Some families have difficulties in their relationships and these clients may prefer that only certain members of their family are involved in planning their care ore receive information about them.

Some families are very close, and their relationships are the most important part of the client's life. This may lead to families having a significant influence in decisions made by the person.

A family members role

Family members are a vital source of information to carers and support workers.

They can provide information that;

- Assists with difficulties such as dementia (by providing background information/ stories)
- Outlines likes and dislikes of a person
- Provides history on past activities and lifestyle
- Provide informal help and support through making decisions

Sometimes as a carer it may be that you're asked to make a range of decisions that may impact on the personal affairs of the person you're caring for.

Family and friends can help informally by making decisions with you. But some decisions can only be made by someone with the legal authority to do so. There are laws in each state that say who has the legal authority to make decisions, particularly for things like providing consent for a medical procedure on a person's behalf if they're no longer able to do so.

As a carer, you may also need legal support to carry out some of the things the person you're caring for will need you to do. This may mean you need to organise a power of attorney or apply for guardianship or administration rights.

Some family members are made legal guardians or given financial and medical power of attorney.

A guardian is a legally appointed substitute decision maker who may make lifestyle decisions, such as where a person should live, as well as give their consent to medical, dental and health care services generally. An administrator acts as a financial manager and looks after a person's property and finances.

A power of attorney is a legal document that gives the nominated person (the attorney) the power to act on a person's behalf and manage their affairs. It enables the attorney to manage the person's assets and financial affairs when they prefer not to conduct them personally, or they are unable to do so. For example, if the person you care for finds it hard to sign documents due to loss of vision or unsteady hands.

In providing care to a family member or friend, there is often a fine line between helping and taking control. If the person you care for has the capacity to make decisions for themselves (check this with their GP if unsure), your responsibility lies with telling them about their options, encouraging them in what you feel is the 'right' decision and then supporting them as far as possible.

The Privacy and Access Act restrict the type and extent of information that carers and families can be given without the expressed permission of their family member.

If the person you care for is not capable of giving permission for you to receive or access information about them, you will need to make an application to the Community Advocate to request this. The Community Advocate will then investigate and if in agreement, make an application to the Guardianship Tribunal, which can give the approval.

Additional resources -

For more information visit: http://www.myagedcare.gov.au/legal-information/guardianship-and-administrators

For more information visit: http://www.myagedcare.gov.au/legal-information/powers-attorney-enduring-powers-attorney-and-enduring-guardians

For information about the care recipient's rights and responsibilities visit:

https://agedcare.health.gov.au/publications-and-articles/guides-advice-and-policies/charter-of-care-recipients-rights-and-responsibilities-home-care

Family patterns and structure

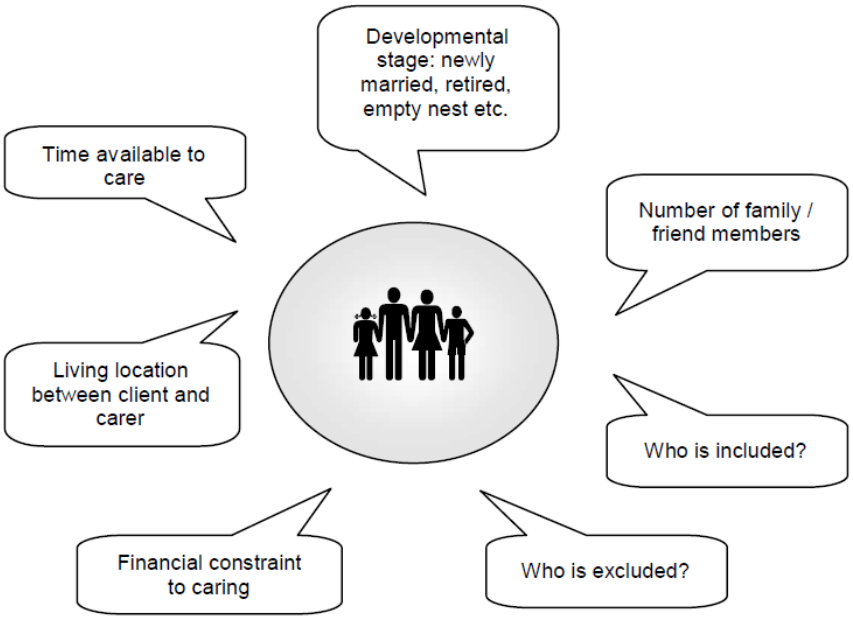
Talking with families will provide an understanding of specific challenges the family may have, and their reactions to these challenges, and provide opportunities for you to gain a better understanding of your client's family/friend structure.

Family structures and patterns can consist of many variables, including:

- Cultural identity
- Relationships between parents and children
- Marital status and relationship history
- Single parent families
- Multiple child families
- Step parents/families
- Gay and lesbian parents

The principle structures of a household can be described as nuclear, extended and blended. The nuclear household contains two generations; parents and children. Extended families are multigenerational and include a wide circle of family. Blended households can include biological parents and stepparents simultaneously.

The family composition plays an important role in care relationships.



Gathering the following information will be helpful to gain important information concerning the client's support structure and provide insight into how the structure will support the loved one now and in the future. Consideration should be taken to collect and/or determine the following information;

Flexibility:

Are family members able to swap roles when and as required?

Strain:

Are some family members struggling with this new role, which is unfamiliar?

Overload:

Is one person taking on too much?

Sharing:

Can family members negotiate to share a role?

Conflict:

Do family members find there are conflicting obligations in terms of their time and attention and that is it difficult to respond equally to these obligations?

Values:

These may influence decision making or attitudes towards the person and their current status or future situations. Family values come from their cultural and spiritual belief systems. As families are faced with difficult choices their value system will play a major role in their decision-making process.

Medical history:

Are there previous family illnesses, losses or crises? Knowledge of these can help with understanding reactions to similar experiences.

Emotional needs-response patterns:

To what extent do family members meet each other's social and emotional needs? What emotions do other family members display?

Is there a balance between?

Support and independence for the client?

Freedom and control that allows the client to make decisions?

Communication patterns:

Open/closed: does the family talk openly about everything or is there evasion of certain topics? Are people allowed to speak for themselves or does someone speak for another?

Coping Strategies:

Does the support network have any? Do they know what they are? Services such as a grief counsellor will be able to assist in this area.

Note: It is not possible to obtain all of this information through direct questioning. Observations through your visits will provide some of the information without making the support network feel uncomfortable.

Impact of family patterns and structure on the person

Family patterns and structure of the family can apply various impacts to a person in need of care.

The following situations can make the most impact on a care situation;

- Family sizes can impact the availability of carers (for small families) or may impact the ability to make decisions and gain consent of all members if families are larger.
- Marital disruption and more complex family relationships can cause conflict or differences of opinions and needs could make care decisions more difficult
- Geographical separation could reduce the care support available and family will need to rely on support workers more
- Parents of no dependents may reduce the family care support options available
- Living alone may limit the family support options available
- Social connections and networks that also make up a family will vary which may impact the person and legal responsibilities and allowances

Additional resources

For more information visit: Visit the website Family structure and style for more information relating to family structure

http://www.euromedinfo.eu/family-structure-and-style.html/

Impact of the caring role on family, carers and the friends

Whilst care giving can be beneficial for carers and friends in terms of their self-esteem there are also many challenges that friends, carers and family face. These include;

- Changing demands of care intensity
- Changes in own family life
- Employment responsibilities (if combining care with alternative paid employment)
- Financial pressures
- Changes in health of the care recipient
- Carer aged related missed opportunities
- Becoming involved in negative family relationships

The constant demands of caring and the many changes in family life may bring about a range of feelings and emotions. Some may feel a sense of satisfaction about being a carer. Others may feel angry and overwhelmed at times. These emotions can be difficult to cope with.

Caring can be physically and emotionally exhausting.

Working age carers who combine paid work with caring duties may also suffer from burnout and stress, potentially leading to worsening physical and mental health.

Work situations may require changing to suit the individual care responsibilities.

Children and young people who help care for a relative or a friend often describe caring as a positive experience where they have felt closer to their families and have develop new skills and experiences because of it. However, where they are not as well supported by the family, young people can miss out on a variety of opportunities; such as going to school, doing homework, spending time with friends, gaining a job or completing further studies. They can experience high levels of stress and worry, and they can feel confused and uninformed.

It is important to find ways to promote the positives and ways to keep children and young people from experiencing some of the negative impacts of care.

Financial responsibilities for a carer, family or friend may include;

- Power of attorney
- Meeting with a person's financial adviser
- Dealing with Centrelink on their behalf
- Getting help at home or moving in aged care

Carers may become financially challenged due to changing work commitments to fit in with care needs or dedicating finances to equipment and aids to support the care needs of the individual.

Amongst the challenges outlined above and those not named here, there is also the fact that the health needs of the care recipient are constantly changing and do remain the focus of care. Depending on the skills and knowledge of the carer, some health changes become too difficult to manage and this can leave carers feeling confused, helpless, scared and overwhelmed. It is a support workers responsibility to recognise when the health status of the client has become or becoming out of the scope of ability of the carer and in turn provide information to support the carer.

It is important that carers are reminded that they need to look after themselves and their other family members too.

Ways that support workers can provide support is to;

- Encourage carers to take regular time – remind them that it is ok and just as important that they do things that they enjoy and socialise with friends. Everyone needs a break and to have fun.
- Provide information of local respite services and encourage family, friends and carers to take up the respite opportunities
- Provide opportunities for communication. Encourage a conversation of how they are feeling. Bottling up feelings does not only increase frustration; it also leads to stress and other health issues. Where needed opt to see professional health services and ask for support if needed
- Assist the carers to identify what they can and cannot do. Assist the carer in determining what is realistic and fair and that in their plan they have included time out for themselves and others
- Hold regular family meetings where everyone can talk about the routines being implemented and thoughts surrounding current care and future needs
- Provide information on a variety of community services and resources to suit individual needs
- Facilitate introductions to services if required

Additional resources

impact of being a carer for individuals in a variety of situations: http://www.healthtalk.org/peoples-experiences/dying-bereavement/caring-someone-terminal-illness/impact-being-carer

Recommend reading a literary review by Sally savage and Susan Bailey at;

http://www.deakin.edu.au/__data/assets/pdf_file/0020/274520/Carers-lit-review.pdf

Service delivery philosophy and models

Basic principles of person-centred practice

"Person-centred care" can be broadly defined to mean a focused consideration of a client's physical and emotional needs and preferences in their care and lifestyle planning. Person -centred care is user focussed, promotes independence and autonomy rather than control,

Involves users choosing from reliable, flexible services, and tends to be offered by those working with a collaborative/team philosophy. Patience, compassion, sensitivity and empathy are vital in a person -centred approach. Many clients face threats to their morale, like increasing physical disability or bereavements. Community care workers are well placed to contribute to morale and quality of life for isolated, disabled older people because few other services see them so regularly.

To practice in a person-centred way with your clients, you need to:

- Listen to and actively acknowledge what is important to individuals
- Ensure clients and their carers/family/advocates are kept fully informed
- Give respect

A person-centred approach requires workers to regard the client as an individual person, not a diagnosis with regards to communication needs. Specific strategies should be used to maximise the information transfer from carer to client, and client to carer. Individualised communication plans may be required for clients who need specific interventions. The plan should detail the equipment required, relevant phrases and term commonly used, instruction and information for new carers and any other additional information that may be helpful.

A person-centred approach includes:

- Putting people and carers at the centre of service delivery
- When the person is a child or young person, service delivery strategies may need to be modified to ensure child safety and provide a child friendly, supportive environment
- Including people in decision-making relating to their care
- Involving people in discussions about service delivery options issues
- Obtaining the person's consent to examine, treat or work with them
- Effective customer service
- Listening to and addressing complaints within scope of own work role.

Strengths based practice

Strengths based practice works to emphasise people's self-determination and strengths. It sees the clients as resourceful and resilient in the face of adversity. It is client-led with a focus on future outcomes and strengths.

Strengths-based practice is a collaborative process between the person, supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets. As such, it concerns itself principally with the quality of the relationship that develops between those providing and those being supported, as well as the elements that the person seeking support brings to the process. Working in a collaborative way promotes the opportunity for individuals to be co-producers of services and support rather than solely consumers of those services.

"A strengths-based approach to care, support and inclusion says let's look first at what people can do with their skills and their resources and what can the people around them do in their relationships and their communities. People need to be seen as more than just their care needs – they need to be experts and in charge of their own lives."

-Alex Fox, chief executive of the charity Shared Lives

The term 'strength' refers to different elements that help or enable the individual to deal with challenges in life in general and in meeting their needs and achieving their desired outcomes in particular. These elements include:

- Their personal resources, abilities, skills, knowledge, potential, etc.
- Their social network and its resources, abilities, skills, etc.
- Community resources, also known as 'social capital' and/or 'universal resources'.

A support worker can apply a strength-based approach throughout their practice by;

- Considering the strengths of the individual
- Asking the individual to identify their own strengths
- Communicate positively with the individual
- Take guidance from the individual on how to approach certain tasks and situations
- Looking at the resources the individual has
- Analysing the abilities, skills and knowledge of the individual and making this the focus

Example of a support worker concentrating on the weakness of a person:

"Lisa, you can't paint, you're nearly blind and you have the use of only one arm. Why would you want to go to art classes? I can book you in though if you really want to go".

Example of support worker applying a strength-based approach:

"Lisa, you can go to art classes. We have arranged for you to access a bright area and we will make sure you have your magnifiers and will set you up with a secondary artist who can support you."

Active support

Active Support is a person-centred approach to providing direct support. The goal of Active Support is to ensure that people with even the most significant disabilities have ongoing, daily support to be engaged in a variety of life activities and opportunities of their choice.

Additional resources

Visit the following blog and watch the three clips on the benefits of active support

http://carecareers.com.au/blog/active-support/

Strategies to work positively with families' carers and friends

The involvement of the family, carers and friends are an important aspect of care and support work. This process can either be a successful partnership or a negative experience filled with challenges.

Activities that foster a positive working relationship between all parties include sharing information and demonstrating respect and trust.

Showing carers and those they care for that you respect them, their privacy and confidentiality, stage of life and circumstances is important in establishing trust. This trust is critical in a support relationship.

You can demonstrate respect for all parties by openly discussing personal information with those who have a direct responsibility to the person with care needs of their carer, ensuring the carer and the person they care for are informed about their rights, disclosing what information will be shared with whom. Encouraging collaboration and applying effective listening skills will also contribute to a positive and successful relationship between carers, families, friends and support workers.

Helping carers work safely is another way you can make a positive contribution along with providing information about additional services and making them aware of the varied policies and procedures that you are required to follow in relation to carers and families.

Care related policies and procedures

The workplace may have policies and procedures related to many functions of your role as s support person working in collaboration with carers, families and friends such as;

- As assessment policy that ensures carers needs are assessed and responded to
- A policy about providing carers with support
- A policy that involves consultation with the carers, families and friends
- Discrimination policies
- Privacy, confidentiality and disclosure policy

Organisations policies and procedures;

- Provide consistency throughout all roles for all individuals
- Give structure and process to specifics tasks and elements within a supporting role
- Guide staff to expected standards
- Provide all staff with accountability
- Cover legislation

Legislation

Legislation and government policy related to supporting carers varies across states and territories with each state having their own guidelines or legislation. There are also national guidelines that relate to the ways in which carers are supported.

Examples of relevant legislation and polices are as follows;

- Carers charter: carers recognition legislation; State carers Policy (SA)
- Recognising and supporting care relationships; Department of Human Services Policy framework (Vic)

There are many other relevant legislations required to be followed both by organisations and by individuals.

These include;

- Workplace health and safety
- Age Discrimination Act
- Privacy, confidentiality and disclosure
- Human rights
- Dignity of risk
- The Aged Care Act

As a support worker, knowing about the types of legislation and policies that apply in your workplace and following them is important in providing high quality and appropriate support to carers. Despite state or territory differences, the legislation is written with the same intent: to ensure that carers are recognised and supported in their roles.

Ethics

Ethics are the beliefs that we hold about what constitutes the right conduct in a particular situation or job. We need to have a sound ethical framework to provide good quality care and to protect the rights of individuals who are aged or with a disability, especially those who may be more vulnerable.

Ethical guidelines are important in providing a safe and clear working environment for workers in assisting them to provide effective and goal-directed services and support.

Simply, they tell everyone what is expected of them in the performance of their work. They also ensure that individuals providing services have adequate training, skills, knowledge or expertise to provide the services that they are offering in the community.

Policy Example:

Policy Title: Carers' Rights and Responsibilities

Policy Statement:

Australian Healthcare QT (AHQT) operates in compliance with the carers Recognition Act 2004.

Australian Healthcare QT recognises the importance of the role of carers in the lives of many of the organisations consumers and acknowledged that social, cultural and other experiences have an impact on the caring role.

Carers have the right to:

- Be treated with respect and dignity
- To be included (with the consumer's permission) in the assessment, planning, delivery and
- Review of services that impact on them and their carer role;
- Have their views and needs taken into account along with the views, needs and best interests of
  - The person they care for, when decisions are made that impact on them and their carer role;
- Be provided with non-personal information, advice and support when the consumer does not
- Give permission for them to be directly involved in the service Share and Care delivers;
- Have their privacy respected and personal information kept confidential;
- Have access to all personal information kept about them by Share & Care;
- Have another person of their choice to support them and advocate on their behalf;
- Have their feedback listened to and comments valued; and
- Make a complaint if they are not happy with the services they receive

Australian Healthcare QT recognises the importance of appointed guardians, people who hold power of attorney or who are advocates for Consumers and acknowledges and respects and will comply with the roles stipulated in the guardianship, power of attorney or advocacy arrangements.

Australian Healthcare QT expects that carers will:

- Be honest, cooperative and courteous in their interaction with AHQT staff;
- Be responsible for their choices and the results of any decisions they make;
- Play their part in helping AHQT to provide them with services.
- When services occur in the Carer's home, take reasonable steps to provide a safe working environment for staff

Ways that ethics are incorporated into practice include acting at all times with honesty and providing services that are considered as high standard and follow high moral principles. Other practices include not accepting gifts or not reporting a reportable incident because someone asked you not to.

Element 2: Assess and respond to changes in the care relationship

Potential Risks of change to the care relationship

The relationship between a carer and the care recipient may undergo a variety of challenges and changes. Changes may occur for a variety of reasons.

Reasons may include;

- Capacity to care may alter
- Health of care provider may impact care needs
- Care needs (both physical or psychological) becoming outside the scope and skills of the carer
- Unusual behaviours displayed by client
- The care change may require additional support for short term and include respite, or additional support workers engaged, or the requirement might be to consider alternative long-term care arrangements.

Changes in the care relationship can result in both physical and psychological risks of harm for both the carer and the person receiving care and support.

The risks include;

- Injuries sustained to both carer and client from the carers inability to provide physical support
- Physical and psychological injuries from situations relating to mental health issues
- Stress and depression of the carer
- Stress and depression of the care recipient – feeling a sense of loss

As a support worker, you need to be alerting to changes in the care relationship and consider how to assess potential risks which might arise when a change occurs. You may need to take some action or seek further advice about how to provide appropriate support to help the caring relationship to become more positive and to facilitate its ongoing maintenance

Change and transition

Life cycle transitions

There are a variety of transitional points throughout our lives.

The early adult transition involves moving away from family and assuming adult roles.

The midlife transition (often called a midlife crisis) is a time for becoming less driven and developing more compassion. Typically, adults become increasing aware of aging in their forties and fifties. Throughout the fifties women experience physical changes and psychological adjustments to aging and the loss of fertility that result from fluctuations in the female hormone estrogen.

The late adult transition is characterised by the changing roles and relationships of later life. The young-old adults are roughly between the ages of 65 and 75, however the term refers to more the health and vigoro of the individual. The elderly is described between the ages of approximately 75 and 85 plus. Concerns about physical health increase for both men and women in their sixties, seventies and eighties. Death is an inevitability that confronts all of us. Bereavement is a part of life for older adults, as friends fall ill and die. Older adults often confront a form of social prejudice known as ageism, a term that encompasses a number of misconceptions and prejudices about aging. Older adults experience the full range of human interests and concerns at this age and are often faced with stereotypes based on people's prejudices or fears about ageing.

Examples of life cycle transitions include;

- Moving out of early childhood
- Attending school
- Leaving school
- Becoming an adolescent
- Becoming an adult
- Beginning work or further study
- Finding a partner
- Having children or deciding not to have them
- Reaching middle aged
- Retiring from work
- Changing life direction
- Becoming elderly
- Planning for end of life

Typical transition points for a family

In the same way that individuals have their own developmental pathway, over time families also grow and change. Family life cycle is a common term used for this course. A family life cycle includes common transition points over time.

Typical family transition points may include:

- A couple relationship becoming more committed (e.g. move in together or marry);
- Birth of a child (and subsequent children);
- Child starting primary school and then secondary school;
- Child becoming an adolescent;
- Work/study changes;
- Child getting a driver's licence;
- Child leaving home (first and last child leaving home in particular);
- Parent/s retiring from work;
- Birth of grandchildren;
- Death of parent/s.

Life cycle transitions differ greatly, and different people respond to the same event in different ways. Family relationships are of key importance to psychological wellbeing throughout the lifespan.

Understanding and being able to plan ahead for a life cycle transition means you can offer appropriate support and guidance at these times.

Transition involves **change**.

Psychologist Erik Erikson highlighted conflict as a common theme and consequence of change.

These conflicts can arise through;

- Changes in close relationships during life cycle transitions
- Cognitively questioning ourselves (our identity, age related goals for ourselves, evaluating our achievements to the extent that we are 'on time' or 'off time' etc)
- Finding new boundaries in relationship aligned to transition stage

Throughout transitions you may identify adults displaying the following;

- Moving toward others – fulfilling the need for love and acceptance
- Moving away from others – establishing independence and efficacy
- Moving against others – an individuals need for power and dominance

Some examples of types of transitions that can occur throughout our life span include;

- Moving from kindergarten to mainstream school
- Moving from primary school to higher school and higher education beyond that
- Moving out of a family home into either shared accommodation or independent living
- Joining in community groups and social networks
- Beginning employment after school
- Changing employment/employers
- Trying new careers
- Cutting back hours of work or retiring
- Leaving hospital after an extended illness or treatment period to begin living in the community
- Changing support services and/or support staff changes
- Introduction of external support workers to the care team
- Moving from independent living to residential care

When transitions occur as a result of life cycle stages there can be positive and negative impacts. As a support worker it is useful to consider possibilities and think about how a transition may affect a person, as well as others involved in the care relationship, such as family members, carers and friends.

Positive and negative impacts

Utilising the above list of lifecycle transition please see below examples of the positive and negative impacts which may occur as a result.

Life cycle transition	Positive aspects	Negative aspects
Moving from kindergarten to mainstream school	Sense of independence, learning and development occurs	Feelings of uncertainty, routine disruption, change of environment and associated boundaries
Moving from primary school to higher school and higher education beyond that	Development growth, expand social networks, increased independence	Social networks may be disrupted by friends moving to other schools, fear of new environment. Sense of importance change - moving from senior position to junior
Moving out of a family home into either shared accommodation or independent living	Reduced commitment and responsibility, decrease loneliness and feelings of isolation, increase social networks and opportunities to collaborate, possible increase in independency	Communication difficulties that may arise, sharing with another person when used to having own way, if moving in with partner may decrease social networks and family. If the person is not ready to transition it might be a negative experience.
Joining in community groups and social networks	Increase opportunity for meeting new people and gaining friendships, build confidence and self-esteem through going out and socialising	Risks of injury or falls, environment providing challenges with mobility etc,
Beginning employment after school	New social network, feeling of accomplishment, increased self-esteem and confidence, satisfaction for contributing to society, financial freedom	Nervousness and insecurity about applying new skills and knowledge and meeting new people, change of routine and increased responsibility may provide stress and anxiety

Life cycle transition	Positive aspects	Negative aspects
Cutting back hours of work or retiring	Increase time allocation to commitments, more balance achieved between work expectations and other commitments, reduction in stress of trying to fit in all in. Retiring: luxury of being able to spend more time on social outings and hobbies, assist caring for grandchildren or others in need	Change of routine and contribution to society may be stressful. Financial strain Insecurity of the unknown
Leaving hospital after an extended illness or treatment period to begin living in the community	Moving back into familiar surroundings, routines and all known things increase happiness,	If the person is not ready to transition it might be a negative experience.
Changing support services and/or support staff changes	Increase opportunities to gain valuable support that meets a need.	Relationship change can cause distress. New routines and new people will take time to become familiar.
Introduction of external support workers to the care team	An opportunity for support to be provided where needed may increase mobility or improve situation. Assist the carer and or support people in a helpful way	Uncertainty of expectations may be stressful to the person
Moving from independent living to residential care	Reduced commitment and responsibility, possible decrease loneliness and feelings of isolation, increase social networks	If the person is not ready to transition it might be a negative experience. The person may experience a sense of loss and sadness from moving away from their home and from all the things they know and love

Ensuring all stakeholders are involved with the transition planning will increase the opportunity for the transition to be successful. Communication and providing key information along with emphasising the benefits and positive aspects of the change will maximise care recipient ability to cope with the transition.

It is important that carers inform family members of all aspects of care and any changes that take place concerning their relative. This includes falls, slight mishaps, changes to medication etc. Senior staff members are responsible for the latter. Sharing the care is a natural and professional attitude towards family and significant others. Developing a good relationship with the person's family is an important part of the wider aspects of quality care.

Maximising support and involvement

A major component of a support workers role includes supporting carers, families and friends to maximise ongoing support and involvement in the life of the person. Each person plays a significant part in the care and wellbeing of the care recipient.

A support worker can maximise carer, family and friend's involvement and support by;

- Fostering a supportive relationship
- Encouraging participation
- Providing opportunities for meeting and sharing of information
- Allow for open communication
- Facilitating the engagement of relationship experts in the event of a breakdown
- Encourage collaboration and contribution with care plans
- Continually assess family, friends and carer dynamics
- Keep an eye out for a decline in health and wellbeing of carers

Element 3: Monitor and promote carer rights, health and wellbeing

Legal and ethical requirements

Confidentiality, privacy rights and disclosure

The carer holds a position of trust within the support team. Information will be made available to the carer to conduct this role. In addition, you may also learn private information while undertaking your role. Details such as financial information, personal relationship information, the client's thoughts and feelings are some examples. How you treat all this information is legally bound by your employment status. The maintenance of privacy and confidentiality of these details is a strict requirement when undertaking a support role with individuals. You may need to relate information to others in the support team and to supervisors. Professional conduct requires this to be undertaken in a manner that maintains respect and courtesy for the private information you may need to share.

When a person becomes a client of your service, the organisation receives a lot of personal and confidential information about the client and their family. It is your role to ensure that this information is kept private and confidential. Confidential information that is given to you by clients' needs to be shared, confidentially, with your supervisor or manager. Withholding this information may breach your duty of care responsibilities.

Care workers have a legal and ethical obligation not to disclose information that is considered confidential that they have gained through carrying out their work. Confidential information may be that which relates to individual clients and their families, their colleagues and the organisation they work for. Inappropriate disclosure of confidential information may have adverse implications on the client, their family or the organisation.

You should be aware of your organisation's policies and procedures in relation to confidentiality. Your organisation's policy on confidentiality may relate to:

- Storage of records
- Destruction of records
- Access to records
- Release of information
- Verbal and written communication

Carers should seek to understand why we undertake tasks the way we do. It is then easier to make the reasoning process understandable to the client.

Additional resources
For more information about privacy, confidentiality and disclosure visit:
https://www.oaic.gov.au/individuals/privacy-fact-sheets/general/privacy-fact-sheet-17-australian-privacy-principles
http://www.aacqa.gov.au/for-the-public/privacy-and-confidentiality

Work role boundaries

All formal working relationships need rapport and trust to function well. This is particularly relevant to the relationship between a client and their care worker.

It is certainly important that the care worker makes sure clients feel at ease with approaching and relating to them – but it is equally important that the lines don't become blurred.

The relationship between an individual and their care worker should never come at the expense of maintaining clear professional boundaries. Successful and ethical working relationships are based on a clear understanding of what the workers' role is – and just as importantly – what their role isn't.

Professional boundaries are limits which protect the space between a worker's professional power and their client's vulnerability. Problems for care workers that can arise if these boundaries aren't maintained are:

- Becoming overly involved or attached to a client
- Showing exceptional behaviour towards a client
- Being emotionally entangled or showing fluid work/home boundaries
- Disclosure of personal information of the client by the worker, including excessive self- disclosure
- Considering the client to be a 'friend' or allowing the client to have that view

Professional boundaries are complex and often contentious subject because they relate to our personal values. They are experientially, culturally and historically influenced – and they change over time. Although we may talk about what's 'right' and 'wrong' and that we should use 'common sense', it's not always clear cut. For example, a care worker might feel it's rude not to accept a gift, even though it is the policy of Better Caring that gifts should not be accepted.

Appropriate relationships with vulnerable clients are those which recognise that we provide personal services and as such we have enormous power over their lives.

In all our relationships we set limits. One of the key issues for workers is to be able to recognise when we may be crossing the invisible line which separates a client from a worker, and which defines our relationship as professional and therefore workable.

Providing care to clients with disabilities (physical, intellectual, mental health, or neurological) raises many challenges for care workers. The role of the care worker can mean that you are in many intimate situations with clients and their friends and families. You may have access to private or confidential information. You may also encounter situations where you are confronted with needs, requests or demands for services or support that are not your role as care worker.

Duty of Care

Care workers have a duty of care to anyone who might reasonably be affected by their activities, requiring them to act in a way that does not expose others to an unreasonable risk of harm – physical, psychological or financial. As a worker you are required to protect an individual from risks of injury or harm that you can foresee or anticipate. This means you are required to act with a knowledge of the individual (particularly about their disability and their living situation), and of your own abilities, knowledge and limitations. You should not give assistance or advice outside your role or expertise (e.g. financial advice, family counselling or relationship advice).

Additional resources

Visit the following website for information relating discrimination legislation:

https://www.humanrights.gov.au/employers/good-practice-good-business-factsheets/quick-guide-australian-discrimination-laws

Need for services

Identify when services are needed to support the care relationship

While unpaid carers provide a valuable service to society and looking after family members or friends brings great rewards, there is growing concern about increased psychological distress, strain and overall health deterioration endured by family carers.

Isolation and lack of support might prove a high burden and result in distress or mental health problems.

There are many signs that may indicate that a carer is needing specific support. These may include, but are not limited to;

- Fatigue or exhaustion
- Low immunity – always being sick
- Having difficulty with tasks that are normally completed with ease
- Communicating negatively all the time
- Attending a doctor more often
- The family home in disarray
- Problems meeting own personal needs
- Requests for service information
- Decrease in attending personal activities that are usually looked forward to

Respond to the need for services

It is vital that when any of the signs listed above are displayed that you as the support worker provides an opportunity to discuss it. It is important to avoid situations where a carer is unable to provide any care at all for the person due to ill health, fatigue or struggling with all that is expected.

There may be many ways you are able to support a carer. Here are a few areas that could be helpful for the carer.

Respite

Taking a break from caring responsibilities is vital for most carers. Respite is a service type which makes it possible for a carer to have some time to attend to their own activities and spend some time away from their regular caring tasks. They might use the time to socialise with friends, get some exercise, see a movie or simply enjoy some quiet time alone. Respite can be taken on a regular basis or at an as needs basis. It can also be a short-term arrangement such as a weekend or organised for suit a longer period of time. For example, 3 weeks to allow the carer to take a holiday.

Peer Support

Support from a peer group can be useful in helping carers feel less alone and isolated. Caring can be a lonely task and one which takes up a lot of time. It is easy to lose contact with friends or feel like there is no one around who really understands their situation. A peer support group such as a carer's network or group meeting can be helpful in bringing carers into contact with others who are experiencing similar situations.

Education and Training

Sometimes carers might feel overwhelmed simply because they do not have the education needed to manage specific tasks or handle particular situations. This can occur particularly when a condition or situation is changeable, or when there is a progression of an illness, disability or condition. Education can help a carer to be more aware of what causes particular events or symptoms and what they can do about it. It also helps them know what to expect in the future

Impacting issues

Identify and respond to issues that may impact on the physical and emotional health and wellbeing of the carer

As there are many reasons an individual requires a carer so to it are ways that the emotional health and wellbeing of a carer may be impacted.

Situations that can impact a carer are;

- Health deterioration that has transitioned to palliative care
- Increased severity of dementia person
- Physical health of the carer changes that reduce their ability to carry out physical tasks
- Behavioural changes and negative outbursts by the care recipient
- Care level changing to high intensity
- Multiple roles
- Conflict in relationships with family and service providers

Where the above situations have been identified it is the responsibility of the support workers to respond to these issues to ensure the wellbeing of the carer is maintained. Reporting the situation and establishing support services must be actioned.

Additional resources

The following article outlines the nature and impact on caring for family members

https://aifs.gov.au/publications/nature-and-impact-caring-family-members-di/executive-summary

Providing support services information

Provide carers and families with information about carer support services

All you have to do is add the text 'support service' into the search engine for google to be inundated with available support services. As a support worker, you will able to assist deciphering all of the information and matching it to the exact needs of the clients. Your organisation may have a preferred support services list with already established relationships and contact details. These recommended services are usually the first point of contact because they have already been assessed for quality and most likely have quality systems established that allow for continual review.

Support services may include;

- Financial management
- Understanding fees and funding
- Equipment hire/purchase
- Community activities and sports
- Meals on wheels
- Council handy man

The Alzheimer's Association co-ordinates locally based Carer Support Groups which bring relatives together at meetings to learn and support each other. Guest speakers at these meetings give information which is valuable and relevant to various aspects of financial, social, lifestyle coping, relaxation etc, all designed to assist families adjust to the changes in their loved one.

Additional resources

The following organisations provide support for carers;

Relationship counselling - http://www.relationships.org.au/what-we-do/services/counselling

Family relationship advice line - http://www.familyrelationships.gov.au/services/fral/pages/default.aspx

Carers Australia - http://www.carersaustralia.com.au/

lifeline services - https://www.lifeline.org.au/Get-Help/Facts---Information/Lifeline-Services

Kids helpline - https://kidshelpline.com.au/

Organisations such as Life your way assists in managing a variety of needs http://carersupport.org.au/wp2/index.php/lifeyourway/

Different pathways into service settings for the person and the implications for friends, families and carers

Over the past 30 years, the focus of aged care pathways has moved from predominantly just moving into residential aged care to utilising a wide range of community care services instead.

To understand how people, use the mix of community and residential services that are available, a knowledge of transition patterns and pathways is vital.

Importantly, the care needs of people can vary considerably when they first seek assistance from a government program, and so even at this early stage different people require different services—from limited assistance in a community care program to high-level care in a residential facility.

People access services to suit their circumstances, and so patterns of service use are diverse in terms of the programs accessed and the frequency and order in which they are used.

Pathways may consist of;

- Going to hospital and due to complications needing to stay longer
- Individually visit services such as councils, organise and pay for the services on an individual self-funded way
- Independent living moving to having support services provide care in the home
- Independent living moving to residential care
- Hospice moving into palliative care

Impact on friends, carers and families will vary and greatly depend on the skills, knowledge, circumstances, relationship and pathway situation.

Individuals can be impacted by;

- Engaging with services that they have not heard about before; such as social workers, ACAT team, ATAS
- Having to become familiar with new terminology
- Creating space and time to attend planning sessions and meetings
- Financially
- Overwhelmed with the documentation that is required to be completed
- Becoming legally responsible for the person
- Having to attend to the needs of the original residential setting

Families, carers and friends at times, find themselves in situations that they have no previous experience in and at times do not have the required knowledge and skills needed to complete what is required. You as the support worker will be able to provide valuable support in these situations. You may support the person by facilitating the engagement of additional support services to assist, or provide information pertaining to the process and services that are being utilised.

i	**Additional resources** For more information relating to pathways visit; http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442475614

CHCPAL001 - Deliver care services using a palliative approach

Welcome to the learning resource for the unit CHCPAL001 - Deliver care services using a palliative approach.

This unit applies to workers in a residential or community context. Work performed requires some discretion and judgement and is carried out under regular direct or indirect supervision.

On completion of this unit you will have covered the requirements for:

1. Apply principals and aims of a palliative approach when supporting individuals
2. Respect the person's preferences for quality of life choices
3. Follow the person's advance care directives in the care plan
4. Respond to signs of pain and other symptoms
5. Follow end-of-life care strategies
6. Manage own emotional responses and ethical issues

You will be able to demonstrate your ability to supported, reported and documented issues and needs of 3 people in palliative care.

You will gain knowledge about the:

- Philosophy, principles, benefits and scope of palliative care
- The needs of people dealing with a life-threatening or life-limiting illness and the emotional impact of diagnosis
- Cultural, religious and spiritual differences in relation to death and dying
- The stages of grief and personal strategies for managing reactions to grief
- Advance care directives and end-of-life care strategies
- Pain relief and comfort promotion
- Nutritional and hydration requirements during a palliative approach
- Legal and ethical considerations for working in palliative care, including:
- Dignity of risk
- Duty of care
- Human rights
- Privacy, confidentiality and disclosure
- Work role boundaries – responsibilities and limitations
- Relevant policies, protocols and practices of the organisation in relation to the provision of both a palliative approach and palliative care
- Responsibilities to self and colleagues
- Various signs of imminent death and/or deterioration
- Communication strategies to build trust, show empathy, demonstrate support and empowers the person, family, carers and/or significant others

A copy of the full unit of competency can be found at: http://training.gov.au/Training/Details/CHCPAL001

This learning resource is designed to support your learning and act as a guide to further research. We encourage you to access other texts which include; standards and legislation and other resources relating to your industry that can be sourced throughout the internet or library.

Element 1: Apply principals and aims of a palliative approach when supporting individuals

Introduction to palliative care

When clients are faced with terminal illness it is often a very traumatic time for both clients and their support networks. Many questions will be asked and answered; many more will come as the client progresses through levels of their disease and changing physical circumstances bring new challenges psychologically, emotionally, spiritually and culturally for all concerned.

As a Personal Care Worker your role is to assist your client with the improvement of quality of life, the promotion of comfort and the preservation of dignity and choice.

What is palliative care?

Palliative care means to provide dignity, peace and comfort as the client progresses through their end of life journey. The focus of palliative care shifts from trying to cure the client, to caring for the client, focusing on comfort and quality of life. Supporting emotional, spiritual and cultural needs combined with attention to pain management and maximising remaining functional abilities are key areas of palliative care.

There is no specific time frame for palliative care. As the illness progresses, management of service delivery needs to be monitored and adjusted accordingly, to ensure your client receives services appropriate to their needs.

The palliative care team

A palliative care team is made up of individuals with varied and specialised skills and knowledge.

Palliative care team members include;

- Allied health professionals – social workers, physiotherapists, occupational therapists, psychologists, pharmacists, dietitians
- Support workers – nurse assistants, personal care attendants and diversional therapists X Medical practitioners – general practitioners (GPs), palliative care specialists and other specialist physicians with a related interest
- Nurses – generalist and specialist nurses in community, hospital and in-patient palliative care settings, and independent nurse practitioners
- Families
- Carers
- Aboriginal and Torres Strait Islander health workers
- Alternative therapists skilled in massage, aromatherapy, relaxation music or colour therapy
- Bereavement counsellors
- Spiritual carers from a range of pastoral, spiritual and cultural backgrounds
- Professionals with language skills and cultural knowledge of ethnic groups
- Volunteers

Your role in the palliative care team

It is essential for you to understand your specific role in the palliative care team; that is, how you contribute to the person's care. This depends on the person's illness, their treatment, the wishes of the person's family, where the care is being delivered and your own job role. Your role in the palliative care includes being able to communicate and collaborate with all key stakeholders and most importantly maintain knowledge and understanding of the individual palliative care plans. Your role requires you to plan your time and maintain high levels of organisation.

Recognise the holistic needs of the person over time

As the need for aged care services increases in both residential and community sectors the expectation of service delivery is changing. Clients are now being provided with services that promote and support their independence and provide them with holistic care. It is important to consider that all areas contribute to the well-being and holistic health of your clients.

Consider the holistic factors that make up a person's whole being:

- Physical
- Psychological/emotional
- Social
- Cultural/spiritual
- Sexual
- Intellectual

Values and philosophy underpinning work in the sector may include:

A holistic and person-centred approach, embracing:

- Promotion of wellbeing of staff, clients and communities
- Early identification of problems
- Delivery of appropriate services
- Commitment to meeting the needs and upholding the rights of people
- Commitment to empowering the person and/or the community
- Ethical behaviour
- Preventative strategies
- Exercise of responsibilities and accountabilities within the context of duty of support for clients

As palliative care requires a holistic approach it is important that we consider how we can incorporate all aspects of a person's life and how service delivery can accommodate these needs.

To ensure clients receive the best possible service delivery the following principles should be adopted:

- Effective management of pain and other symptoms and the provision of psychological, social and spiritual support occurs, where requested and where required, in a culturally appropriate manner
- The client, family and carers are recognised as the unit of care
- The care of the client is based on the needs and wishes of the client
- Multi-disciplinary teams provide integrated medical, nursing, allied health and community services to clients and families
- Bereavement support for the client, family and carer is integral to palliative care
- Effective palliative care service delivery occurs in the context of an informed health sector and palliative care information and education is available to the wide professional and local community
- Effective palliative care services are committed to quality improvement and research in clinical and management practices in palliative care
- Effective administrative arrangements at Commonwealth, State/Territory, community health and support services levels provide palliative care services that are appropriate for the palliative care needs of local communities

(Adapted from Background for a National Strategy for Palliative Care in Australia, Commonwealth Department of Health and Family Services 1998)

These principles should be adapted by your organisation and will be blended into the provision of services you deliver. Consultation with your client and their support network upon admission will provide maximum opportunity to achieve a holistic approach to palliative care.

Support the person, carers, and family

Family, carers and friends will be faced with an emotional rollercoaster whilst supporting their loved one through their end of life journey. Personal attitudes to death and dying, personal experiences, grief and loss will all play a part in how the client's support network cope with their loved one's illness. A client who receives palliative care has an unknown time frame left to live. This can be very hard for the family to deal with and often the grieving process starts well before their loved on actually passes away.

Note: Palliative care services support both client and their family as one unit.

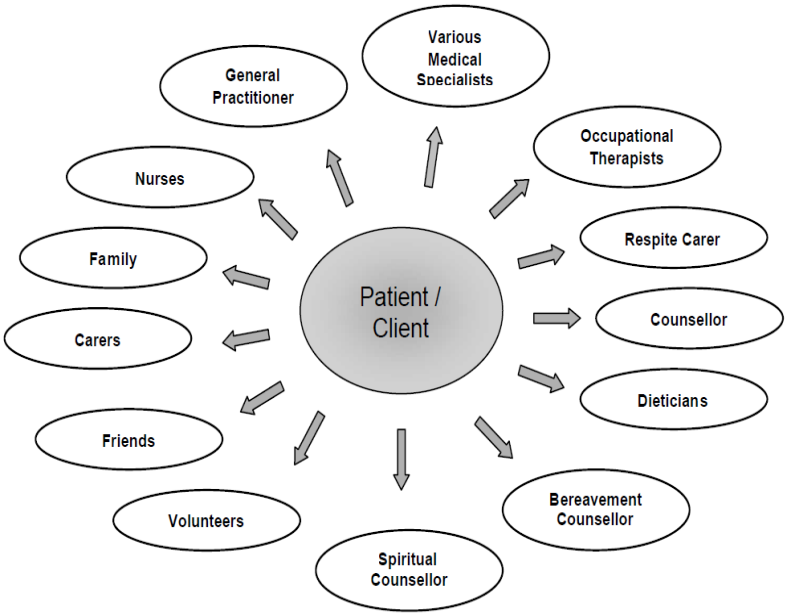
Supporting clients

Clients who are dying face numerous emotional and psychological issues coming to terms with their death. Understanding the process of dying will help the client confirm their sense of identity, self-worth and accomplishments.

Clients need to feel empowered by their choices.

As a client progresses, they may not be able to cognitively function. This decline will not allow them to freely make choices or decisions.

You can support the client in many ways by implementing key strategies to meet the specific needs. This includes maintaining the individual's social networks and activities.



Strategies to support this include;

- Discussing the situation with their family and gaining their support
- Talking to the individual's friends so they understand the individual's feelings
- Preparing a plan to help the individual to maintain their social contacts
- Ensuring access to family members and friends is maintained and supported
- Respecting the individual's choice of friends
- Respecting the individual's decision not to see people

The pattern of care may differ for every individual faced with a life-limiting illness or who is at the end of their lifespan. Factors that influence a person's pattern of care include where the person lives, the services in their area, their specific needs, beliefs, values, spirituality and culture and the needs and desires of their family members and friends. These individual care needs will be detailed in a care plan. The care plan provides documented support for when the person is no longer able to make decision for themselves.

You can assist in the development a responsive care plan by ensuring effective communication is being conducted throughout the process, considering cultural, religious and other factors and differences that is important to the person along with having a caring attitude.

By working with the client and their family we are able to identify the client's preference and adopt strategies to ensure the client receives their choice/preference when carrying out service delivery.

Respecting client preference will allow for optimum care of the client.

Supporting families

By working with the client and their family we are able to identify the client's preference and adopt strategies to ensure the client receives their choice/preference when carrying out service delivery.

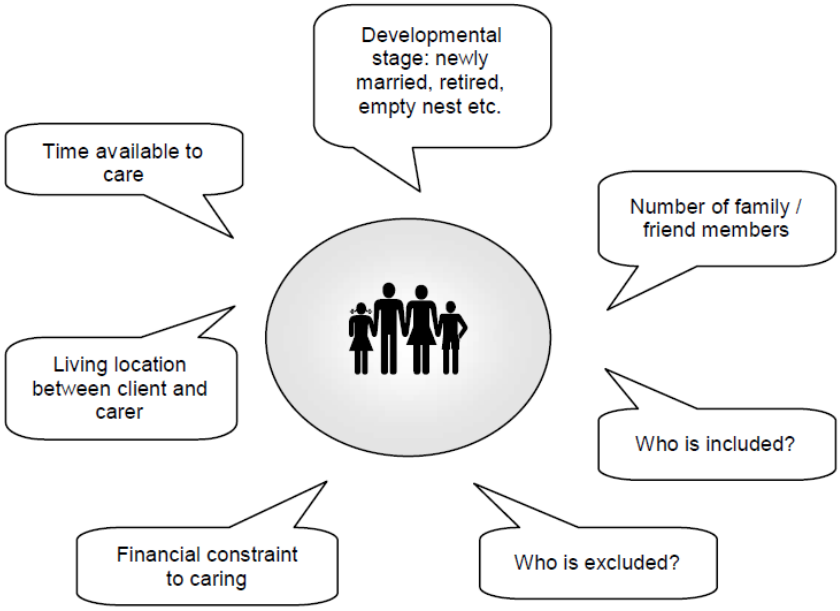
Respecting client preference will allow for optimum care of the client.

Personal care workers will support the client and all family networks to provide support and comfort during this difficult time. The personal care working role may include them being positioned in the persons home or in a care facility. Depending on the care location the care requirements may alter.

The personal care worker may be required to do: general housework, shopping, respite care, personal hygiene for the client (e.g. showering), assist with physiotherapy exercises or even perform cultural/spiritual rituals with the client (as appropriate with client's belief systems).

Talking with families will provide an understanding of specific challenges the family may have, and their reactions to these challenges, and provide opportunities for you to gain a better understanding of your client's family/friend structure.

Family/Friend Structures can consist of many variables, including:



The following video will assist you in understanding a palliative approach. A palliative approach is not limited to the last days or weeks of a person's life. The primary goal of a palliative approach is to improve a person's level of comfort and function and to address their psychological, spiritual and social needs. Providing active treatment for the resident's condition may still be important.

i	**Palliative approach** https://www.youtube.com/watch?v=KERzNi6GEhk

Communicate with all parties about the persons quality of life, pain and comfort

Communication

Being able to support the client and their network is an essential skill in caring for a client with complex needs. Without this skill the communication processes will be ineffective, messages will be blocked leaving the client/carer feeling frustrated and alone.

Communication is a two-way process involving a sender, a message and a receiver. Effective communication is when both the sender and the receiver have the same understanding of the message being communicated.

Carers need to be aware of the various forms of communication. Communication is not just about language and talking, we also communicate through our body language and actions.

Effective communication skills include:

- Listening Skills: can receiver/sender hear communication? Are you watching the person for non-verbal cues?
- Understanding of cultural differences
- Self-awareness: feeling and responses (both you and the client) need to be acknowledged, accepted, managed ad appropriately expressed
- Respond with empathy and respect
- Use of questions: open-ended questions, closed questions and leading questions
- Ensuring written skills are adequate so communication can be read

Communicating information

When sharing information with families relating to quality of life, pain and comfort, it is important to be factual and provide examples of how you have determined the level of pain and discomfort. Being able to openly discuss changes in care and talk comfortably about issues relating to palliative care is important for all parties. Clients/patients, families and carers respect and value this as a part of your role.

Once the family has an understanding of the status of the client, they can make decisions more clearly.

Strategies to support effective communication relating to palliative care:

- Plan ahead for discussions about the care when possible
- Find questions or phrases you are comfortable using to initiate and continue conversations about palliative care
- When organising appointments where prognostic information may be communicated check who should be there

Information needs to be tailored to suit the individual needs of both the person and families. Making sure the information is easy to understand, clear, jargon-free and provided in a timely manner will help all parties absorb what they need to know.

Other communication tips include;

- Ensure information and the delivery is consistent
- Acknowledge emotions and concerns
- Do not give misleading or false information
- Provide time for and encourage questions and further discussion

Further information about communication in palliative care situations. Whilst this is from a medical practitioners perspective it provides valuable tips on how to set the scene, be prepared, encourage participation and questions, consider emotions, gaining acknowledgement of understanding.

Communication in Palliative care situations.
https://www.caresearch.com.au/caresearch/tabid/3392/Default.aspx#Vid

Workers may be required encourage the client and their support network to share information also and provide opportunities to do so. Providing the family with an opportunity for a "cuppa" will promote a relaxed environment in which sensitive discussions can take place. Privacy at this time is very important. If the client is living in a residential facility and is sharing accommodation with another person, drawing the curtain or if possible, move the client and family to a conference room to provide a sense of privacy.

Respect the family and carers and integral part of the care team

As outlined in the unit Support relationships with carers and families (CHCCCS025); families and carers are an integral part of the care team and as such require the utmost respect. An important element of your role is not only sharing information and providing support the person in need, but also sharing information and providing support to the care team. The care team may consist of friends, family members and other health professionals (see page 3. The palliative care team).

Palliative care can impact the carer and care team in a multitude of ways. For example;

- The relationships the carer has with their spouse or partner or children, other family members and their employment
- The time and energy they have to devote to their personal lives
- Their mental health
- Their financial situation
- Their physical health
- Their capacity for social activities

You can provide emotional support to the care team by the following;

- Encouraging them to express their feelings to help them cope with uncertainty, denial, anger, depression and feeling like they have lost control
- Acknowledging the emotional and physical burden on individual family members of caring for someone who is dying
- Recognising and allowing for different coping styles between individual family members and carers
- Providing family members with privacy to express their concerns and the difficulties they are experiencing
- Providing reassurance if they feel guilty about issues; for example, relationship issues, wanting it to be all over, not wanting to be at the individual's bedside all the time
- Offering interventions such as pastoral care

Element 2: Respect the persons preferences for quality of life choices

We are all individuals with our own personal identity. A person will hold an individual opinion as to who they are, what they are, how they should function as a human.

Your clients have established patterns of behaviour and daily routines that will be firmly entrenched through their choice of lifestyle. It is important when providing services with clients that we ensure there is no loss of personal identity.

Both professional carers and family carers need to be aware of their individual opinions, beliefs and values and the effect they may have on their client's lifestyle if implemented without client permission.

It is important that we respect the client's personal identity and implement as much as possible their own lifestyle choices to reflect the individual whilst following organisational policies and procedures.

Culture

Culture is learned through socialisation, in other words, the way individuals learn to live in society. It is through this process of socialisation that people learn to live in accordance with the expectations and standards of society. Family interaction, school and formal religions influence the cultural expressions and behaviours of groups and individuals.

Culture is expressed through the clothes we wear, our health care, attitudes towards taking medication, expression of pain and our rituals, e.g. death rituals, marriage ceremonies.

When a client is admitted to care services it is essential that all aspects of the person are documented on their care plan. Individuals must be allowed the freedom to live their lives according to their own cultural and spiritual beliefs.

Information about specific cultural practices will help to improve the quality of the services you provide to clients. However, it is always important to identify individual needs and preferences and remember that no individual can be reduced to a set of cultural norms. Within any culture, peoples' values, behaviour and beliefs can vary enormously.

Strategies to support an individual's needs include;

- Involve their carers in the discussion to determine what level of care they can provide in the individual's home
- Put the individual in contact with the palliative care or community nurse to discuss with them what help is available and how to access it
- Assist them with making an appointment to have an Occupational Therapist visit their home to assess their physical needs and recommend necessary modifications
- Help them to source and access equipment and aids that they may need
- Check with local council to see what support they can provide
- Provide them with a list of GPs, nurses, and other health care professionals in the local area who can provide service and support in the home

Spirituality

Although commonly thought of as referring solely to religion and religious beliefs, spirituality has broader implications. Spirituality may be thought of as "being moved by some outside source". Whilst formal religion is one-way people may express their spirituality, many people experience spirituality through a love of art/craft, music, nature or pets.

Throughout our lives we develop a connection with activities, environment, sound that we love. It is important when dealing with clients we accept their connection to their own spiritual belief systems.

Strategies to support the implementation of spiritual support include;

- Allow the individual to guide all spiritual interventions
- Provide a supportive presence and avoid judgement
- Coordinate spiritual services and people
- Ensure access to spiritual activities
- Obtained requested items for spiritual practices
- Avoid interrupting the individual during spiritual activities
- Follow spiritual beliefs in regards to medical treatment

Further key considerations of cultural and spiritual awareness:

- Be aware of your own cultural and spiritual influences
- Be aware of judging other people's behaviour and beliefs according to the standards of your own culture
- Be aware of making assumptions about cultural influences and applying generalisations to individuals.
- Understand that the behaviour and beliefs of people within each culture can vary considerably
- Understand that the extent to which people adopt practices of the dominant culture and retain those of their culture can vary with communities and even families.
- Understand that not all people identify with their cultural and religious background
- Understand that culture itself is a fluid entity.
- Understand the importance of familiarising yourself with different cultural practices and issues
- Understand the importance of appropriate communication

Customs, rituals and celebrations

To enhance quality of life for clients, provision must be made available for clients to participate in cultural and spiritual practices. This may be facilitated by:

- Providing clients with access to cultural and spiritual groups.
- Encouraging family and friends to participate
- Providing cultural and spiritual areas that clients may express cultural and spiritual beliefs

Information regarding cultural and spiritual networks available in the community should be provided to the client upon initial assessment. Information may be provided through brochures, access to telephone services, media such as tapes, CD, and DVDs.

If cultural and spiritual services cannot be provided to the client within their living environment, access to these support services should be encouraged through family and friends or provided by the organisation where possible.

Life style choices

Client lifestyle choices will be noted in the care plan. As the client's needs increase adapting choices to meet the client's physical capabilities will need to be documented in the care plan. If lifestyle choice cannot be maintained communication between members of the Palliative Care team will need to be established to adapt changing needs.

Clients from various backgrounds will express their lifestyle choices in different ways through various customs and practices and it is your role to be open and respectful to these needs. Ensuring privacy and freedom of expression in an appropriate environment will fulfil the needs of the client.

Create a supportive environment

Throughout palliative care you will have opportunity to provide a supportive environment to the client and their support network. The environment and supportive needs may change throughout palliative care depending on the current status and needs of the person.

Creating a supportive environment can include;

- Providing opportunities for your client and their loved ones to spend uninterrupted time together;
- Providing an environment in which the client has the best opportunity to heal
- Altering the room surrounding to create a peaceful atmosphere of 'everydayness' or 'at-homeness'
- Providing an environment that is safe which includes; secure, culturally safe, respectful and dignified

You can create a supportive environment throughout periods of loss and grief by; applying simple gestures such appropriate touch and communicating with empathy and compassion. Small gestures amount to large support for family and clients through this period.

Applying a non-judgmental approach

Applying a non-judgmental approach means to make a conscious effort not to be critical of the actions or thoughts of others. If you are putting this into practice, then you are attempting to do your job while withholding judgement on the person you are working with and all associated parties.

The non-judgmental approach ensures that no matter the personality, intellect, ethnic origin, religious belief or any other individual factors will not prejudice the delivery of optimal care.

Working within the scope of your role

'Scope of practice': the legal definition of the activities that a professional can or cannot do. As carers we are guided by our job roles. These job roles have "descriptions" which provide us with a set of responsibilities and skill levels that we should base our work performance on. It is important that we remain within these guidelines as they create boundaries for our profession.

The role of Personal Care Worker comes with many "hats". You are there for the client physically, emotionally and psychologically. Many clients will look to you for answers and reassurance. This may sometimes place you in an awkward position as you want to please your client but may not know the right answers. You need to be mindful of your position, acknowledge your limitations of your job role yet provide support for your client in a caring and professional manner.

There are occasions where situations and issues may arise within palliative care roles that become outside the scope of your role.

These include;

- The individual may request voluntary euthanasia
- The individual may be unable to make decisions on their own
- The individual is failing to get the proper nutrition and hydration
- The individual may refuse pain relief
- The individual may request no CPR is given if the need arises

If these situations occur it is your responsibility to report to your immediate supervisor or manager and document all facts.

Element 3: Follow the persons advance care directives in the care plan

An Advance Care Directive (also known as a living will) is a document that sets out wishes of the client in relation to treatment decisions in advance, i.e. it is written at a time of "wellness" in preparation for a time when the client is unable to consent to treatment.

Legal implications

Currently, the law regulating advance directives in Australia is a combination of legislation and case law. Some States in Australia have legislation dealing directly with this issue, namely, South Australia, Australian Capital Territory, Queensland and Northern Territory. New South Wales, Tasmania and Western Australia have no direct legislation available as to advance directives.

Advantages

Advance Health Directives are advantageous because they:

- Encourage communication about end-of-life decisions
- Give directions to treatment decisions when the client is no longer able to decide for themselves
- Ensure that the will of the client is being met, i.e., patient autonomy is respected

Disadvantages

The disadvantages of Advance Health Directives include:

- Clients may change their mind about what they want when they are unwell, i.e.. the healthy do not make the same choices as the sick.
- They can be difficult to interpret in the real world, e.g., the advanced directive scenario may not match the current medical scenario.
- Discussion about advance directives can provoke anxiety particularly if not sensitively handled.
- Where to store them, i.e., how do we know that a client admitted to accident and emergency department in a coma has an advance directive?

Where a person no longer is capable of making decisions for themselves an appointed advocate, power of attorney, carer or family members may be able to make a decision regarding directives on their behalf.

Interpret and follow advance care directives

Depending upon client's wishes for end of life choices Advanced Care Directives may include:

- Medical treatment preference, including those influenced by religious or other values and beliefs
- Particular conditions or states that the person would find unacceptable should these be the likely result of applying life-sustaining treatment, for example severe brain injury with no capacity to communicate or self-care
- How far treatment should go when the client's condition is 'terminal', 'incurable' or irreversible'
- The wishes of someone without relatives to act as their 'person responsible' in the vent they became incompetent or where there is no one that person would want to make such decisions on their behalf. (Adult Guardian provide these services)
- A nominated substitute decision-maker that the treating clinician may seek out to discuss treatment decisions
- Other non-medical aspects of care that re important to the person during their dying phase
- Relevant state and territory legislation or guidelines on advance care directives

Complying with end of life decisions

With the assistance of the palliative care team, the client has made their end of life choice known and where appropriate implemented routines to ensure they receive quality of life based on the principles of a holistic approach.

As the client reaches the final stages of their life, the choice in where they die may not always be what they wanted. Some clients may not be able to be cared for in their original environment and will need more specialised care for their final days.

Watching a loved one decline and die is very distressing. Family members will sometimes override client choices on the pretence that what they are about to do will benefit the client. If the client is unable to physically acknowledge change to their end of life choice, there is little chance that the choices previously made will remain the same without some sort of written evidence/record.

Communication amongst family members regarding legal documents is very important. If the client does not pass this information on, as the client progresses, family members may not follow the client's end of life choices.

Your role as a Personal Care Worker is to follow the guidelines of the client care plan. If you witness family overriding client's end of life choice, ask them why they are making those choices. Report this to an appropriate member of the care team (e.g. your supervisor) in line with organisation protocols.

Reporting changing needs and issues

As the client edges toward the end of their life's journey, changes will need to me made to support the client's increasing needs. The palliative care team will review the client's care plan upon start of daily service to ensure any changes have been documented and discussed with the client and relevant parties.

Care workers will need to identify that consent has been given for new procedures/routines to client's care by appropriate team members and delivered in accordance with the client's end of life choices.

Clients have the right to change the end of life care. After discussion with the client, the care worker should seek appropriate advice regarding the client request before implementing new routines. Whilst client's rights must be acknowledged, legal implications may be at the forefront of new requests should they be performed without appropriate research and administration.

Throughout the end of life process, it is crucial to identify a person's changing needs and document actions taken. The way this is reported will vary depending on the organisation, however it is important to remember the significance of providing accurate, detailed and relevant information at this stage of a persons end of life. A client's records can be used in legal proceedings as evidence or may be viewed by the family power of attorney.

Reports need to be updated immediately as the change or issues occurs. When completing documentation and reporting on the persons changing needs, it is also imperative that the information provided is clear and concise, abbreviations are to be avoided unless all parties are aware of the meaning, document only what has been observed, be legible and avoid sweeping terms. For example, using the word 'appears' – 'the client appears to be in pain' which cannot be supported. Use definite statements of fact.

When completing documentation or recording information into a computer, please consider that other people will be reviewing it to. For example, change of shift, supervisors, doctors and/or other health professionals.

Monitoring the impact

In some occasions the families and carers have some or majority of input to end of life decision for the individual, however there are occasions where they do not have any input and as a result shows that their preferences may not be aligned to the patient's actual treatment wishes. These situations can become quite stressful on all parties.

End of life decisions that may impact families, carers and/ or significant others include;

- Do not resuscitate orders
- Use of pain medication
- Non-use of opioids
- Requires for spiritual/religious care

Monitoring the impact of the person's end-of-life needs, issues and decisions on families, carers and /or significant others will require care workers to provide additional support and at time refer to either external and internal counselling services or refer to appropriate members of the care team.

Where internal support services are not helping the situation, referrals may need to be made to external organisation's such as counsellors.

It is important for care workers to work in line with organisation protocols to ensure they are supported.

Legal and ethical Considerations that you may be required to comply with include;

- Medical treatments
- Maintaining the individuals wishes
- Dealing with conflict

You can demonstrate compliance by;

Advanced care directive	Comply with legal and ethical considerations
Medical treatments	Ensure medical treatments meet the individual's preferences Ensure you are honest if treatment goals are not met Comply with the individual's advanced care directives
Maintaining the individual's wishes	Respect the individual's wishes Encourage ongoing discussion with the individual, their family, doctor, and guardian to ensure that the individual's and family's wishes are current Maintain the individual's personal goals
Dealing with conflict	Respect the individual's preferences and decisions Ensure the individual, their family and carers are provided sensitive support and assistance in any possible way

Supporting the rights of individuals through service delivery

Support workers are required to deliver services in a manner that supports the right of individuals to choose the location of their end of life care.

There are alternatives to provide the client with their end of life location should it not be their first preference. It is important to think about who the client is and adapt their environment to suit the life style choices. End of life choices and decisions a person may make can include; selecting the type of medical treatment, pain control, the ability to decide on or refuse treatment types and the life support choices they want to use. The people they want around them at the end of their life along with how family affairs are looked after may also be present at this state. Some people have not pre-made arrangements for how they want their funeral to be or are now concerned with the location of their death.

You can demonstrate active support through asking the following questions and adopting the following strategies:

- Can their spiritual and cultural preferences be adapted to a new environment?
- Is there a familiar smell/noise that may make the client feel at ease?
- Family photos/trinkets placed beside the bed
- Is there privacy for the client and their support network?
- Has the client been given opportunity to be with their loved ones as they die?

It is most important that the client feels they are secure and in a familiar environment. If possible, being surrounded by loved ones will allow the client to feel at ease and accepting of their situation. Talk with family members and the palliative care team to adjust the care plan as needs arise. Following the care plan provided by your organisation you will deliver services in a manner that supports the right of client to choose the location of the end of life care.

Strategies that may be implemented to support the individual's choice of location for their end of life care include;

- Involve their carers in the discussion to determine what level of care they can provide in the individual's home
- Put the individual in contact with the palliative care or community nurse to discuss with them what help is available and how to access it
- Assist them with making an appointment to have an Occupational Therapist visit their home to assess their physical needs and recommend necessary modifications
- Help them to source and access equipment and aids that they may need
- Check with local council to see what support they can provide
- Provide them with a list of GPs, nurses, and other health care professionals in the local area who can provide service and support in the home

Change of end of life decisions

It is quite common for individuals to have pre-made plans relating to their end of life. Individuals may decide to make changes to their end of life plan. When this occurs, it is your responsibility to report to whoever is your direct report. For example; either a manager, facility manager or supervisor.

The care plan will need to be revised to reflect the changes and the persons family members, so they are aware of the new needs or issues. Progress notes must be detailed outlining the changes and it is good practice to follow up so you know that your comments and changes have been read and acted upon.

You can also ensure you remain up to date on any possible changes to the care play by regularly checking for changes on the care plan.

Element 4: Respond to signs of pain and other symptoms

Observation and documentation of the persons pain and symptoms

Signs of pain

When clients are diagnosed with a terminal illness, one of their first thoughts are of the pain that will be caused by their disease. The thought of dying a slow painful death has come from the public perception that death is painful.

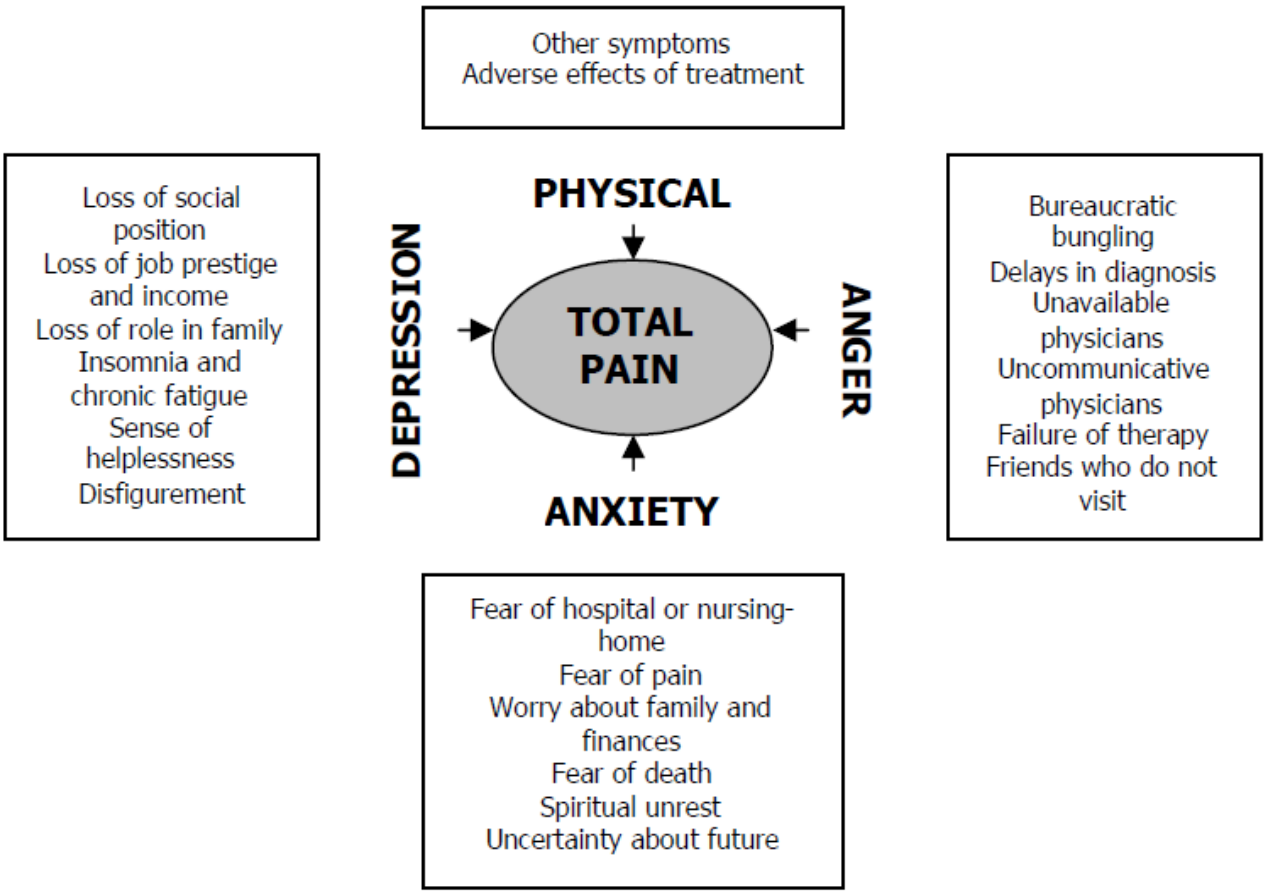
Depending on the type of disease the client has, pain may or may not be a significant factor. Pain management will depend on disease type, medication that can be used to provide comfort to the client and the client's perception of pain.

Note: The most important rule in pain management is the patient's perception of their pain and to acknowledge the pain as real.

Dr Cicely Saunders first introduced the concept of total pain in 1967 and it is still used today.

Looking at the diagram on the next page, we can identify that there is more than just a physical component to pain. Pain may be physical, emotional, spiritual or a combination.

These personal factors will affect how the client will relate to and demonstrate their pain.



Types of pain

Pain comes in many forms. The sudden, sharp, and usually temporary pain produced as a result of getting a finger caught in a door is quite different than the dull throbbing pain of a backache that doesn't go away. Though they are both painful sensations, a pinched finger and a backache feel very different.

There are several ways to describe and define different types of pain. Pain can be characterised in terms of its duration or its cause.

Pain categorised by duration

The most common way that pain is categorised is in terms of time — essentially, how long the pain lasts and how quickly it disappears. Using this classification, there are two general types of pain.

Acute pain is short-term and chronic pain is long-term, at least three months without interruption.

These pain types are not mutually exclusive: both acute and chronic pain can be felt at the same time. Nor are these pain types rigid: for example, acute pain, especially if not properly addressed and treated, can become chronic pain.

Pain categorised by cause

Pain is also categorised in a few other specific ways. Procedural pain comes as a result of diagnosis and treatment. Needle pokes, also called sticks, for taking blood or injections are the most common cause of procedural pain. Procedural pain is distinctive because the source of the pain is known and the pain can be addressed before it occurs. Cause is often used to further define chronic pain. For example, it can be referred to as chronic cancer-related pain or chronic non-cancer pain. This distinction leads to different assessment and treatment approaches.

Chronic pain

Chronic pain usually (but not always) falls into one of two categories:

1. Nociceptive pain (no-si-sep-tiv) is caused by damage to body tissue and usually described as a sharp, aching, or throbbing pain. This kind of pain can be due to tumours or cancer cells that are growing larger and crowding other body parts near the cancer site. Nociceptive pain may also be caused by cancer spreading to the bones, muscles, or joints, or that causes the blockage of an organ or blood vessels.

2. Neuropathic pain occurs when there is actual nerve damage. Nerves connect the spinal cord to the rest of the body and allow the brain to communicate with the skin, muscles and internal organs. Nutritional imbalance, alcoholism, toxins, infections or auto-immunity can all damage this pathway and cause pain. Neuropathic pain can also be caused by a cancer tumour pressing on a nerve or a group of nerves. People often describe this pain as a burning or heavy sensation, or numbness along the path of the affected nerve.

Cancer pain can be nociceptive or neuropathic.

The symptoms of chronic pain include:

- Mild to severe pain that does not go away
- Pain that may be described as shooting, burning, aching, or electrical
- Feeling of discomfort, soreness, tightness, or stiffness

Pain is not a symptom that exists alone. Other problems associated with pain can include:

- Fatigue
- Sleeplessness
- Withdrawal from activity and increased need to rest
- Weakened immune system
- Changes in mood including hopelessness, fear, depression, irritability, anxiety, and stress
- Disability

To be able to assist your clients manage their pain it is essential that you:

- Observe the client and record changes: physical/psychological
- Actively listen to what the client is telling you
- Record changes according to workplace procedures
- Reflect on your client's disease and the stage they are at
- Explain services you are providing to client/carers and family
- Review and evaluate the services being provided and update care plan as necessary (in consultation with your supervisor)

Identifying physical pain

Clients in your care will have an established care plan that outlines a holistic approach to your clients total care needs. The plan will have identified areas of pain and symptoms and the type of pain management that is used. As your client progresses with their disease/illness/ageing you will need to identify new areas of pain and observe other symptoms. You must inform and record your findings in their care progress notes. This can be done in a variety of ways and will depend on your organisation's policy and procedures. As new areas of pain develop and are identified, you must document and report to your supervisor, so care plans can be updated to reflect new and emerging care needs.

As a carer you need to feel confident in your role as a pain assessor and be able to accurately provide information to your client/family to assist in the client's pain control. Building a rapport with your client will assist in communication and put the client at ease with delivery of questioning. Effective communication will provide the best opportunity for difficult issues such as pain management. Combination of verbal and written communication strategies will provide for best outcomes.

Document responses the client makes in their progress notes, so the notes can be reviewed on a regular basis. As new areas of pain develop and have been identified by you, you must document and report to your supervisor, so care plans can be updated to reflect new needs for your client's comfort.

Some written communication techniques used are rating scales. These help the client identify to the assessor the severity and location of pain.

See the example below:

Visual analogue pain scale

How severe is your pain today? Place a vertical mark on the line below to indicate how bad you feel your pain is today.

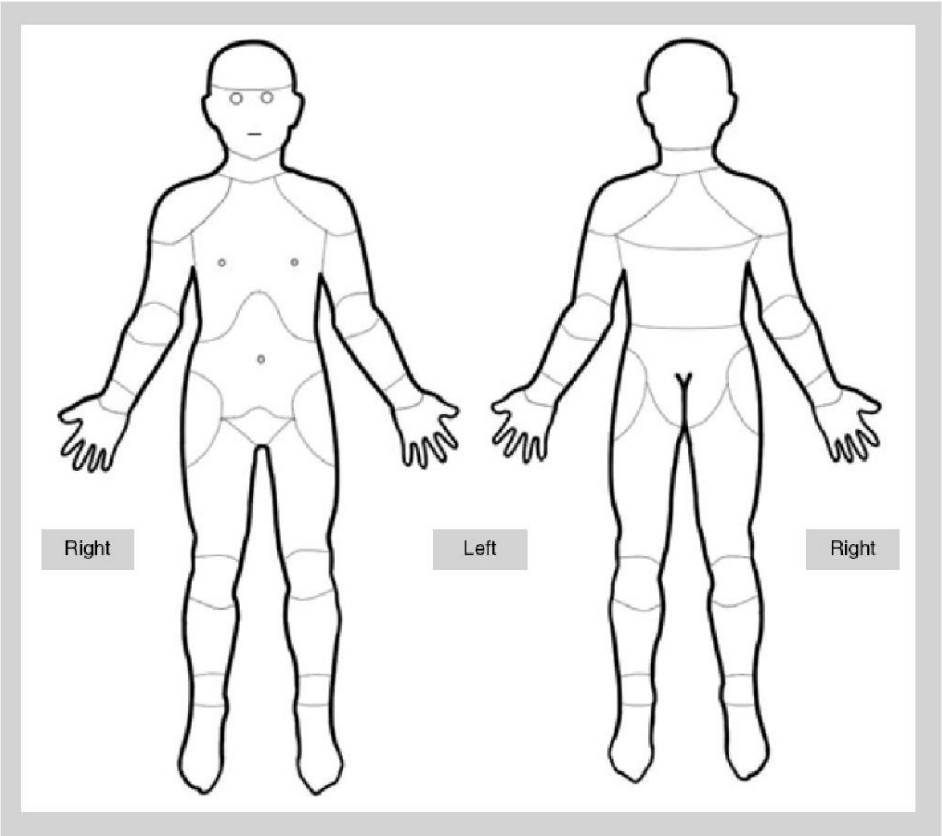
A Visual Analogue Scale (VAS) is a measurement instrument that tries to measure a characteristic or attitude that is believed to range across a continuum of values and cannot easily be directly measured.

Operationally a VAS is usually a horizontal line, 100 mm in length, anchored by word descriptors at each end, as illustrated above. The client marks on the line the point that they feel represents their perception of their current state. The VAS score is determined by measuring in millimetres from the left hand end of the line to the point that the client marks.

These measurements are a useful way of monitoring pain over time and responses to pain relief interventions.

It is useful to document the site of pain also. This can be done on a body chart as shown below:

Pain location chart



The following are some signs that that may indicate a person is in pain:

- If a person is normally loud and noisy, and become suddenly very quiet and withdrawn
- Cease doing activities or actions done previously
- If a person is normally very quiet and withdrawn, they may get loud, act stubborn, and hit people
- Eating habits change (for example: only wanting to drink or eat soft foods
- Loss of control of your bowel and bladder
- Depressive or saddened facial expressions
- Where someone is not able to speak they might blink their eyes very fast much of the time or grimace (make strange faces).
- Change of movement

A person may also display the following;

- Knees drawn up to chest and rock like a baby
- Touch, rub, pull or pick at a body part that is hurting
- Start to pull away from peoples' touch and protect your arms or legs
- Suddenly begin to stumble or fall, when you had no problems before
- Sleep more or less than usual
- Whimpering or groaning
- Becoming confused suddenly

It is important to remember management of your client's pain will provide opportunity for maximum comfort and well-being. Done on a regular basis it will provide information towards determining the type and cause of pain thus assisting in appropriate drug and alternative therapy use.

Spiritual pain

People with terminal illness can experience many kinds of loss and each of them has its own kind of grief. Some of these may include:

- Loss of purpose and hope in life
- Unresolved past loss
- Current losses (e.g. loss of health/independence)
- Anticipated loss (e.g. leaving loved ones behind)

Spiritual pain and suffering may also be caused by the person feeling abandonment by God.

Signs of Spiritual Pain/Suffering may include;

Emotional

- Restlessness/agitation/anxiety
- Denial of illness or of reality of prognosis
- Anger
- Fear
- Powerlessness and loss of control
- Depression/flat affect
- Dreams or nightmares

Behavioural

- Refusal to take pain medication
- Refusal of assistance with ADLs
- Power struggles with caregivers or family
- Puts self in unsafe care position
- Frantically seeks advice from everyone
- Active forms of self-harm
- Loss of independence
- Lack of engagement with activities that bring comfort or joy
- Withdrawal/Isolation
- Questions about "why" or duration of dying process
- Statements about "not wanting to be a burden"
- Metaphorical or symbolic language suggesting distress or unresolved concerns
- If history of religious practice/affiliation, refuses religious leader or stops practice

Physical

- Unrelieved pain
- Shortness of breath
- Sleeplessness
- Other signs
- Conflict between the goals of palliation and religious beliefs
- Fixation on nutrition, herbal remedies, or miraculous cure

Personal growth and healing often occur at the end of life. Although a terminal illness may be perceived or experienced primarily as negative or devastating, for many persons it becomes an opportunity for personal growth and healing. In its Greek origin, the word "crisis" includes a sense of possibility, connotes opportunity. Spiritual growth at end of life is possible for all persons regardless of belief. Persons need not share a religious or philosophical framework that says that good can come out of difficult times or life out of death in order to experience growth and healing at the end of life.

Spiritual growth does not diminish suffering. Contrarily, that some healing happens does not diminish the very real suffering experienced both by the person who is terminally ill and by their family.

What precipitates personal and spiritual growth at the end of life?

- As persons are less able to engage in life activities due to functional limitations, they have time for spiritual reflection and spiritual practice
- Dependency, loss, fear, and suffering lead many persons to turn to (or return to) their religious tradition for meaning, strength, and comfort
- Individual may take emotional and spiritual risks they would otherwise avoid
- Because family members will not have another opportunity with their loved one, they often seek healing, connection, and reconciliation
- Facing death evokes spiritual questions (about forgiveness, afterlife, the value of life itself) not normally asked in the course of daily living
- For medical staff opportunities for personal growth abound in our own feelings of powerlessness, experience of multiple losses or painful deaths and as we bear witness to the courage, love, and faith of patients and families

How can the palliative care team help facilitate personal and spiritual growth for patients and families at the end of life?

- By treating physical pain and other symptoms so patients and families have room to focus on relationships, life review, and spiritual practice
- By offering assistance in finances and insurance matters and providing respite to limit caregiver stress
- By helping the patient and family identify spiritual, relational, and emotional "goals" or "tasks" in addition to the management of physical pain
- As an "outsider," by noticing opportunities for healing and growth in the course of an illness that the patient and family might overlook
- By asking whether their spiritual, philosophical, or religious framework offers comfort, meaning, or direction for action
- By sharing stories of how other patients and families have found meaning, hope, and healing during this time of life
- By being emotionally and spiritually "present" in the face of suffering and despair
- By inviting the participation of the psychologist, social worker or chaplain

Other practices that may help a person who is experiencing spiritual pain include;

- Prayer
- Relaxation techniques
- Chanting
- Ritual cleansings
- Acts of atonement
- Shamanic treatments
- Acupuncture
- Herbal remedies

Emotional pain

Sadness is a part of being human, a natural reaction to painful circumstances. Clients with terminal illness will throughout their journey's disease display signs of emotional pain. It is not practical to expect your clients to be happy to face their physical decline and death. Death has many complex issues and the client's experience of this will be varied.

Emotional Pain can be displayed through a number of different ways:

- Physically: behaviour outbursts, crying
- Cognitively: clients may have negative thought processes that will affect their activities of daily living and interests
- Emotionally: feelings of frustration, sadness and despair

Through general observation of the client you will be able to identify when the client is in emotional distress and apply appropriate strategies. Clients who experience emotional pain may appear to be physically weak and lacking in energy. Fatigue is not just physical but also has psychological and cognitive dimensions. Fatigue coupled with the client's current medical condition can often lead to further health problems.

Strategies to assist your client to maintain an emotional balance:

- Talk with the client and acknowledge their feelings
- Educate client on issues that are bringing emotional trauma, provide information where applicable (e.g., pamphlets)
- Encourage the clients support network to discuss the situation causing emotional distress with the client
- Encourage the client to decrease non-essential activities
- Ensure client is comfortable
- Diffuse stress and anxiety with activities such as music therapy, conversation, reading etc
- Set realistic goals with client so they are not 'over powering' or too difficult for the client to manage

i	**Palliative Care:** www.tas.palliativecare.org.au/file/205/download?token=2SpzPKXQ **Helping with comfort and care** https://www.google.com.au/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=helping+with+care+and+comfort

Implementing strategies to manage pain and promote comfort

Prior to implementing strategies to manage someone's pain it is important to assess the individual. When assessing an individual's pain consider the following;

- Site of the pain
- Intensity and quality of the pain
- The onset, duration and pattern of the pain
- How the individual is showing their pain
- Current alleviation methods
- Effects of the pain
- Likely causes of the pain
- Pain management history/past interventions

You can ask the individual questions relating to where the pain is coming from, when did it start, what is the measurement of the pain.

i	**Pain Assessment:** http://www.racgp.org.au/afp/2015/april/pain-management-in-residential-aged-care-facilities/

Before strategies are implemented it is important that they are discussed with the palliative care team and the client. Assessment by the client's medical practitioner is essential before commencement of any alternative therapies. This is to ensure the strategies being implemented do not have adverse effect on the client.

Strategies to promote your client's comfort may include:

- Regular observation, reporting and documentation of client's comfort levels
- Provision of pain relieving medications by appropriate member of staff (as per organisation protocols)
- Physical comfort: Frequent position changes and supportive pressure relieving devices to aid in comfort, for example, ergonomic chairs and gel cushions.
- Personal Hygiene: Depending on client's level of pain, hygiene routine may need to be altered. Sponge bath may be more beneficial paying particular attention to groin area if incontinent. Oral hygiene important as taking oral fluids is difficult, excess food may be left to pool in mouth causing ulcer and bad breath. Observation of nostrils to ensure no irritations, (oxygen cannula or nasogastric tube are common causes).
- Breathing difficulties: Minimise activities that exacerbate breathing difficulties, for example, bring leisure activities to the client. Ensure client is in appropriate position to aid the airway.
- Nutrition and hydration: Ensure client is provided with food or beverages of their choice and within the limits of their tolerance for food and fluids. Thorough observation and recording clients condition is documented to enable appropriate staff to reassess.
- Sensory Perception: As client progresses, sensor perception may diminish. Use of touch and speech is very reassuring when applied appropriately. Therapeutic touch – appropriate touch to demonstrate concern when verbal communication cannot.
- Spiritual Needs: Client may request a spiritual or religious leader to perform religious or spiritual practices. Client may ask you to help them with their spiritual routine. Ensuring privacy, assisting routine and providing client with religious or spiritual object will help assist in their spiritual comfort.

Additional strategies may include applying heat or cold packs, using physiotherapy techniques, managing environmental factors such as light and temperatures, massage and diversional therapy, aromatherapy, magnetic therapy, acupuncture or hydrotherapy.

Administering food and fluids

Consideration must be taken on how food and fluids are administered to people as a variety of issues may arise.

- There can be issues with the individual’s ability to swallow food safely
- Some families will insist on trying to continue to feed someone even when it is no longer safe
- Families may also insist on intravenous fluids or artificial feeding (e.g. PEG) once someone can no longer eat or drink
- Some see the use of artificial nutrition and hydration as interventions in what should be a natural process
- Continuing PEG feeding at end-of-life may pose a burden on the dying person

Observing hydration and nutrition

Observing individual’s hydration and nutrition will provide you with an indication to where their current health is situated and where there is a deterioration in their health.

Some observations that could be made include (but are not limited to):

- Recurrent vomiting
- Diarrhoea
- Weight loss
- Dysphagia (difficulty swallowing)
- Advanced or worsening dementia
- Lack of interest or unwillingness to take food and fluids

Comfort measures that may be implemented once an individual can no longer eat or drink may include wetting the persons lips, using lip balms, providing sips of water or ice (being careful to avoid aspiration) or ensuring that mouth care is provided regularly.

i	**Pain management strategies:** http://www.apsoc.org.au/PDF/Publications/Pain_in_Residential_Aged_Care_Facilities_Management_Strategies.pdf

Note: Don't rush your visit with the palliative client. Your daily visit may be the antidote for all concerned in the client's environment, providing a temporary disruption from an often-tense situation.

Evaluation and documentation of the effectiveness of strategies

Document responses the client makes in relation to the above points, in their progress notes for later review. This information will ensure that throughout changes of shift personnel, staff are aware of what strategies are providing comfort and what strategies are not working. This will eliminate the situation of putting the person through further strategies that provided no comfort, promoted stress or provided negative effects to pain management.

Not all strategies are going to be effective for all people.

Strategies that can assist you evaluate the effectiveness of a pain management strategy include;

- The individual's appearance: Observe whether they look pale if their face shows signs of pain if they look scared or if they look peaceful
- The individual's posture: Notice if they are curled up, slumped over, clutching a specific part of their body or if they look relaxed and comfortable
- The feel of their skin: Whether the skin is hot, cold, dry, clammy or normal for their condition
- Their behaviour: Observe whether the individual is moaning, crying or calm; if they are not sleeping; if they are refusing to eat or drink; if they are finding it difficult to communicate or if they seem confused
- Any smells: Unusual smells in their urine, faeces, vomit, body, breath or coming from bandages
- How the individual feels: Whether they tell you they feel better and are comfortable if they say their pain is worse or has moved to another area, or if they have a temperature
- How long the pain relief is effective: particularly if the individual asks for more pain relief before the next dose is due

Misconceptions surrounding pain relieving medication

Misconceptions relating to use of pain-relieving medication can be detrimental to health and management of client pain.

You should feel confident to ask questions and seek clarification about medications you do not know about. If you use medications in the wrong combination or withhold medication based on your own personal beliefs rather than client needs, detrimental consequences could arise.

Some common misconceptions may include:

- Pain relief should only be given for pain that is currently present
- Doctors and nurses are the best judge of a client's pain
- Clients should not receive pain relief until cause is determined
- Clients may become addicted
- Strong analgesics may shorten life
- Pain management alone is not palliative care
- Client may become too drowsy to communicate with family

As a Personal Care Worker, you are not permitted to provide diagnostic or medication advice.

Who do I ask? You should report immediately to an appropriate staff member or your supervisor to seek clarification on your organisation's medication administration policy. Possible health ramification to your client could be life threatening if you administer incorrect dosage of medications.

There are also many restrictions in place in regards administering medications. For example;

Opioid medications - This type of pain relief can only be delivered by an authorised member of the palliative care team; for example, a Registered Nurse or doctor. Other pain treatment therapies may also have to be administered by trained, qualified or approved staff. The Drugs, Poisons and Controlled Substances Act 1981 outlines the legal requirements in regards to administering medication

For further information regarding pain management visit;

i	**Pain Management:** http://www.palliativecarebridge.com.au/resources/PainManagementInPalliativeCare.pdf

Regular evaluation of implemented strategies will assist in future palliative care programming for the client. Refer to your organisation's protocols for review and planning protocols.

Element 5: Follow end of life care strategies

Regularly check for changes in care plan

Care plans are not static documents; they are regularly updated, taking into account the changing needs and preferences of the individual. Implementation of care plans must be monitored closely. Revisions and feedback are important in the evaluation of this working document. Changes and adaptations are put into place as required.

Regularly check for any changes on care plan that indicate decisions made by the person have been reviewed.

As the client edges toward the end of their life's journey, changes will need to me made to support the client's increasing needs. The palliative care team will review the client's care plan upon start of daily service to ensure any changes have been documented and discussed with the client and relevant parties.

Care workers will need to identify that consent has been given for new procedures/routines to client's care by appropriate team members and delivered in accordance with the client's end of life choices.

Providing a supportive environment

It is essential that the client's environment is pleasant, comfortable and reflects the person's needs and wishes. Decorate the room with items of client's choice, for example, family photos, flowers and small mementos. This will bring comfort to the client spiritually and emotionally. Remove all medical equipment from the client's room that is not required on a regular basis to maintain personal environment. For clients confined to a bed or a chair try providing a day bed in another room that has constant activities. Clients will feel wanted and valued.

Respecting and supporting preferences and culture

When providing end-of-life care follow the care plan and work within the scope of your role. Respecting and supporting the person's preferences and culture throughout this time is a major part of your responsibilities.

Good quality care has been characterised as being tailored to each individual and family, focused on them and related to their needs, provided through the presence of a caring relationship by staff who demonstrate involvement, commitment and concern.2 Caring has behavioural and motivational elements; it has physical manifestations but also psychological, spiritual and social dimensions. 'It is of great importance to the dying to feel that their cultural needs, values and practices are understood, accommodated and affirmed by those caring for them,' according to Schwass (Schwass M, 2005).

To optimise our care, care workers must ensure that social and cultural aspects of life and death are identified, embraced and understood. Planning and preparation will ensure that the belief systems and cultural norms are applied throughout end of life care.

i	**Importance of culture and ethnicity:** http://palliativecare.issuelab.org/resources/17334/17334.pdf

Maintaining dignity of the person

You can maintain the dignity of the person throughout providing planned end-of-life care by including the following in your practice;

- Support the person to have as much control over decisions, care and treatment as possible
- Support the person to die where they want and in a way that they choose
- Ensure that pain, discomfort and other unpleasant symptoms are recognised quickly, reported and addressed
- Recognising family members and friends
- Listening with empathy and compassion to the person and offering comforting words
- Help people to plan and to say goodbye to loved ones
- Allow people time for reflection and provide professional support where needed
- Encourage, as far as possible, meaningful activity and discussion to support a sense of self-worth and purpose
- Ensure you are fully aware of people's cultural and religious preferences when providing end of life care
- Caring competently for his or her physical needs (such as personal and oral hygiene) in a gentle, compassionate and respectful way
- Being comfortable with appearance
- Ensuring that everything you do complies with any advanced statement that the patient may have made

Throughout the end of life care, dignity of the person can be maintained through a variety of ways. This includes ensuring that the individual is in appropriate clothing or asking the person if they would prefer to be in a chair or bed. Discovering the needs and wants of the person at this time is crucial as they may not easily provide their needs and wants without being asked. You may ask the person if they would like to be massaged lightly with scented oils, so the smell of the hospital is removed. The individual might like the number of visitors to be restricted or have everyone there. There might be specific cultural aspects of death that the person would like you to complete which by finding out will help maintain their dignity.

Furthermore, the following points will assist in maintaining the dignity of the person;

- Removing mirrors from the room
- Ensuring they remain covered at all times
- Discretely attending to incontinence
- Ensuring privacy when attending to physical needs
- Maintaining hygiene and presentation

Care of a patient and their family doesn't end when the resident dies. There are arrangements that need to be made to meet the wishes of the person. The care plan will provide details of actions the staff will need to take at the time of death.

Recognise signs of imminent death or deterioration

Process of dying

As the client deteriorates, signs of dying may become apparent. The client may display these signs within the last couple of days of their life.

Ensure your client has adequate privacy and is comfortable.

Signs of imminent death include

Signs and symptoms of how the body prepares itself for the final stage of life include;

- Coolness – hands, arms, feet and then legs become increasingly cool to touch
- Skin changes
- Sleeping increased
- Disorientation
- Incontinence
- Restlessness
- Reduced production of urine
- Reduced intake of fluid and food
- Breathing pattern change
- Vision like experiences
- Withdrawal
- Decreased socialisation
- Unusual communication
- Giving permission
- Saying goodbye

i	**Signs of imminent death :** http://www.palliativecarensw.org.au/pdfs/PCNSW-Signs-Symptoms-of-Approaching-Death-ARTICLE.pdf

Signs to know that death has occurred

- No breathing
- No heartbeat/pulse
- Loss of control of bowel and bladder sometimes occurs
- Eyelids may be slightly open and pupils bigger than usual
- Eyes fixed in one spot
- Jaw relaxed and mouth slightly open.
- Change of body temperature

If you are present with the client at time of death, immediately notify the client's support network. Notify appropriate staff of palliative care team as a Doctor may be required to attend to determine time of death before they are placed in the hands of the Funeral Director. Report to your supervisor to ensure you are following organisation protocols.

Encourage the family to say their goodbyes to their loved one and assure them there is no need to hurry to do anything, and to stay with the client for as long as they wish.

For cultural and spiritual reasons, some family members may not wish to view the client when they have died. Support them by moving them to another room and provide comfort to them until further help has arrived. Place a sheet over the deceased to cover the body but do not attend to post mortem care until authorities have declared the client dead.

Once the client's family has received immediate support prepare the body for post mortem care. Place the client in the supine position. Place pillow under head, lay arms beside body and cover the body with a sheet. If the client's relatives wish to view the body, place a sheet over the client to cover to chest. You will need to refer to your organisation's policy and procedure regarding removal of tubes and monitoring equipment.

You can maintain the dignity of the person immediately following their death by;

Removing any equipment from the body, such as tubes

- Following any cultural or religious rituals
- Closing their eyes
- Placing their arms by their side
- Placing a pillow under the head to prevent discolouration due to blood pooling, and a towel under the chin so their face does not sag
- Maintaining their usual facial features; for example, replace dentures or hair covering
- Gently washing the body to remove soiling
- Providing their family and the palliative care team with a chance to say their farewells before the individual's body is removed
- Collecting their clothing and belongings
- Providing a formal debriefing for the palliative care team

Providing emotional support in the occurrence of death

The family of a deceased client may need a variety of support. This support may include emotional, spiritual or medical support, counselling or advice relating to legalities and finances.

Death of the client brings many emotions to those left behind. You will be required to provide support for the emotional needs of others. This can often be hard as you go through your own stages of grief for your client.

Depending upon organisational protocols offer your clients the opportunity of a Bereavement Counsellor or Priest from their local parish. Bereavement Counsellors are professionals who help people experiencing the loss of their loved one.

Many different cultures have their own beliefs regarding death.

Below are some examples of different cultures and their belief in what should happen once a person has died.

- Jewish family members are not supposed to see the body after death, so they can remember the deceased as alive rather than dead.
- African Americans believe of the importance of "giving them a big send-off" This belief influences decisions concerning the type of coffin and vehicle for carrying the coffin to the funeral or burial site. Families may spend large amounts of money on big or "beautiful" caskets to make sure that the "send-off is sufficient
- African American and Filipino believe the body cannot be cremated because the soul must go to heaven.
- Hindus and Buddhists believe cremation eases the passage to another life and families may keep the deceased's ashes in the home. Prayer and food or water are believed to ease the soul's passage.
- Hispanic, Hindu, and Buddhist believe that food and water may be set out on a windowsill or put on an altar. The water helps the soul look toward the light, and prayer helps the soul to rest. Coffee may be put in a windowsill to make the spirit rest

Note: Referring to your client care plan will provide you with the appropriate cultural and spiritual preference your client intended to be carried out upon death.

Remember - always refer to your organisations policies and procedures regarding post-mortem care before proceeding.

In helping others through their grieving process, it is important to:

- Be a good listener. Encourage the person to express their feelings and emotions and never judge. Don't shy away from the person; they may feel isolated and alone
- Don't always rely on words: a squeeze of the hand, a touch on the shoulder or an embrace can be very comforting
- Don't hide your own grief, share the experience
- Show that you haven't forgotten - remembering special dates is important
- Offer assistance with meals and daily chores
- Show confidence in the person
- Reassure them that it is OK to feel like this
- Encourage list making as a way to set priorities
- Be there

Approaches to avoid

- Telling them about your grief experience instead of listening
- Comparing your grief with others
- Telling them that they're grieving in the wrong way
- Give advice about how to get over the loss
- Reasoning with them about how they should or should not feel

What to say to family/friends

When caring for someone who's lost a loved one, specific questions and phrase can help him express his/her feelings. These may include:

- I'm sorry for your loss
- Tell me how you're feeling
- What special memories do you have?
- Were you there when (name of loved one) died? What was that like for you?

Keep in mind that you don't always have to say something. Sometimes your presence alone can be just as therapeutic as verbal communication. Crying with a family member and touching him/her on the hand, arm, shoulder, or back is also acceptable, when appropriate, and shows your compassion.

Some comments to avoid

- "At least you've still got your children"
- "He's happy in heaven"
- "You'll feel better soon"
- "You've got to pull yourself together and be strong"
- "She's lucky to have lived to a ripe old age"
- "She's better off"

Caring for your client after death

You will need to have knowledge of end of life procedures that your client has chosen. This will be documented in the Advanced Care Directive or Enduring Power of Attorney documentation. Spiritual and cultural procedures should be adhered to in order to respect the rights of your client. Depending on client's choice in cultural and spiritual preferences, you may be assisted by family/friends to prepare the body. Do not start post mortem care until you have sought advice from your supervisor and have permission from client's family.

Element 6: Manage own emotional responses and ethical issues

We are all humans who face the challenges of life through different means. The death of a client affects all members who work in a caring environment even when death is expected. Each individual will handle the death of their client in their own way. The longer a Care Worker spends time caring for a client, the more vulnerable that Care Worker is to feelings of loss when a client dies. Care workers often suffer these feelings of loss and grief in silence.

Follow organisation policies and procedures in relation to managing own emotional responses and ethical issues

Organisations will have policies and procedures that will provide guidance to you for managing emotional responses; For example.

- Emotional safety policy which aims at supporting the psychological demands of working in palliative care work.
- External support policy – where the organisation engaged an external provider
- Staff Communication policy
- De brief policy
- Post-partum support policy and procedure

i	**Policy and procedures** http://mob.mhcc.org.au/media/2241/health-medical-palliative-care-policy-2012-12-14.pdf http://hospicefoundation.ie/wp-content/uploads/2013/04/End-of-Life-Care-Supporting-Staff-a-literature-review.pdf

Policy and procedure within the organisation may include a requirement for you to follow the below points;

- Confidentiality and privacy must be ensured at all times
- Bereavement support must be provided when needed
- The individual's family must be supported in every way possible
- The individual's dignity and quality of life must be maintained
- Spiritual support must be provided when requested
- Care plan and individual preferences must be followed at all times
- Advanced care directives must be implemented when required
- Cultural issues must be understood, and the individual's wishes followed
- Provide psychological support when necessary
- Social support, intimacy and sexuality issues must be addressed
- Issues specifically relating to Aboriginal and Torres Strait Islander people must be understood and addressed

Managing emotional responses

When caring for our clients we follow a Person-centered approach and holistic care. This means that we need to not just look after the client / resident / person but also ourselves as carers, in managing our own emotional wellbeing and ethical issues related to palliative care.

Death and dying itself raises many questions and each person will respond and act in different ways.

Following the death of a client you have cared for can bring about your own mixed emotions, thoughts and feelings and lead to your own reflections.

"There can be no knowledge without emotion. We may be aware of a truth, yet until we have felt its force, it is not ours. To the cognition of the brain must be added the experience of the soul." Arnold Bennett (1867-1931)

McKissock and McKissock (1999) also outline some basic principles for understanding grief:

- It is normal and healthy to express the intense and painful emotions relating to loss
- Grief is important for healings the wounds of separation
- A bereaved person may experience a wide range of feelings-shock, sadness, anger, guilt, despair, as well hope and acceptance
- The painful feelings will diminish with time. If they remain intense and prolonged professional intervention may be required.
- A total absence of grief-when a person carries on as if nothing has happened-is not a healthy sign and may indicate the need for professional help
- A bereaved person may be more prone to illness. both physical and psychological.

Reference: Aged care in Australia: A guide for aged care workers

Emotional responses can include; crying, poor concentration, fear, anger, silence, stress and burnout. Depending on the emotional response felt, the impact will vary.

For example;

Emotional response	Impact of emotional response
Crying	• Team members, individual's receiving care, family members and carers may be personally affected, which will impact on the calming, supportive environment that should be provided by the palliative care team
Poor concentration	• You may be unable to complete the tasks properly that others are relying on you to do • Could result in harm of yourself or others
Fear	• You may be unable to provide the support necessary to other team members, the individual, their family members and carers
Anger	• You may take out your anger on other people by swearing, crying or yelling, which creates an unpleasant and upsetting environment
Silence	• If you isolate your emotions and withdraw from providing care to future individuals following the death of someone you provided care to, this may result in a lower quality of care and prevent effective end-of-life care for others
Stress and burnout	• If you are overly stressed or burnt out, you are unable to complete the tasks that your team members are relying on you to do. This may increase their workload and place added stress on them

Support Agencies:
https://www.betterhealth.vic.gov.au/health/servicesandsupport/palliative-care-looking-after-your-emotions-and-mental-health

Identify and reflect up own emotional responses

A support system within your organisation can assist you in dealing with loss and grief associated with a deceased client. Loss and grief is personalised by your own experiences and expectations. Accepting support and advice from others will assist your ownership of the feelings you are experiencing.

Supporting other team members who have experienced the loss of client will allow them the opportunity to express their fears, anxieties, loss and grief. Showing empathy will allow your co-worker to develop trust with you which will enable them to discuss their feelings with you. Sharing your own experiences and providing advice on self-care based on yours and others experience will also provide support. Providing information on the support systems available within and external to the organisation will provide them with further avenues to connect with and seek support from.

Support groups allow feelings to be dealt with in situations when you may be working under considerable strain that does not allow you to easily release your emotions. Staff should never be made to feel guilty or inadequate when they express distress about the death of a resident.

Personal responses to emotionally charged situations may have potential impact on self and others. Acknowledgement of the personal response may require you to remove yourself from the current situation. This does not make you a bad worker. This reinforces the ability you have as a carer to acknowledge when personal response may inflict harm on others.

Managing ethical issues

Aged care workers are guided by two sets of ethics: their own personal morality and the ethics formal and informal common to the profession as a whole.

At times working in the Community services sector you may also be confronted with Ethical Issues in a palliative approach.

"An ethical issue or dilemma is when there is a conflict over an action or decision, due to competing points of view or possible course of action. in palliative care these issues often arise around sensitive and or personal concerns relevant to the older person who is dying."

Some common ethical issues include:

- Decisions regarding medical treatment-for example, to continue or discontinue medication: whether to provide hydration
- Conflict that may occur in relation to personal values and decisions made by or for the older person- for example the aged care worker may agree with the person or family's decision
- When to stop or initiate procedures
- Requests for assistance to die

(Reference: Aged care in Australia: A guide for aged care workers , 2nd, 2011.)

Be aware of facilities policies and procedures in relation to managing emotional responses and ethical issues, refer to the policies and procedures manual in your workplace. Raise any ethical issues or concerns with the supervisor or other appropriate person.

Raising ethical issues or concerns with the supervisor or other appropriate person

Ethical issues in palliative care are quite comprehensive. Why? Ethical dilemmas occur when we could justify acting in more than one way. To choose between moral principles is to make a moral judgment. Ethical discussion and decision-making demand that we move beyond our own particular values and adopt a more reflective style of thinking. Issues in palliative care are complex and solutions vary thus causing a moral improbability to solve.

Some highly publicised palliative ethical issues are:

- Assisted suicide by physicians
- The right to receive euthanasia
- Resources are wasted on dying clients

Ongoing discussion with the client, family, doctor, guardian and organisation to ensure that the client's and/or family's wishes are up to date will ensure end of life ethical decisions are appropriate.

It is important that aged care works when confronted with an ethical issue seek support from their supervisor.

Identify and action self-care strategies

Working in the community sector can be very rewarding, but it also exposes you to feelings of loss and grief.

Grieving at work can be difficult due to:

- Being aware of other workers and their responses
- Trying to remain professional
- Trying to stay positive for other clients

Grief can impact you in many ways; yourself, your working relationships, your family and friends.

For example;

- Yourself – your quality of life and quality of work may suffer
- Your work relationships – your relationships with colleagues and co-workers may become strained, or they may need to increase their workload if your work performance suffers
- Your family – if you are emotional, irritable, sad, etc. this is likely to affect your ability to communicate with family members and maintain your family relationships
- Your friends – you may become withdrawn and less communicative
- The individual – the grief may impact the quality of the care that you provide

In your role as a carer, you will experience loss and grieving, and it is important to recognise your needs and feelings.

Following is a list of strategies you could utilise to assist you in the grieving process:

- Express your feelings - talk about it (it will help it to sink in)
- Accept your feelings - grief is a natural response
- Look after yourself (eat, drink, sleep, get fresh air, avoid alcohol and drugs)
- Ask for help (don't think that you have to cope on your own)
- Be prepared for ups and downs (e.g. memories sparked by birthdays etc)
- Accept loss as a part of life
- Keep a diary to help you understand your path through the grieving process
- Seek professional help if needed
- Ceremonies - attending funerals, ceremonies or memorials can be important!

Using the above information of emotional responses and impact, the following table provides examples of copying strategies that might be useful.

Emotional response	Coping strategy
Crying	• Discuss your feelings • Seek support through your organisation or support groups
Poor concentration	• Give yourself time to grieve – allow time to cry, be angry, take time away from work • Discuss how you feel with work colleagues/supervisors
Fear	• Ask a colleague or mentor assist you through the difficult time
Anger	• Discuss how you feel with team members • Have a memorial service to acknowledge the person's life
Silence	• Seek support from your team and organisation, for example, bereavement training or debriefing sessions
Stress and burnout	• Speak to a health professional – psychologists, social workers or therapists • Allow yourself time out, ensure you get adequate sleep and rest

i	**Dealing with loss and aged care staff:** https://www.caresearch.com.au/caresearch/Portals/0/PA-Tookit/Bereavement_Support_Booklet_for_Residential_Aged_Care_Staff.pdf

Some other activities you may consider helpful include;

1. Set aside a minimum of 30 minutes every day for yourself. Do whatever you enjoy, whether it's reading, working in the garden, tinkering in your workshop, knitting, playing with the dogs, or watching the game.
2. Find ways to pamper yourself. Small luxuries can go a long way in relieving stress and boosting your spirits. Light candles and take a long bath. Ask your hubby for a back rub. Get a manicure. Buy fresh flowers for the house. Or whatever makes you feel special.
3. Make yourself laugh. Laughter is an excellent antidote to stress—and a little goes a long way. Read a funny book, watch a comedy, or call a friend who makes you laugh. And whenever you can, try to find the humor in everyday situations.
4. Get out of the house. Seek out friends and family to step in with caregiving so you can have some time away from the home.
5. Visit with friends. If it is difficult to leave the house, invite friends over to visit with you over coffee, tea, or dinner. It's important that you interact with others.

Reference: http://www.helpguide.org/elder/caregiver_stress_burnout.htm

Access bereavement care and support

Bereavement is the total reaction to a loss and includes the process of healing or 'recovery' from the loss. We all grieve and recover in our own way.

Grief and loss, although painful, are a very normal part of being human; however, people suffering grief and loss can sometimes encounter difficulties.

Bereavement support can be provided to the family and others who have a close relationship with the palliative care client registered with the Palliative Care Service.

Bereavement Support includes:

Individual private counselling;

- Family support;
- Group work;
- Access to written information about the impact of grief and bereavement;
- Memorial services; and
- Referral to other support services.
- Support services at work for grief counselling, stress counselling etc.
- Support systems in the community through caring groups that deal with grief and bereavement

CHCHCS001 - Provide home and Community support services

Welcome to the learning resource for the unit CHCHCS001 Provide home and community support services.

This unit applies to workers in a community services context. Work performed requires some discretion and judgement and is carried out under regular direct or indirect supervision

On completion of this unit you will have covered the requirements for:

1. Determine requirements of individual plan
2. Establish relationship in the home
3. Operate respectfully in the home
4. Complete reporting and documentation

You will be able to demonstrate your ability to:

- Provide services to individual/s in at least 2 different home or community support settings
- Use appropriate inter-personal skills:
- Establish a positive relationship with the individual
- Seek clarification of tasks
- Interpret and following instructions

You will gain knowledge about the:

- Legal and ethical considerations for providing home and community services, including:
- Codes of practice
- Basic home fire safety and associated state/territory smoke alarm legislation
- Dignity of risk
- Duty of care
- Privacy, confidentiality and disclosure
- Practice standards
- Work role boundaries – responsibilities and limitations
- Work health and safety
- Relevant organisation policies and procedures and how to access them, including risk management practices when the work environment is a person's home
- Personal and property security procedures, including personal security protocols and equipment
- Relevant policy and programs, including:
  - Home and community care (HACC)
  - Department of Veterans' Affairs (DVA)
  - Government community care directions
- Implications for work in the sector including:
  - Person-centred practice
  - Consumer-directed care
  - Empowerment and disempowerment
- Indicators of abuse and/or neglect, including:
  - Physical
  - Sexual
  - Psychological
  - Emotional
  - Financial

A copy of the full unit of competency can be found at: http://training.gov.au/Training/Details/CHCHCS001

This learning resource is designed to support your learning and act as a guide to further research. We encourage you to access other texts which include; standards and legislation and other resources relating to your industry that can be sourced throughout the internet or library.

Element 1: Determine requirements of individual plan

Read and interpret individual plan, goals and confirm required equipment, processes and aids

Implementing a plan requires following its instructions carefully. You must always be aware of your own role within and plan follow the information included in it. In order to provide a quality service to individuals, and to be accountable and professional, a support worker must be aware of their personal and professional limitations and seek support when required. A plan might include instructions directed at other professionals, such as managers and allied health professionals. There may be information or instructions included that are outside of your job role or training. The first step in following a plan is to seek clarification to ensure that you are working within your job role, experience and training.

Individualised plans

Personalised planning underpins service provision to people receiving individual services. Individualised planning is an ongoing process involving needs assessment, planning for services and implementing services that respond to an individual's needs. Planning processes and protocols vary between organisations and it is important for you to be aware of the specific policies and protocols of any organisation you are working for.

Roles and responsibilities of support workers

Support workers must have a clear understanding of their roles and responsibilities and knowledge of the implications for work in the sector relating to how best to provide care. There are many job roles within home support services, each with its own responsibilities, as shown here.

A support worker may be responsible for:

- Cleaning stoves, bench tops and fridges
- Mopping, sweeping, vacuuming and dusting
- Changing linen and washing, drying and ironing laundry
- Helping to pay bills
- helping with shopping and preparing meals
- Monitoring the person's wellbeing and reporting any concerns.

Confirm individual needs

It is not enough to simply follow the instructions in the plan without talking to the person about what you intend to do first. People's needs, and preferences change from day to day and so should your approach to support. Talk to the person about your role, as documented in the plan, so they feel they are part of the process. Provide them with the opportunity to discuss or even refuse support, rather than assuming that the person will passively accept your help in the same way every day.

Questions to ask before and during planned support

- Are you happy for me to proceed with what is written in the plan today?
- The plan says you usually have this task done in this particular way. Is that correct?
- What are you able to do independently and what tasks can I assist you with?
- How do you feel you are doing in meeting your goals so far?
- Is there someone else who you would like to be involved in planning or meeting your goals, such as a family member?
- Does this plan meet your needs?

Prepare equipment, resources and/or documents required for the purpose of the visit and contingencies

Some aids, equipment and devices can be quite costly and require an assessment by a doctor, physiotherapist or occupational therapist to ensure the right aid and/or modification is used. Each state and territory have programs to support people needing specific aids and modifications, as described below;

Australian Capital Territory	You can read more about the Aids and Equipment Program at: www.health.act.gov.au/our-services/rehabilitation-aged-and-community-care/oxygen-and-equipment-services
New South Wales	You can read more about the Aids and Equipment Program at: www.enable.health.nsw.gov.au/home/services/aep
Northern Territory	You can read more about the Aids and Equipment Program at: http://health.nt.gov.au/Aged_and_Disability/Aged_Care/HACC_Aged_Care_Equipment/index.aspx
Queensland	You can read more about the Aids and Equipment Program at: www.qld.gov.au/disability/families-carers-friends/aids-equipment/
South Australia	You can read more about the Aids and Equipment Program at: www.sa.gov.au/topics/community-support/in-home-care/domiciliary-care/equipment-program/
Tasmania	You can read more about the Aids and Equipment Program at: www.dhhs.tas.gov.au/service_information/services_files/RHH/treatments_and_services/community_equipment_scheme
Victoria	You can read more about the Aids and Equipment Program at: www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Aids_and_equipment_help_independent_living
Western Australia	You can read more about the Aids and Equipment Program at: www.concessions.wa.gov.au/Concessions/Pages/Community-Aids-and-Equipment-Program-%28CAEP%29---funding.aspx

Packages to support individuals in the home

As people age, many would prefer to live as independently as possible in their own home. The government has developed home care packages to assist people to live longer in their home. People who receive support may require help with a variety of activities. This can include support with:

- Personal care activities
- Transport
- Domestic duties such as laundry, vacuuming
- Meal support
- Nursing and health support
- Outdoor and gardening

Commonwealth Home Support Programme

The Commonwealth Home Support Programme (CHSP) is an entry level home help program for older people who need some help with daily tasks to live independently at home. The aim of the CHSP is to help older people live as independently as possible — with a focus on working with the person, other than doing things for them. It is about building on their strengths, capacity and goals to help the person remain living independently and safely at home.

Depending on the person's needs, support services the person may need include:

Community and home support

- Domestic assistance – household jobs like cleaning, laundry
- Personal care – help with bathing, showering or getting dressed
- Home maintenance – minor general repairs and care of your house or garden, for example, changing light bulbs or replacing tap washers
- Home modification – minor installation of safety aids such as alarms, ramps and support rails in the home
- Nursing care – a qualified nurse to dress a wound or provide continence advice in the home
- Social support – social activities in a community-based group setting
- Transport – help getting people out and about for shopping or appointments.

Food services

- Providing meals at a community centre
- Helping with shopping for food
- Help with making meals and storing food in the home
- Assistance with learning to cook
- Delivering meals to the home.

Allied health support services

- Physiotherapy (exercises, mobility, strength and balance)
- Podiatry (foot care)
- Speech pathology
- Occupational therapy (help to recover or maintain your physical ability)
- Advice from a dietician (healthy eating)
- Other allied health and therapy services.

Respite care

- Care for the person receiving support while the carer takes a break.

Home Care Packages

The Home Care Packages Program helps the person requiring support to live independently in their own home for as long as they can. The Australian Government provides a subsidy to an approved home care provider towards a package of care, services and case management to meet the individual needs of the person.

There are four levels:

- Level 1 - basic care needs
- Level 2 - low-level care needs
- Level 3 - intermediate care needs
- Level 4 - high-level care needs.

The types of services included in a home care package can include:

- **Personal services:** assistance with personal activities such as bathing, showering, toileting, dressing and undressing, mobility and communication.
- **Nutrition, hydration, meal preparation and diet:** assistance with preparing meals, including special diets for health, religious, cultural or other reasons; assistance with using eating utensils and assistance with feeding.
- **Continence management:** assistance in using continence aids and appliances such as disposable pads and absorbent aids, commode chairs, bedpans and urinals, catheter and urinary drainage appliances, and enemas.
- **Mobility and dexterity:** providing crutches, quadruped walkers, walking frames, walking sticks, mechanical devices for lifting, bed rails, slide sheets, sheepskins, tri-pillows, pressure-relieving mattresses and assistance with the use of these aids.
- **Nursing, allied health and other clinical services:** speech therapy, podiatry, occupational or physiotherapy services, hearing and vision services. Home care level 1 and 2 packages are not intended to provide comprehensive clinical or health services. Home care level 3 and 4 packages have a greater emphasis on delivering complex care in the home, including more clinical care where needed.
- **Transport and personal assistance:** assistance with shopping, visiting health practitioners and attending social activities.
- **Management of skin integrity:** assistance with bandages, dressings and skin emollients.
- A home care package may also be used to support the use of:
- **Telehealth:** video conferencing and digital technology (including remote monitoring) to increase access to timely and appropriate care
- **Assistive technology:** such as aids and equipment (particularly those that assist a person to perform daily living tasks), as well as devices that assist mobility, communication and personal safety
- **Aids and equipment:** some aids and equipment that are directly associated with your care needs can included in the package

Consumer directed care

All home care packaged are delivered under a consumer directed care model. Consumer Directed Care (CDC) is a model of service delivery designed to give more choice and flexibility to consumers. Consumers who receive a Home Care Package will have more control over the types of care and services they access and the delivery of those services, including who delivers the services and when.

CDC means that the person receiving support is able to:

- Have more of a say in the care and services which they access, how they are delivered and who delivers them
- Have conversations about their needs and goals
- Work with a service provider to develop an individual care plan
- Agree how much involvement the support worker has in managing the care package
- Know how the package is funded and how their individual budget is spent through monthly income and expense statements
- Request a review of the package at any time to ensure that it meets the ongoing needs of the person

Department of Veterans' Affairs (DVA)

The Department of Veteran's Affairs (DVA) is a government agency that equips health practitioners and service providers with the resources, training and skills necessary for responding to the mental health and rehabilitation needs of clients. They provide services such as:

- Pensions and compensation
- Health care
- Rehabilitation
- Counselling services
- Help for servicemen and women returning to civilian life
- Commemorative and community grants
- Home care assistance
- Subsidised loans for housing and other housing-related benefits

The DVA provides a variety of in-home and community support programmes focused on assisting individuals to continue living independently by supporting their health, well-being, and community connection. The DVA offers support services including

- Veterans' Home Care (VHC)
- Assistance managing medications and health conditions (Veterans' MATES)
- Attendant care and household services
- Veterans' Supplement in Home Care
- Community nursing
- Rehabilitation Appliances Program (RAP)
- Home modifications
- Veteran & Community Grants
- Counselling services

Home care standards

The Home Care Standards were developed jointly by the Australian Government and state and territory governments as part of broader home care reforms to develop common arrangements that help to simplify and streamline the way home care is delivered.

The Home Care Standards (the Standards) were developed jointly by the Australian Government and state and territory governments as part of broader home care reforms to develop common arrangements that help to simplify and streamline the way home care is delivered.

The Standards draw together the differing standards across jurisdictions and the Commonwealth into a single set of quality standards and have the benefit of reducing the administrative burden for service providers.

See next page for Home Care Standards.

Australian Government
Australian Aged Care Quality Agency

Home Care Common Standards

Standard 1

Effective management

Principle: The service provider demonstrates effective management processes based on a continuous improvement approach to service management, planning and delivery.

1.1 Corporate governance
The service provider has implemented corporate governance processes that are accountable to stakeholders.

1.2 Regulatory compliance
The service provider has systems in place to identify and ensure compliance with funded program guidelines, relevant legislation, regulatory requirements and professional standards.

1.3 Information management systems
The service provider has effective information management systems in place.

1.4 Community understanding and engagement
The service provider understands and engages with the community in which it operates and reflects this in service planning and development.

1.5 Continuous improvement
The service provider actively pursues and demonstrates continuous improvement in all aspects of service management and delivery.

1.6 Risk management
The service provider is actively working to identify and address potential risk, to ensure the safety of service users, staff and the organisation.

1.7 Human resource management
The service provider manages human resources to ensure that adequate numbers of appropriately skilled and trained staff/volunteers are available for the safe delivery of care and services to service users.

1.8 Physical resources
The service provider manages physical resources to ensure the safe delivery of care and services to service users and organisation personnel.

Standard 2

Appropriate access and service delivery

Principle: Each service user (and prospective service user) has access to services and service users receive appropriate services that are planned, delivered and evaluated in partnership with themselves and/or their representative.

2.1 Service access
Each service user's access to services is based on consultation with the service user (and/or their representative), equity, consideration of available resources and program eligibility.

Standard 2 continued

Appropriate access and service delivery

2.2 Assessment
Each service user participates in an assessment appropriate to the complexity of their needs and with consideration of their cultural and linguistic diversity.

2.3 Care plan development and delivery
Each service user and/or their representative, participates in the development of a care/service plan that is based on assessed needs and is provided with the care and/or services described in their plan.

2.4 Service user reassessment
Each service user's needs are monitored and regularly reassessed taking into account any relevant program guidelines and in accordance with the complexity of the service user's needs. Each service user's care/service plans are reviewed in consultation with them.

2.5 Service user referral
The service provider refers service users (and/or their representative) to other providers as appropriate.

Standard 3

Service user rights and responsibilities

Principle: Each service user (and/or their representative) is provided with information to assist them to make service choices and has the right (and responsibility) to be consulted and respected. Service users (and/or their representative) have access to complaints and advocacy information and processes and their privacy and confidentiality and right to independence is respected.

3.1 Information provision
Each service user, or prospective service user, is provided with information (initially and on an ongoing basis) in a format appropriate to their needs to assist them to make service choices and gain an understanding of the services available to them and their rights and responsibilities.

3.2 Privacy and confidentiality
Each service user's right to privacy, dignity and confidentiality is respected including in the collection, use and disclosure of personal information.

3.3 Complaints and service user feedback
Complaints and service user feedback are dealt with fairly, promptly, confidentially and without retribution.

3.4 Advocacy
Each service user's (and/or their representative's) choice of advocate is respected by the service provider and the service provider will, if required, assist the service user (and/or their representative) to access an advocate.

3.5 Independence
The independence of service users is supported, fostered and encouraged.

Element 2: Establish relationship in the home

Building and maintaining effective and rewarding relationships with clients has many benefits. A good working relationship allows a support worker to demonstrate their credibility, professionalism and other non-technical qualities. Support workers offer intangible services, the quality of which cannot be judged by prospective clients. Although it takes time, building and maintaining a client relationship is a cost-effective exercise which contributes to productivity and efficiency. Complaints and misunderstandings cost time and money – a good client relationship is like an insurance policy that ensures there will be a quicker and easier resolution of any difficulties or conflicts.

Follow organisation's procedures to assure the person of your identity before entering the house

When you arrive at a client's home, particularly for the first time, you will need to ensure that you preserve your client's privacy and confidentiality before going inside. You will also need to identify yourself to assure your client that you are a bona fide support worker there to provide services. Your supervisor will instruct you on the process to follow for your organisation; they will have notified the client that you are coming and sent them a copy of the roster for their services. You will then need to follow the approved procedure to identify yourself to your client.

This procedure will usually include the following steps:

1. Make sure you are wearing your name tag or identification badge.
2. Check your roster for the address details.
3. Check the street name and house or unit number.
4. Knock on the door and wait for a response.
5. When someone answers the door ask for your client by name
6. Wait for them to confirm their identity.
7. Introduce yourself by including the following details:
    - Your name
    - The name of the organisation you work for
    - What you have come for and the duties you have come to perform.

Wait to be invited to enter.
If a family member rather than the client greets you first, you will need to repeat your introduction to the client themselves. After you have visited your client for the first time, you will not need to check the address so carefully, but you will need to greet your client by name and remind them of your name and why you are there.

Clients with a disability, an acquired brain injury, dementia or other cognitive problems may need you to tell them who you are, where you are from and what tasks you are there to perform each time you visit.

Communicate with the person to provide information, clarify purpose of visit and confirm the person's consent

Effective communication is essential in the establishment and maintenance of appropriate relationships, with clients and their carers.

Communication is a two-way process. During communication process signals/messages are passed from one person and received by another. Communication can be either verbal or non-verbal. Clients from non-English speaking backgrounds find communicating through both means extremely difficult. These clients may interpret communication differently and may not always understand the communication message being delivered.

Different cultures express themselves through different processes e.g. a physical gesture when communicating may be well received in one culture but not another. Developing an understanding of how the client communicates within his or her own culture will help ensure the carer demonstrates cultural sensitivity when communicating.

Introducing yourself

It is important to introduce yourself to clients and their carers.

"Good Morning. I'm Kerry. We haven't met before. My role is…… I am usually here on Tuesdays, Thursdays and Sundays."

Other factors to consider when introducing yourself include:

- Remember to smile
- It may be appropriate to shake hands
- Use the person 's name
- Err on the side of formality and address client as "Mrs Goldsmith". She may invite you to use her first name at a later time
- Consider the client 's communication needs; for example, hearing or visual loss, dementia, or English may be a second language

Conducting Exchanges

Conducting exchanges with the client in a manner that develops and maintains trust; most clients entering your service for the first-time lack trust. They are unsure of the unfamiliar and the unknown. The environment you create, your personality and your communication skills affect client's trust in you. Trust has to be developed, nurtured and maintained.

Your communication skills must include the use of empathy, good listening habits, non-judgmental feedback and support, courtesy, good observation skills and the ability to respect individual differences in clients. This includes respecting client's cultural sensitivities and needs.

Maintain courtesy

Courteous behaviour includes:

- Using the right tone of voice (don't patronise)
- Maintaining eye contact
- Calling the client by their preferred name
- Being aware of personal space requirements
- Respecting the client's environment and personal possessions
- Maintaining privacy and dignity during routines, and
- Encouraging choice and decision-making

Empowerment vs Disempowerment

In its broadest sense, empowerment is the expansion of freedom of choice and action. It means increasing one's authority and control over the resources and decisions that affect one's life. As people exercise real choice, they gain increased control over their lives. Empowerment often addresses members of society that are affected by discrimination - for example - discrimination based on age, disability, race, ethnicity, religion, or gender.

Examples of empowerment include:

- Support with activities of daily living
- Seeking feedback from the client
- Assisting with activities of daily living to reduce stress
- Encouraging the older person to invite family and friends for support
- Allow time for the older person to speak.
- Offer support and positive responses
- Recognise the older person's strength

Disempowerment can be described as the deprivation of power or influence. This can occur when dehumanising or depersonalising practices occur. Some people regard the practices within institutional style care as disempowering for clients. Some disempowering activities could include

- The excessive use of clinical terminology
- Poor building design hampering social interaction
- High staff turnover
- Absence of client-centred care
- Outdated nursing practices
- An absence of opportunities for clients to complain about the service

Provide opportunity for the person to identify and express any issues or concerns in relation to the visit and/or associated matters

Support activities can take on many forms from the basic ADL's to extensive additional care including attending to their shopping, and gardening and house maintenance. These activities need to be factored into the individualised care plan so that they are not time limiting or invasive.

Your job role will determine how you contribute to the ongoing relevance of the client's individual plan. This contribution usually involves participating in discussions with the client and supervisor to identify areas of the individual plan that requires review. It is important that these discussions promote;

- Open communication between client, workers and/or all family members,
- Acknowledge the clients perception of their needs and their individual plan,
- Support client's self -determination.

In some organisations, these discussions take place at a scheduled time for review (monthly or three monthly) and include the client and/or their representative, and member of the health care team. They are sometimes called "Case- Conferences" or "Care Plan Review". Your involvement in a client's individual plan will depend on your job role within the organisation. At all times, you must work within the parameters of your job role and organisational policies, protocols and procedures. If you identify aspects regarding a client's individual plan that is outside the scope of your job role, always refer to your supervisor.

When providing services to clients, your organisation will be endeavouring to uphold the principles of access and equity which require that they develop a client-centred culture. This means:

- Ensuring that clients' individual needs are identified and addressed.
- encouraging clients to have a say in the way in which the service is provided
- Facilitating client involvement in decisions around the provision of support and support.

It is important that workers, where possible, obtain the client's input and agreement prior to providing services. Supervisors and Case Managers are often involved in the planning of services for clients and should at this point involve the client in the planning process. Carers can seek feedback from the client regarding the way the service is provided and also obtain their agreement prior to performing specific tasks.

Engage appropriately with others in the place of residence in accordance with organisation policies

When providing care for people, it is important to learn as much as possible about the person, their family relationships and the family dynamics. Gathering information about the family relationship and dynamics enables the personal care worker to gain a better understanding of the kind of support they provide.

The family dynamics and relationships can affect the individual in some ways this can include:

- Time spent on care tasks and household duties
- Money available for the purchase of items, sources of income
- Transportation to access community support/activities
- The level of supervision that is being provided
- The level of risk

Being aware of the family dynamics and relationships can also help to identify the roles and responsibilities of all people involved in providing care. The table below summarises some of these roles and responsibilities:

The individual	• Responsible for providing a safe workplace for personal care workers • Right to plan their care as much as possible • Responsible for providing care providers with up to date information
Personal care worker/support worker	• Responsible for carrying out personal care/support activities according to the care plan and organisational requirements and within the scope of their role • Responsible for documenting and reporting any changes to the care plan, health and well-being of the individual, the care relationship, other issues e.g. WHS, abuse • Advocate on behalf of the individual if required
Family members/friends who are carers	• Responsible for sharing relevant information • Right to receive information in regards to the care provided • Advocate on behalf of the individual if required

Family members play a significant role as a carer, and it is important to acknowledge the role they play because:

- It is likely that a family member has provided care for the individual already up to the point of a person receiving more formally planned care
- A family member who has provided care is likely to have detailed information about the individual 's needs, preferences and choices
- Family members can be important providers of emotional support
- Family members might act as advocates for an individual
- Family members may be providing financial support for the individual 's care
- Family members can provide a link or point of contact in respect to an individual 's social life

As a personal care worker, it is important to understand the skills that that carer has and how they match the care and support needs of the person. By doing this, tasks can be shared, and workers and carers can ensure that the person receives all the support and care they require. Recognising the skills and knowledge of the carer and how this can complement the role of the care worker is important because:

- It can save doubling up on tasks that the carer might be willing and able to perform which releases the care worker to perform other tasks
- It can make developing a care plan easier as the carer's input can provide valuable information as to an individual 's needs, choices and preferences
- The carer may have skills specific to a particular individual that a care worker doesn't

Check for hazards to own and others' health and safety and implement controls to manage risk

Employers have a responsibility under the WHS Act to provide a working environment that is safe and without risks to health, so far as is reasonably practicable. Identifying and controlling workers' exposure to these common hazardous tasks is an important part of complying with this responsibility and preventing workers from being injured at work.

Roles and responsibilities under the WHS Act

Service providers (employers)

The employer has a duty to ensure that all work activity for home care workers is safe and without risks to health. This duty extends to any person who may be affected by the organisation's activities (e.g. other people present in the home at the time the worker is working). Under Victorian work health and safety laws, a workplace is defined as a place where employees work.

In the case of employees working in private homes, while the worker is undertaking work, that home is a workplace. A vehicle is also a workplace when being used by a worker to carry out tasks required by the employer. As part of the assessment for clients and carers, home care service providers should assess all homes, any work activity to be undertaken in the home, and safety risks to workers. These risks should be addressed in order to support both the client and worker. Regular staff training, supported by guidelines, clear processes and policies on safety issues should be provided. It is critical for service providers to have policies detailing safe work practices.

As the majority of home care work takes place without onsite supervision, policies and procedures are needed to ensure that there are clear reporting processes and that issues are appropriately responded to. Recipients of home care services are diverse and have specific needs. The processes for managing WHS provide the foundation for safe practices across the industry but they must also be able to adapt to the individual circumstances of the client. These processes and practices must also respect the dignity, privacy and independence of clients.

Employees

Employees have a duty to take reasonable care for their own health and safety and for the health and safety of others who may be affected by their actions while at work.

Clients

Under Section 26 of the WHS Act, a person who, to any extent, manages or controls a workplace must ensure, so far as is reasonably practicable, that the workplace, and the means of entering and leaving it, are safe and without risks to health. A client or carer has that duty where his or her home becomes a workplace. Accordingly, the client must do all that is reasonably practicable to notify workers and the service provider of any hazards associated with the premises as soon as they become aware of them. Where the carer does not share the client's home, their assistance may be sought to ensure appropriate worker safety.

Basic home fire safety

The majority of residential fires begin in the kitchen and are often as a result of cooking being left unattended on the stove. Other common causes of fire include mechanical failure and falling asleep whilst smoking.

There are simple steps which people can follow to make their home fire safe:

- Make sure smoke alarms are installed and working - test them monthly and change batteries annually.
- Have an escape plan in place, practice it and make sure your family/carer knows about it - it's particularly vital for people with reduced mobility to practice their escape plan. Where possible, know two safe ways out of every room in your home.
- When at home, leave keys in or near deadlocks so that you can quickly escape in an emergency.
- If you have difficulty hearing, then consider installing special smoke alarms which have a flashing strobe light and vibrating pad that can be placed under a pillow and which activates when the smoke alarm sounds.
- Don't fight the fire - get out and stay out and dial Triple Zero (000) immediately. Never assume that somebody else has done so.
- Close internal doors when leaving the home to reduce fire spread.
- Smoking in bed is dangerous. NEVER smoke in bed.
- Have an approved electrical safety switch (residual current device) installed.
- Don't overload power points.
- Switch off small appliances when not in use.

Security and fire safety

In our attempts to make our homes secure against intruders and burglars, we often overlook issues of life protection in the event of fire. There are many security devices, such as deadlocks and window grills, that prevent intruders from getting in or thieves removing goods. The danger, in a fire situation, is that these security devices may prevent you and your family from getting out.

People have died in fires because they had dead-locked themselves in and removed the key from the lock. You must be able to quickly escape from your home in the event of fire.

Tips:

- Install deadlocks that can be opened from the inside without keys.
- If keys are needed, leave the key in the lock or on a hook on the centre of the door but out of reach of potential intruders.
- Limit the number of keys needed to open doors by having locks keyed alike.
- When installing security grills on windows, select a unit that feature keyless options on the inside.
- Ensure that any window grill bars/screens readily open outwards from the inside.
- Be prepared to smash a window as a means of escape. Use a solid object to break the window, and clear away jagged glass. Place a blanket over the window frame to protect yourself against cuts.

Smoke alarms

Victorian law states that smoke alarms (complying with Australian standards AS 3786) must be installed in all homes, units, flats and townhouses. It is the legal responsibility of all owners and landlords to install working smoke alarms.

Residential homes constructed before 1st August 1997 need only 9-volt battery powered smoke alarms installed. Residential homes constructed after 1st August 1997 must have smoke alarms connected to 240-volt mains power. In addition, a backup battery must be installed in the smoke alarm.

All fire services in Australia recommend photo-electric smoke alarms when installing or replacing existing smoke alarms. Smoke alarms need to be maintained in accordance with the manufacturers specifications.

All smoke alarms:

- Must contain a battery
- Need to be tested regularly
- Need to be replaced after 10 years

Locating a smoke alarm

Smoke alarms must be located between each bedroom area and the rest of the house.

- In addition, inside any bedroom where someone sleeps with the door shut
- In a two-story home a smoke alarm is required on every story, located in the path that people will use to evacuate.

Note: Cooking fires are common. High ceilings or the layout of your house may increase the time it takes for your smoke alarm to operate. Consider installing a photo-electric smoke alarm closer to the kitchen area.

Testing and Maintenance

Smoke alarms should be tested regularly

- Monthly: Test by pressing the test button with a broom handle
- Yearly: Vacuum around your smoke alarm vents

Yearly: Replace your 9-volt battery each year at the end of daylight saving

Remember all smoke alarms need to be replaced after 10 years. When replacing an existing nine-volt battery smoke alarm consider installing a photoelectric smoke alarm with an inbuilt ten-year lithium battery. This will eliminate the need to change the battery every year.

Security in the home

House break-ins are one of the most common crimes. Often, they are crimes of opportunity, with the thief gaining entry through an unlocked door or window.

Reduce your risk of becoming a victim. Follow these steps to secure your home:

- Make it as difficult as possible for a thief to gain entry.
- Install and use key-operated locks on doors and windows.
- Don’t place keys outside under door mats or in obvious places.
- Make it as difficult as possible for a thief to take your belongings with them when they leave.
- Don't leave keys in doors or windows when you're not at home.
- Consider installing an alarm system.
- Make sure alarms are functioning.
- Reduce temptation.
- Engrave or microdot all items of value.
- Keep cash, keys and valuables out of sight and out of easy reach.
- Be cautious about sharing personal information.
- Only list your initials and surname in the phone book.
- If you use an answering service, don’t leave a message that implies you live alone (e.g. rather say 'we' than 'I').
- If you use social networking sites, don’t give personal details such as your home address or phone number.
- Don’t share personal information with strangers (e.g. don't tell them where you live or when you'll be away).

Risks associated with ageing

Older people are at greater risk of physical injury than younger people. In particular, they are more at risk of falls associated with medication, musculoskeletal problems, brain disease.

There is a wide range of risk factors that may result in a fall. Many of them relate to the normal ageing process or particular medical conditions. Others are connected with the behaviour of the older person and the environment they live in.

Falls prevention is important and not difficult. The more things we can do to eliminate or reduce the risks of falls, the less likely older people are to fall.

The predominant risk factors of falls are:

Hazards	Prevention (risk management) strategies
Balance and walking Decreased muscle strength Slower walking & shorter steps Increased sway from side to side Decreased reaction time and reflexes Decreased awareness of body position Decreased sensation Stroke Parkinson's disease Arthritis in lower limbs Foot conditions	Encourage your clients to keep fit and healthy to reduce the effects of ageing Seek appropriate treatment for your client for medical conditions to reduce the symptoms and therefore reduce the risks Work with the Care Team (e.g. physiotherapists) to improve muscle strength, range of movement and coordination of your client. Seek appropriate advice for your client on appropriate walking aids and ways to increase safety. Reorganise furniture so a walking aid can be used without hindrance.
Feet, footwear and clothing Untreated foot problems Inability to care for feet Inappropriate footwear Clothing that trails	Ensure clients' clothing and footwear fits them and is appropriate for the climate. Arrange for clothing to be modified (e.g. dressing gowns that are too long should be taken up). Footwear should fit securely and have a non-skid sole with a broad low heel. Discourage clients from walking around wearing only socks or stockings. Encourage clients to turn the bed light on before getting out of bed, to avoid tripping over bedding on the floor in the dark. Seek appropriate treatment (e.g. Podiatrist or specialist shoe fitter).
Healthy living Missing meals can result in weakness and dizziness Alcohol consumption can impair balance and judgement Lack of physical exercise/activity	Encourage clients to participate in regular, gentle exercise/activities Ensure clients eat three meals each day, along with morning and afternoon tea Balanced diets include plenty of vegetables and fruit, cereals, pastas and breads, dairy products, and of course plenty of water to remain hydrated.
Eyesight and hearing Reduced visual field Reduced contrast sensitivity Reduced depth perception Reduced acuity Reduced glare sensitivity glaucoma Cataracts Macular degeneration Impaired hearing	Ensure clients have regular checks with an eye specialist (optometrist) and an ear specialist (audiologist). Encourage clients to use sunglasses and hats to reduce glare Modify the environment (e.g. turn blinds, draw curtains, change the volume on radios, telephones etc) to facilitate comfort and improved vision and hearing.
Medications Side effects such as dizziness, drowsiness or confusion can increase the risk of falling	Report any concerns you have about a client's medication to your supervisor Don't provide any advice of any type about medication to your client Management and control of medications is the role of the doctor, nurse and pharmacist. Encourage your client to report any concerns they have directly to them.

Home safety Lack of handrails on stairs Damaged steps Rugs & cords Poor lighting Uneven garden paths Pets	Encourage clients to seek advice about what modifications may be suitable for their home. For example, damaged steps should be repaired, anti-slip strips can be applied, install handrails, use lighting on steps, remove clutter from steps. Keep floors clean & dry Tack or tape down loose floor coverings or upturned edges. Grab rails may be useful in bathrooms and toilets. Apply non-slip mats on the floors of baths and showers. Wipe up talcum powder and water off bathroom floors. Remove leaves and moss from paths around the garden.

Risks in the home

Below provides examples of risks which can be found in the home and these risks can be assessed:

Entrances to the home (front, rear, side):

Assessment should have considered whether pathways to the home were level and not slippery; whether gates were easy to open; whether entrance/exit doors were in working order and unobstructed; and whether any pets were contained

Internal layout and conditions (including equipment):

Assessment should have considered whether smoke detectors were in place; the floor surfaces were non-slip or appropriate for wheel/shower chair use; whether mats would present a hazard; whether power points were safe and appropriately located; and whether equipment such as vacuum cleaners, irons, washing machines, dryers were safe and available

Bedroom:

Assessment should have considered whether the room was sufficiently large to undertake care tasks; whether lighting was adequate; and whether bed height was appropriate for transfer and washing activities

Bathroom/toilet:

Assessment should have considered whether the area was sufficiently large to undertake care tasks; whether the room was adequately ventilated; whether the shower/bath provided adequate access; whether drainage was adequate; and whether appropriate cleaning products were available

Kitchen:

Assessment should have considered whether the bench tops were at an appropriate height for tasks; whether food preparation equipment was clean and safe; whether the stove was in safe working order; and whether kitchen furniture was stable

Laundry:

Assessment should have considered whether laundry equipment was safe and sufficient for the tasks; whether washing and cleaning products were appropriate and available; and whether buckets and mops were appropriate and available

Identify, assess and reduce risks

The table below describes a risk management process which can be used to identify , assess and reduce risks.

Step 1. Identify the hazard	Hazard identification is the process used to identify all the possible situations in the workplace where people may be exposed to injury, illness or disease. "Find it".
Step 2. Assess the risk	Risk assessment is the process used to determine the likelihood that people may be exposed to injury, illness or disease in the workplace arising from any situation identified during the hazard identification process. "Assess it".
Step 3. Control the risk	Risk control is the process used to identify all practicable measures for eliminating or reducing the likelihood of injury, illness or disease in the workplace, to implement the measures and to continually review the measures in order to ensure their effectiveness. "Fix it". Risk control measures may be: • Substituting the plant or substance with another one that is less hazardous • Using engineering controls (e.g. modifying the design of the workplace or plant, or environmental conditions) • Isolating people from the source of exposure • Changing the objects used in the task involving manual handling • Using mechanical aids for manual handling tasks
Step 4. Follow workplace procedures and protocols	Your workplace will have many documented policies and procedures for you to follow. It is Important that you understand and follow these, for your own safety and for the safety of others.

i	For more information on how to work safely in the home environment, refer to the following website: https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0018/82503/community-working-safely-in-peoples-homes.pdf The following website provides a checklist which can be used in a home based environment to assess the safety and security of the home: https://www.commerce.wa.gov.au/sites/default/files/atoms/files/home_based_care.pdf

Element 3 : Operate respectfully in the home

Negotiate how to best implement the individual plan to suit the person within organisation procedures and respecting that the work setting is the person's home and personal space

Individualised planning must support the person's strengths, interests, health and emotional wellbeing and self-determination. This means that planning responds to what each individual needs and prefers, what they are interested in, what their rights are, and their decisions and choices. The role of the worker is to support, empower, and negotiate with people to make decisions about their plan and their goals so the plan reflects the person's particular needs.

It is your responsibility to implement the individual plan to suit the person you support, while respecting that the work setting is the person's home and personal space. A critical part of supporting people and meeting their personal preferences is ensuring that people have a sense of control over the support that is provided. Your focus, as a support worker, is to follow the individual plans and negotiate a level of support that allows the person to be as independent as possible. The way you interact with people and their families, the level of information you provide and the degree to which you allow them to make choices will have a significant impact on the success of the support you provide.

Person-centred care

In a person-centred approach, planning is tailored to the person and focuses on their unique aspirations. The result is an outcome that matters to the individual. Person-centred care is treatment and care provided by health services that places the person at the centre of their own care and considers the needs of the older person's carers. It is also known as:

- Patient-centred care
- Client-centred care.

Person-centred practice is treating clients as they want to be treated. When you get to know the client well, you can provide care that is more specific to their needs and therefore provide better care. By promoting and facilitating greater client responsibility, clients are more likely to engage in treatment decisions, feel supported to make behavioural changes and feel empowered to self-manage.

What are the principles of person-centred practice?

- Getting to know the client as a person
- Health care workers need to get to know the person beyond the diagnosis and build relationships with clients and carers.
- Sharing of power and responsibility
- Respecting preferences and treating clients as partners in setting goals, planning care and making decisions about care, treatment or outcomes.
- Accessibility and flexibility
- Meeting clients' individual needs by being sensitive to values, preferences and expressed needs. Giving clients choices by providing timely, complete, and accurate information they can understand, so they can make choices about their care.
- Coordination and integration
- Working as a team to minimise duplication and provide each client with a key contact at the health service. Teamwork allows service providers, and systems working behind the scenes, to maximise client outcomes and provide positive experiences.
- Environments
- Physical and organisational or cultural environments are important, enabling staff to be person-centred in the way they work.

Potential impacts that the provision of personal care may have on a client may include:

- Embarrassment – e.g. A client who is embarrassed about undressing and showering with a carer present
- Fear – e.g. A client may be fearful that due to a change in their mobility, they may fall
- Disempowerment – e.g. A client who feels they no longer have power to make decisions or voice their preferences in relation to their personal need supports.
- Humiliation – e.g. A client who is humiliated when a carer assists them with toilet hygiene following an episode of faecal incontinence.
- Discomfort – e.g. A client who is uncomfortable about having different carers enter their home to provide personal needs support.

Comply with duty of care requirements of role in relation to the person and any other people

Duty of care is a legal responsibility of employers, employees and others to follow safe and health work practices at all times. A duty of care exists when someone's actions could reasonably be expected to affect another person.

Workers in aged care who involve themselves in the lives of individuals must exercise proper professional care in the way they carry out their legal duties or responsibilities. Aged care workers are personally accountable for the provision of safe and competent care and must be aware that undertaking activities that are not within the scope of practice for which they are competent, might compromise individual safety.

You have a duty of care to

- Your individual
- Yourself
- Your employer
- Others around you

You are required by law to make every attempt to protect the rights and enhance the safety of individuals in your care. This means it is your responsibility to ensure reasonable care takes place and the individual is not placed at harm or risk while in your care.

To decide what is reasonable you need to ask yourself the following questions:

- What is in my job description?
- What type of care is expected?
- What is duty of care?
- What are the workplace health and safety requirements?
- What is practical?

Taking reasonable care in all aspects of your work is extremely important. Reasonable care is doing everything possible to prevent any foreseeable dangers while attempting to balance the individual's right to safety and independence.

Reasonable care involves:

- Performing your tasks to the best of your ability and knowledge
- Knowing and working within policy and procedural guidelines
- Asking your supervisor for help when appropriate
- Following directions from your supervisor
- Conducting safe work practices
- Using initiative where appropriate

The common law duty owed by non-nursing personnel without special training or qualifications (such as assistances in nursing, personal carers, attendants, wards-men) is that they exercise the diligence and skill belonging to an ordinary person of common sense. They are not expected to practise professional skills which would be expected of a nurse. In particular, they must not attempt to do anything which an ordinary, reasonable person would avoid doing under the circumstances.

Breaching duty of care

Duty of care is breached if a person acts unreasonably and does something that may cause harm or neglects to do something which results in the individual experiencing harm. Community service workers can be in breach of their duty of care if:

- An individual is injured physically, emotionally or financially
- Care is inappropriately or poorly provided
- Confidentiality is not maintained
- Complaints or needs are not responded to
- Policies and procedures, standards, ethics or principles of their profession are not followed
- Incidents are not recorded truthfully and accurately
- Relevant and important information is not reported on
- Activities that they are unqualified to do are performed

Dignity of risk

Dignity of risk refers to respecting individual's self-determination and rights to make a decision for themselves. To take advantage of any opportunities for learning, skill development and sometimes taking calculated risks.

As a support worker it is almost an instinctive to want to protect, to care and eliminate any possibility of risk to the individuals you are caring for. But what if they decided to participate in an active that you felt was too risky?

You have a responsibility to ensure the safety and wellbeing of individuals is imperative, however your role is to also encourage independence, promote choice and person individual focused care. At times, this can be a fine line to walk.

Demonstrate respect and sensitivity toward the person and their place of residence

Professional boundaries

It is important to be aware of the limits and boundaries that apply to your job role. You can learn about the boundaries of your role by:

- Reading the position description
- Reading the workplace policies and procedures
- Clarifying concerns or questions with a supervisor

When working with individuals on a regular basis and as closer relationships form, there is the potential for boundaries to blur. It is essential to maintain a professional relationship with individuals.

Below is a list of boundaries and limitations that may exist within your job role

- Not accepting gifts from people or carers
- Not providing care, support or other services outside those listed in relevant documentation
- Dealing with conflicting priorities
- Use of individual resources and possession

You can establish a professional relationship with the individual, carer and family members

- By focusing on the individual with a person-centred approach
- By focusing on meeting the individual needs
- By establishing a trustworthy and mutually respectful relationship with the individual (i.e. respecting their privacy, confidentiality, dignity, choices, right to self-determination, etc.)
- By only communicating limited personal information to the individual
- By adhering to your organisation's policies, procedures and protocols

Deal with ethical dilemmas, behaviours of concern, possible abuse and/or neglect in accordance with relevant policies and procedures

Dealing with ethical dilemmas

There are times when you must make a difficult decision based on an ethical, rather than a legal, situation. There are a number of ethical issues you need to be aware of.

Some common ethical issues include:

Understanding relationship boundaries: When working with individuals on a regular basis and as closer relationships form, there is the potential for boundaries to blur. It is essential to maintain a professional relationship with individuals.

Accepting gifts: While accepting a small token of gratitude may be harmless, accepting gifts, money or a loan is strictly prohibited under codes of conduct for employees in the aged care industry.

Maintaining individual safety and security: Some individuals live in circumstances that are a threat to their own safety and security. You have a duty of care to protect the individual from harm. However it is not appropriate for you to enforce lifestyle changes or make demands of your individuals.

Dealing with conflicting priorities: Sometimes, individuals try to coerce a worker into undertaking duties that are not within the scope of their job responsibilities. While this may be due to an innocent misunderstanding, you and your team must not cross professional boundaries at any time.

Using individual resources and possessions is a strict code of ethics that aged care workers follow. You must not misuse, damage or appropriate the individual's belongings. The individual has the right to have their possessions respected by the people that care for them.

Confidences: When an individual offers information about themselves they trust that the carer will not abuse such disclosures by telling others, use this information to support gossip or to harm or ridicule the individual. Privacy and confidentiality considerations need also be made here.

Expertise: Aged care workers and all other health professionals should stay within their areas of expertise. This means not providing care, treatment or advice that you are not qualified of authorised to provide.

When faced with any of the above-mentioned ethical dilemmas it is useful to utilise ethical decision making processes. Ethical decision making refers to the process of evaluating and choosing among alternatives in a manner consistent with ethical principles. In making ethical decisions it is necessary to:

- Notice and eliminate unethical options
- Evaluate complex ambiguous and incomplete facts
- Select the best ethical alternative
- Have ethical commitment, ethical consciousness and ethical competency
- Use ethical thinking and decision-making
- Notice the ethical issues and commitment to act ethically are not always enough, using reasoning and problem-solving skills are often necessary

Reporting unethical conduct

Unethical conduct can occur in many situations. It is sometimes difficult to identify because it may occur behind closed doors when no-one else is around. Unethical conduct can be:

- Not following the care plan properly
- Walking someone alone who needs to be assisted by two people
- Breaching confidentiality
- Recording an incident untruthfully
- Recording a treatment without having performed the treatment
- Skipping care tasks
- Performing a procedure you are unqualified to do
- Unethical behaviour is more likely to occur when a person is:
- Overworked
- Worried or stressed
- Working with individuals who have high-care needs
- Not building a good rapport with their individuals
- Not suited to the work environment

It is your responsibility to recognise and report any unethical conduct that you observe or suspect among team members and others. Unethical behaviour should be reported as soon as possible to your supervisor, either face-to-face, by telephone or through a formal incident report. Discuss the situation with them if you are unsure about a particular behaviour. Explain what you have seen and heard and seek their advice. Alert team members to a breach in conduct to prevent it from occurring again. Report the incident to the individual's family or advocate as they may be able to prevent the breach from happening again. You may also need to report or ask advice from others such as police, lawyers, complaints services, advocates, health professionals or senior management.

Dealing with behaviours of concern

Challenging behaviour is any behaviour that causes significant distress or danger to the person of concern or others. It can include an outburst of aggression, or resistant type behaviour by clients.

Challenging behaviours are difficult for everyone involved. Whilst managing these behaviours may be part of the job, it is not acceptable for workers to be hurt.

Report early signs of challenging behaviours. Talk about your concerns with your supervisor or at team meetings. Early reporting enables management to take action.

Preventing challenging behaviours

Any situation or feeling can act as a trigger for challenging behaviour. This is frequently unpredictable. However, the approach made towards the person is very important.

- Pause – stand back, take a moment before approaching and assess the situation.
- Speak slowly and clearly in a calm voice.
- Explain your care actions.
- Try not to rush the person, act calmly.
- Show respect and treat people with dignity at all times.
- Minimise boredom, social isolation and irritating factors in the environment such as noise, uncomfortable clothing.
- Enhance comfort, exercise, participation in activities, decision making and dignity.

Communication is the key

Avoid harsh aggressive or abrupt statements. Don't say things such as "You must….", "Don't…..", "Stop…….". Use alternatives and "I' language like "I would like you to…" It would help me if……", " I feel scared when…….".

When challenging behaviour happens

- Back off where possible.
- Keep calm.
- Call for help.
- Leave the person to calm down, if possible.
- Remove others from the environment, if possible.
- Be aware of body language and tone of voice used to the person.

Employers have a duty of care to do all things possible to prevent or minimise any harm that may occur as a result of challenging behaviours. This includes providing a means of communication for emergencies, an emergency response system and procedures.

Workers must follow reasonable instructions in managing challenging behaviour and protect the safety and health of themselves and others.

Recognise signs of abuse or neglect

Abuse is a complex issue. It can be financial, physical, emotional, sexual, or failure to provide adequate care for a person's basic physical, social, and emotional needs. You owe a duty of care to all of your clients to keep them safe and free from harm. Your duty of care is increased in instances where people are more vulnerable to harm from others due to age or impairment. It is useful to know the factors that may contribute to a person being at risk of abuse or neglect.

People at risk are those who:

- Have a cognitive impairment, for example dementia
- Live alone
- Have a history of family abuse
- Suffer alcohol and substance abuse
- Are stressed
- Have financial issues
- Are emotionally unstable
- Are relatively powerless, for example people with disabilities and older people

Type of abuse	Examples	Signs to watch for
Physical abuse is when harm is done to the person's body	Hitting, pushing, slapping and shoving Inappropriate restraint Not providing enough food or drink	Unexplained bruises, marks or swelling Bleeding Broken bones/fractures
Financial abuse is when a person's money is taken from them or used in a way that is not helpful to them	Controlling a person's goods or possessions Forcing a person to change their will	Unexplained bank withdrawals Unusual signatures on bank documents Disappearance of goods and possessions
Emotional abuse affects a person's feelings and can make them feel afraid or worried about being isolated or hurt	Belittling the client Isolating the client Not respecting the person's customs or cultures	Fear Lethargy Lack of grooming
Neglect is when a person is not provided the care and support they are entitled to	Ignoring cleanliness, nutritional and comfort requirements	People with dementia may not be able to tell you, or remember things that have happened to them or who has neglected them Unusual weight loss, malnutrition, dehydration. Untreated physical problems, such as bed sores. Unsanitary living conditions: dirt, bugs, soiled bedding and clothes. Being left dirty or unbathed. Unsuitable clothing or covering for the weather.
Environmental abuse is when a person's environment is neglected	The person's place of care is neglected and isolated	Inadequate heating Inadequate sanitation

Often the abuser or person causing the harm is a worker, relative, or close friend. This can cause the victim to have feelings of shame and guilt and that they are to blame. It also means that the victim is reluctant to complain or report experiences of abuse as they are dependent on the care or company of the abuser.

Reporting abuse or neglect

If a team member reports a situation to you, make sure you collect as much detail as possible. Depending on the situation, it may be your responsibility to take action or to report the matter to your manager. Your manager may ask you to follow the situation up by reporting to an external agency such as the police or state protection authority.

Compulsory reporting of abuse and neglect is a legal requirement. For example, all government-funded residential aged care services must report all incidents or allegations of sexual or serious physical assault to the Department of Health and Ageing. The introduction of compulsory reporting of alleged and suspected sexual and serious physical assault commenced in July 2007.

The compulsory guidelines stipulate that reportable abuse is:

- Unlawful sexual contact with a resident of an aged care home; or
- Unreasonable use of force on a resident of an aged care home.

When reporting abuse to the Department of Health and Ageing, the following information is required:

- What relationship does the discloser have with the provider? (For example, key personnel, authorised person, staff member, ex-staff member or other persons.)
- Name of the alleged offender – if known.
- Alleged offender relationship to resident. (For example, staff, relative, other resident or unknown.)
- What has the approved provider done to protect other residents from the alleged offender?
- Were there any witnesses?
- When did the incident occur?
- Where did the incident occur?
- Who has been advised? (For example, police, family, medical adviser.)
- When did the approved provider become aware of the incident?
- Who else is aware of the incident?
- Where is the care recipient? (For example, still in care, hospitalised.)
- Has the approved provider made counselling or support available to relevant parties? If so, provide details.

To report abuse you must follow your organisation's procedures. Report and respond only to those signs for which you have witnessed or have evidence. Here is a list of what service providers must do when instances of suspected abuse occur:

- Inform staff about the compulsory reporting requirements for allegations or suspicions about abuse
- Report abuse to the relevant people, such as your supervisor, the director of nursing who in turn may be required to report the matter to the appropriate body
- Provide your clients with an opportunity to talk about what is happening with them and inform them about services to assist them
- Keep records of all incidents involving allegations or suspicions of reportable abuse
- Ensure staff members are protected from victimisation by keeping their identity confidential.

Maintain confidentiality in accordance with legislation and organisation policy and procedures

Confidential information that is given to you by clients, needs to be shared confidentially with your supervisor or manager. Withholding this information may breach your duty of care responsibilities. Mail addressed to specific clients or colleagues may not be opened by other people. This is a legislative requirement.

Maintain confidentiality and privacy

When a person becomes a client of your service, the organisation receives a lot of personal and confidential information about the client and their family. It is your role to ensure that this information is kept private and confidential. Confidential information that is given to you by clients' needs to be shared, confidentially, with your supervisor or manager. Withholding this information may breach your duty of care responsibilities.

Care workers have a legal and ethical obligation not to disclose information that is considered confidential that they have gained through carrying out their work. Confidential information may be that which relates to individual clients and their families, their colleagues and the organisation they work for. Inappropriate disclosure of confidential information may have adverse implications on the client, their family or the organisation.

You should be aware of your organisation's policies and procedures in relation to confidentiality. Your organisation's policy on confidentiality may relate to:

- Storage of records
- Destruction of records
- Access to records
- Release of information
- Verbal and written communication

Obligations to disclose information

In the following situations however, you have a moral/legal obligation and duty of care to disclose to your supervisor confidential information you have been given by a client:

- Information that could cause harm to the client or others
- Information regarding illegal activities
- Information requested by the court.

Element 4: Complete reporting and documentation

Comply with the organisation's reporting requirements, including reporting observations to supervisor

It is important that you comply with the administration protocols of the organisation you work for. These protocols are in place to ensure government rules and regulations are met, but most importantly they are in place to ensure the duty of care for all individuals is upheld. It is your job to know your organisations policies and procedures for completing and storing forms and documents you use. If you are unsure on anything, you must always clarify with you supervisor.

Store and maintain workplace information correctly

Organisations that provide aged care services must store information and maintain it to the proper standards. For example, different types of information must be kept for a certain amount of time. Information should also be stored in a safe but accessible place. Organisations must store information that is confidential and legal as well as essential for the accreditation of the facility. The type of information that an organisation may store includes:

- Individual information such as finances and medical information
- Staff personal information
- Records of incidents/injuries
- Medication incidents
- Safety audits

Information can either be stored manually for example in a filing cabinet, or more commonly these days in a computer or network database. Aged care information should be kept on site in order for it to be accessible. When information is no longer required it should be destroyed appropriately.

Information stored needs to be relevant, and for this reason an aged care provider must maintain information by keeping it up to date. Most importantly information should be stored in a manner that promotes its condition.

Complete and maintain documentation according to organisation policy and protocols and using technology required in the workplace

Protocols are an agreement to a particular sequence of activities, which assist carers to respond consistently in a complex area of clinical practice. Procedures may be written where the task is highly technical and dependent or an exact order of events, or to support unqualified nursing staff in order that they develop competencies.

Where necessary, each policy statement will be supported by protocols (guidelines) and/or procedures (for more exacting specific tasks).

The old saying "if it's not documented in the medical record it was not done" has never been more timely as state and federal governments continue to enact legislation to protect various healthcare consumers.

Standards of care arise from:

1. Regulations based on state and federal legislation or statutes.
2. Practice guidelines

Failure to document or faulty documentation on your part is risky behaviour that should be avoided. Knowing that, it is highly suggested that you obtain a copy of the documentation standard (policy) where you are employed and become very familiar with it.

Documentation protocols

It may seem obvious but be sure to include the date and the time you wrote your entry. The date should include the year; the time should indicate am or pm. don't chart in blocks of time such as 0700 to 1500. This makes it hard to determine when specific events occurred.

Other essential information to record is: the client's history (including unhealthy conditions or risky health habits such as scalp lice, smoking, failure to take prescribed medication, etc.) A client's history is usually reflective of trends and may offer valuable hints about what to expect in the future. It is important that you chart any subjective (what you hear) and objective (what you see) observations (especially changes in health status such as the emergence of a productive cough, difficulty in breathing or feelings of anxiety or depression). Document any actions that you did in response to any of your observations and the client's response to your actions. These responses to your interventions are commonly called client outcomes.

Other information that needs to be recorded in the medical record includes any **education or instructions** you give to the client, his family or significant other.

Anytime a client, family member or significant other is given a referral to a community resource, it should be recorded. It is obvious that any authorisation or consent for treatment is a documentation priority so that legally, permission to provide care has been given.

We don't often think about phone calls as documentation, but they can contain certain information for which we have obligations such as advice that we may give to a client or a phone order that we may take from a doctor.

It is a very good initiative to record or make a record of phone calls, a log of such phone calls could be included in the patients file and / or in a separate LOG file... an example of such could be

For a Client Call

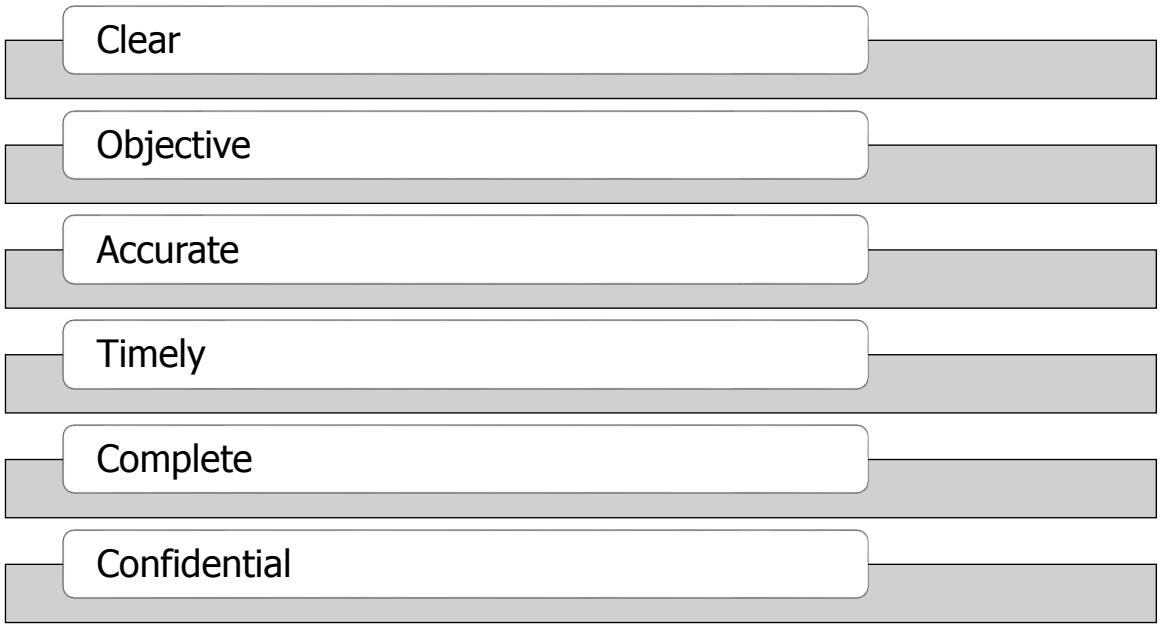
- Date and time of call
- Caller's name and address
- Caller's request or chief complaint
- Advice you gave
- Protocol you followed (if any)
- Other caregivers you notified
- Your name

For a Physician Call

- Date and time of call
- Physician's name and "T/O" to indicate order
- Verbal order, written word-for-word
- Documentation that you've read back the order, to be sure you heard it correctly
- Documentation that you've transcribed it according to your facility's policy
- Your name

Be sure to record your full name, credentials and job title in the required section on documentation forms. Some forms will ask you to record your initials as well. Your signature must be in cursive writing so a word of final caution: do take the time to sign your name legibly

It is important that workplace documents have set standards. Documents need to be:



Ensure any arrangements for follow up visits are recorded and implemented

At the end of a home visit, it is important to schedule a follow up visit. This is to ensure that the client is aware of the next visit, and the purpose the next visit. You should also record and document the time, date and purpose of the next visit in a communication diary.

i	The following is a home visit policy which summarises procedures to follow when organising and conducting a home visit: http://nht.org.au/wp-content/uploads/2014/08/Home-Visiting-Policy.pdf

CHCAGE002 - Implement falls prevention strategies

Welcome to the learning resource for the unit CHCAGE002 implement falls prevention strategies.

This unit applies to support workers in a residential or community context. Work performed requires some discretion and judgement and may be carried out under regular direct or indirect supervision

On completion of this unit you will have covered the requirements for:

1. Prepare to implement falls prevention strategies
2. Identify potential risk of falls
3. Implement falls prevention strategies
4. Monitor falls prevention strategies

You will be able to demonstrate your ability to:

- Implement falls prevention strategies for at least 2 older people and monitored and evaluated those strategies in a collaborative, positive and respectful manner

You will gain knowledge about:

- The ageing process and how it might affect the risk of falls
- Factors, including stroke, contributing to the risk of falls and their impact on older people and their carers
- Normal posture, gait and balance and how to recognise deviations
- Medical causes of falls, including stroke and how to recognise signs of those causes
- The physical and psychological effects of falls on older people and their carers
- Falls prevention strategies and indicators of when a strategy should be halted
- Legal and ethical considerations for working with older people, including:
- Duty of care
- Human rights
- Privacy, confidentiality and disclosure
- Work health and safety
- Documentation requirements including the importance of accurate, objective and appropriately detailed records

A copy of the full unit of competency can be found at: http://training.gov.au/Training/Details/CHCAGE002

This learning resource is designed to support your learning and act as a guide to further research. We encourage you to access other texts which include; standards and legislation and other resources relating to your industry that can be sourced throughout the internet or library.

Element 1 Prepare to implement falls prevention strategies

Berg et al (1997) define a fall as 'losing your balance so that your hands, knees, buttocks or body touch or hit the ground or floor'. Tideiksaar (1998) defines a fall as 'an event in which a person inadvertently comes to rest on the ground or another low level such as a chair, bed or stairs'.

Roles and Responsibilities

Responsibility means that a person has an obligation or duty to perform a role or function to an expected standard. Responsibility can be delegated, as long as it is delegated to someone who is competent to carry out the activity.

The aged care worker must be multi-skilled and flexible in their work practices when they deliver care. Aged care workers are also required to work in an interdisciplinary team.

An interdisciplinary team includes a range of health professionals and care workers who work with the client, family and significant others, and/or advocate to deliver quality care for the older person. Working within the interdisciplinary care team requires effective teamwork and effective communication skills. Collaboration and consultation between team members is critical to ensure that the rights and needs of the older person are central to the assessment, planning, implementation and evaluation of the care process. The older person is always central to this process, and care strategies should at all times be discussed with and agreed upon by the older person.

Understanding your own role and responsibilities in the organisation is vital to ensure that you undertake only those activities for which you are responsible.

Due to the multifactorial nature of falls, it is preferable where possible that the assessment of fall risk be undertaken by different members of the multidisciplinary health care team rather than a single member. However, if the multidisciplinary health care team is involved in the assessment process, responsibility for ensuring its timely completion should be allocated to one staff member. If it is not possible for a multidisciplinary approach to be used, then one staff member may be primarily responsible, bringing in medical and other health care professionals as indicated and possible.

When you are determining identified strategies in preparation of implementing falls prevention strategies make sure it is within your role and area of responsibility. It can be tempting to help out by performing tasks that are not within your level of competence or part of your role. However, you have a duty of care to work competently within your role boundaries and provide care that is consistent with your role and level of responsibility. Taking on additional tasks can result in unsafe practice and can mean that older people do not receive the quality and standard of care they need.

The person conducting a falls assessment will vary depending on the organisation, assessment requirements and role requirements. Assessments may also be carried out by health professionals, aged care workers, coordinators, the older person's family member's carers or even the older person themselves.

Discuss identified strategies with your supervisor and relevant health professionals to ensure you are working towards providing the best care for the individual. Another reason for notifying the supervisor

is that they are also accountable for the actions you take. If the supervisor is not notified, then how will they know something has occurred.

Impacts of falls on the person and carers

Physical and psychological effects of falls on older people and their carers

Falls can have a devastating impact on the health and wellbeing of older people. Falls can impact a person and their carer both physically and psychologically.

Once experiencing a fall an older person can lose their confidence and become withdrawn from the loss of independence. The fear of falling again also effects the mental wellbeing of older people and can often lead to isolation and loneliness.

Chandler et al (1996) and King and Tinetti (1995) report a link between the fear of falling and increased levels of depression, dependency and anxiety. The fear of falling itself can increase the risk of a fall occurring because the individual tends to 'freeze', becomes agitated and panics. Posture often becomes unbalanced, with the individual leaning forward or over-reaching to gain an apparently supportive structure, such as a chair.

People with a fear of falling tend to reduce their activity levels, possibly as a means of avoiding the fear-enhancing situation of being more mobile. Reduced activity and associated increased levels of dependency can result in greater demands being placed on family and professional carers. Subsequent increased levels of help can reinforce the feelings of helplessness in those who have fallen. As care needs increase, the older person may find that admission to a nursing home becomes necessary. However, the relationship between the fear of falling, depression and increased dependency remains poorly defined and would benefit from further study.

Physical impacts can include; pain with moving due to a fall or decreased physical abilities that lead to the inability to move the way they used to. As a result, individuals may be confined to moving a particular way which can cause many frustrations.

Many falls do not cause injuries; however, it has been said that one out of five falls do cause a serious injury. Falls can cause broken bones, head injuries, bruises and overall soreness of muscles. 95% of hip fractures are caused by falling, usually by falling sideways.

Carers are also impacted from a fall. The psychological effects on the carer include emotional feelings of helplessness, anger, frustration, over protectiveness and fear can become overwhelming. The carer may become over cautious and protective as they are fearful of another fall.

Research shows that among people over the age of 75:

- 33% have experienced a fall
- A high percentage of people who have fallen have lost their confidence
- Fall victims experience a decline in independence
- Over 60% feel they are more vulnerable to further falls

A fall may not only be the consequence of an already identified condition but may also be the symptom of an as yet undiagnosed illness.

Discuss identified strategies with supervisors and health professionals

Falls happen for a reason and it is possible to identify risk factors and take measures to reduce those risks. Identified strategies should be discussed with not only the client but also supervisors and other health professionals, this ensures each person is on the same page and the care for the client is consistent.

A range of measures can be taken in the home or residential care setting to reduce the risk of falls. General safety measures include:

- Encouraging the older person to exercise regularly to improve balance, strength and flexibility
- Encouraging the selection of shoes that are comfortable, fit well and have slip-resistant soles
- Ensuring that mobility aids are within reach and used when mobilising
- Installing good lighting in corridors, bathrooms, living areas and bedrooms
- Ensuring floors are uncluttered and free of any items that can cause trips or falls, for example electrical cords or loose rugs
- Providing support as necessary to the older person who is at high risk of falling
- Making sure that chairs and beds are easy to get into and out of
- Wiping up spills immediately
- Having safety rails and grab rails in the shower and beside the toilet
- Regular review of the older person's medications by the doctor
- Ensuring glasses and hearing aids are used
- Limiting alcohol intake.

Assessments and interpreting findings

The following things should be done in preparation for an assessment;

- Confirm assessment requirements with supervisor or relevant health professional and by checking the client's case file
- Identify assessment requirements outside scope of roles and responsibilities, such as administering assessment tools they are not qualified to administer, and reporting such to supervisor or relevant health professional
- Work with the older person and their carer to establish what will be required to be involved in the assessment and in any further assessments or strategies that might follow
- Provide information to the older person and carer of the worker's own role, responsibilities and accountability according to their job description
- Obtain the persons consent for the assessment.

Because there is an increased risk of falls among older people, each person in an aged care facility, as well as those who are receiving care at home, should be assessed to identify their risk of falling. A risk assessment tool will help identify those who are at high risk of falling, and preventive strategies can be put in place to minimise the risk.

Studies of older people living at home have been carried out in Australia and overseas. These studies have found that of the one in three people aged 65 years and over who fall each year, one in ten have had multiple falls. It is estimated that 30% will require medical aid due to injuries sustained. This number becomes even higher in residential and acute care settings (Department of Health and Ageing 2005).

Assessment involves collecting information about the older person through observation, physical examination and interviews.

Information can be collected by talking to the client, their family or friends, past carers or health workers. Each new client will be interviewed, and comprehensive assessments are carried out to ensure that their abilities and care needs are identified.

A range of forms and tools are used for assessment, and each health professional will undertake an assessment according to their area of professional expertise. As an aged care worker, your role in assessment will include documenting the client's abilities — for example communication, mobility, eating and drinking, personal hygiene, toileting, social and emotional needs. You will need to observe your client, assess their level of independence or ability, and then document your observations. This contributes to a comprehensive assessment of their personal care needs. Assessment provides the opportunity to report and record your observations.

The information gathered from the interview and through assessments is documented in charts and in the clinical notes. The reason for this is that other health professional can see the clients' history, the results of assessments so far and any further follow up required. This is the beginning of a clinical file that has confidential details that must be stored appropriately to follow the appropriate legislations.

The clinical files of clients should store in a locked filing cabinet; if stored electronically each person who can access the files needs to have individualised log-on and passwords. When the file is open, do not leave it unattended and if you need to go put the file but in locked cabinet or log-off from the computer.

Explaining information to the older person and carers

Considering individuals and carers level of understanding, cultural background needs and rights

It is important that clients and their families are informed of the assessment findings and the strategies that will be put in place to prevent the risk of falls. Clients should be informed of their needs and rights when it comes to the extra support, they are entitled to that will assist in preventing falls.

Communicate in a supportive and encouraging manner that is respectful of the older person and their carer's level of understanding and cultural background. An interpreter should be used if there is a language barrier to understanding.

Findings interpreted from the assessment and information relating to risks and fall prevention strategies implemented should be provided to both the older person and the carer.

There is an appropriate flow of information when it comes to risk assessments and prevention strategies being put in place. The information given to clients and carers should be given at the level of their understanding and at the level they can put the identified prevention strategies into practice.

There may be a number of factors that affect your ease of communication with the client. Poor hearing or sight and confusion or memory problems may mean that you need more time to develop a relationship and establish an effective way of communicating. You should be aware of these factors and the need to strike the right balance in your interactions with the person. You will need to be sensitive to signs about the level of interaction with which they are comfortable and to acknowledge that the person may take some time to accept and trust you.

When explaining information to clients it is important to;

- Take the time to listen
- Be focused on the person's needs
- Be respectful of the person's opinions, beliefs and point of view
- Encourage the person's independence by planning and evaluating the services you are providing
- Inform the person of alternatives
- Assist the person to solve problems
- Negotiate other options rather than telling the person what to do.

Permissions, cooperation and commitment

Types of consent;

- **Verbal** — the client tells you in words that they want a service or agree to some intervention.
- **Written** — the client signs a form or forms requesting or agreeing to the service or intervention.
- **Implied** — the client implies in some way, for example nods their head, when you ask them if they want you to do something and assists you in the task. For example, you ask a client if they want a shower and they nod their head and start to take their clothes off.

For a person's consent to be valid, the person must be:

- Capable of making that particular decision ("competent")
- Acting voluntarily (not under pressure or duress from anyone)
- Provided with enough information to enable them to make the decision.

Seeking consent is part of a respectful relationship with an older person and should usually be seen as a process, not a one-off event. When you are seeking a person's consent to assessment, treatment or care, you should make sure that they have the time and support they need to make their decision. People who have given consent to a particular intervention are entitled to change their minds and withdraw their consent at any point if they have the capacity (are 'competent') to do so. Similarly, they can change their minds and consent to an intervention which they have earlier refused. It is important to let the person know this, so that they feel able to tell you if they change their mind.

Legally, it makes no difference whether people sign a form to indicate their consent, or whether they give consent orally or even non-verbally (for example by holding out an arm for blood pressure to be taken). A consent form is only a record, not proof that genuine consent has been given. It is good practice to seek written consent if treatment is complex or involves significant risks or side-effects. If the person has the capacity to consent to treatment for which written consent is usual but cannot write or is physically unable to sign a form, a record that the person has given oral or non-verbal consent should be made in their notes or on the consent form.

Obtaining the older person's informed consent is a legal and ethical requirement that shows respect for the older person's rights

Including the person and the carer in applying strategies will contribute to the success of the control measure by taking into consideration the person's needs, abilities and requirements. If you gain the commitment to the process the older person and the carer is more likely to follow through processes when workers are not there. People like to feel included and allows for person centred care. Maximise the participation of the older person; asking them questions rather than asking the carer first, but also utilise the knowledge and support skills of the carer.

Element 2 Identify potential fall risks

Considerations when conducting risk of falls

When conducting an assessment to identify the risk of falls the following considerations should occur;

- The ageing process and how it affects the risk of falls
- Conduct assessment in a manner respectful of the older person's privacy, dignity, wishes and beliefs
- Finding out if the older person is afraid of falling, and if they are, record this as a risk factor
- Determine how the older person has coped with any previous fall/s because they are at greater risk if they have not coped well
- Identify and explore factors in the older person's lifestyle that might affect their level of risk, such as the amount of exercise they have, their diet, if they drink alcohol, and if they have a history of falls
- Determine the older person's physical indicators of risk of falls using appropriate tools and methodologies such as Quick Screen
- Conduct the assessment in a manner that minimises unnecessary discomfort to the older person by conducting the assessment in a room of comfortable temperature with comfortable chairs, and give the older person breaks as needed
- Maximise the participation of the older person; asking them questions rather than asking the carer first, but also utilise the knowledge and support skills of the carer
- In collaboration with supervisor and/or relevant health professional, determine any condition/s that the older person has that might affect their level of risk, such as Parkinson's disease or arthritis or depression.

The older persons concerns about falling

Fear of falling

Fear of falling affects between 29 to 92 per cent of older people living in the community who have fallen and between 12 to 65 per cent of those older people who have not fallen. An older person's fear of falling can be defined as "an ongoing concern about falling that ultimately limits the undertaking of daily activities". Lord, Sherrington, Menz, & Close, 2007.

The term 'falls self-efficacy' is often used in falls prevention research to discuss an older person's fear of falling. Falls self-efficacy can be defined as "a person's belief in their ability to undertake certain activities of daily living without falling or losing balance". Fuzhong, Fisher, Harmer, and McAuley, 2005.

A fear of falling can be an issue for the health and well-being of older people while also being a protective factor. A fear of falling becomes a serious public health concern when older people do not perform daily activities they have the ability to perform. This restriction of activity may lead to a loss of lower limb strength, a further reduction in mobility and physical function and social isolation. However, a person's fear of falling can be protective when this fear stops people from undertaking activities with a high risk of falling and potential for injury.

Older people can develop a fear of falling due to:

- A previous fall
- Feeling unsteady
- Poor health
- A belief that they are unable to do normal activities (low falls self-efficacy)
- Functional decline, or a reduced ability to perform tasks associated with everyday living for example: dressing themselves
- Frailty
- Poor vision
- No emotional support from family or friends
- Inactive lifestyle.

Consequences of a fear of falling

There are considerable negative physical and emotional consequences that can result from a fear of falling. These are often referred to as a 'debilitating downward spiral' or a 'cycle of fear of falling'. The consequences that develop as a result of a fear of falling can include:

- Loss of confidence
- Reducing both physical and social activities
- Depression
- Hesitancy and tentativeness
- Loss of mobility and independence
- Increased risk of falls
- Increased frailty
- Risk of nursing home admission.

These consequences have a negative impact on an older person's quality of life and can also contribute to an increase in health care costs as people access more health care services

Reversing the downward spiral of fear

When working with older people in the community, it is important that falls prevention projects/programs do not make people afraid of falling by focusing on negative risk factors and the consequences of falls. Falls prevention projects/programs will be more effective if positive healthy active ageing messages such as 'stay active' and 'improve your strength and balance' are used. Projects/programs should adopt the term 'concern about falling' rather than 'fear of falling' as this term is less emotional and may be easier to discuss.

It is possible to address the concerns of falling by intervening with any of the factors within the spiral but improving functional ability must be addressed at the same time. A 2007 systematic review of the fear of falling research (by Zijlstra, van Haastregt, van Rossum, van Eijk, Yardley and Kempen, 2007) assessed which interventions effectively reduce the fear of falling in older people living in the community. This review found that the fear of falling can be significantly reduced by:

- A home-based multi-factorial falls prevention program
- Home-based exercise
- A community-based Tai Chi group

These interventions help to manage both the fear of falling and reduce this risk of falls occurring in the community. In addition, the review also suggested that future falls prevention projects/programs could teach older people to perform activities safely to reduce their concerns and increase their confidence in safely performing physical and social activities

Conduct assessment in a manner respectful of the older person’s privacy, dignity, wishes and beliefs

Client-focused care means that older people must be involved in decisions about their care. As an aged care worker, you will provide information and support to help the older person make choices and advocate, when appropriate, to ensure their rights are upheld.

Individualised care recognises that ageing is a unique process and each person will respond differently. As an aged care worker, you play a vital role in supporting the needs and rights of clients, and you also have a responsibility to work ethically, collaboratively and competently to achieve quality outcomes for older people in your care.

Respect

'Respect is the objective, unbiased consideration and regard for the rights, values, beliefs and property of all people.' (Wikipedia, 2006)

Respect is esteem for, or a sense of the worth or excellence of, a person, a personal quality, ability, or a manifestation of a personal quality.

Practical Tips for Showing Respect

Ensure that treating older people with respect is fundamental to training and induction for all staff (including domestic and support staff) and followed up by supervision and zero tolerance of negative attitudes towards older people. This may mean reduce external distraction such as banging doors, other people's conversations, be non-judgmental and do not use stereotypes, minimise impact of clients' behaviour/physical/ medical factors such as;

- A client is in a wheelchair, so you need to conduct the interview in a place that is readily accessible.
- A client has a severe form of diabetes, so plan the meeting at a time when the diabetic is stable.
- A client finds it very difficult to sit and concentrate for long periods of time, so plan to have some breaks.
- Use lots of different techniques of interviewing to engage the person who lacks concentration.

Privacy

Privacy is the quality of being secluded from the presence or view of others. The rights of individuals and obligations of organisations with the collection, use, disclosure, and retention of personal information complies with the Privacy Act.

Modesty and privacy in personal care - ensuring that people receive care or treatment in a dignified way that does not embarrass, humiliate or expose them. For example, closing doors in the bathroom and toilet; pulling curtains closed when changing persons' clothes. Remember, think how you would feel if these aren't done for you.

Confidentiality of treatment and personal information - ensuring that personal files and records and financial information are kept confidential, and only shared with the consent of the person concerned. Discussions about a person's well-being, treatment and any personal information should be carried out where others are unable to hear. Conversations of a very confidential nature, for example about medical diagnosis or toilet arrangements, should be discussed in a private space and not with only a curtain between the individual and others. Privacy of conversation with family and friends should be facilitated through access to a private room or telephone and personal mail should be received unopened. Particular care should be taken to ensure privacy when using interpreters. In small communities the service user and interpreter may know each other or have common friends. This can cause a great deal of anxiety in terms of confidentiality and alternative solutions should be sought.

Privacy of personal space - staff should gain permission to enter and demonstrate respect for personal belongings and boundaries. It is important to achieve a balance so that vulnerable people are not either isolated by privacy policies or put at risk, for example through providing privacy for personal and sexual relationships. Staff need appropriate training to ensure relationships can be positively, respectfully and safely supported.

Practical Tips for Showing Privacy

- Ensure there is a confidentiality policy in place and that it is adhered to by all staff (including domestic and support staff).
- Make issues of privacy and dignity fundamental to staff induction and training.
- Only those who need information to carry out their work should have access to personal records or financial information.
- Where people have personal and sexual relationships, their privacy should be respected in conjunction with careful assessment of risk to vulnerable people.
- Choose interpreters with the consent of the service user.
- Ensure that all staff gain permission before entering someone's personal space such as knocking, if there is no doors to ask for permission to enter rather than barging in
- Ensure that access to personal possessions and documents is only via the owner's expressed consent.
- Ensure space is provided for private conversations and telephone calls.
- Ensure service users receive their mail unopened.
- Single-sex bathroom and toilet facilities should be available.
- In residential care, respect people's space by enabling them to individualise their own room by having photos, pictures and furniture
- If a person requires close monitoring or observation, issues of privacy should be carefully considered.

Dignity

Dignity consists of many overlapping aspects, involving respect, privacy, autonomy and self-worth. The meaning of dignity used is based on a standard dictionary definition:

"A state, quality or manner worthy of esteem or respect; and (by extension) self-respect. Dignity in care, therefore, means the kind of care, in any setting, which supports and promotes, and does not undermine, a person's self-respect regardless of any difference."

While 'dignity' may be difficult to define, what is clear is that people know when they have not been treated with dignity and respect. Helping to put that right is the purpose of all aged care workers.

Daily living aids that help seniors maintain dignity and independence.
Elderly people may need assistance sometimes to stay independent. Independence for an older person can be achieved by various means in society today.

There are devices that help the elderly maintain their dignity in the community and at home. These devices are used for urinary incontinence. Briefs and special under clothes help prevent leakage of urine in to clothing. This is especially important when elderly people are out in the community.

Practical Tips for Showing Dignity

Treat your elderly patients, as you would wish to be treated. This includes assisting with hygiene related needs, talking to them about their condition, medications, and any new developments that may arise. Do not talk down to or yell at the elderly patients in your care. Be sure to show respect. Explain and make sure that they fully understand any tests that are needed.

Beliefs and Wishes

Belief is the psychological state in which an individual holds a proposition or premise to be true. Wishes are what you hope for.

You may find you are working with people from a wide variety of cultural backgrounds. Along with these differing backgrounds will come a diversity of beliefs, values and customs affecting many aspects of daily life, including:

- Diet
- Clothing
- Social behaviour
- Friendship groupings
- Concept of time
- Religious rituals
- Medical treatment.

It is important that you recognise the importance of any cultural influences in these areas. It is also important that you understand the person's status within their own culture, for instance, the person may be an elder in an Aboriginal Culture. Lack of understanding of cultural influences will make communication with the client more difficult and will result in increased stress to both you and the client.

It is important that you take cultural and individual beliefs, views and wishes into account when providing support to the client, for instance, there may be quite different expectations about day-to-day such as the female client only wants to be showered by a female worker; routines and communication processes. It will be important to:

- Find out what differences and expectations exist
- Find out how important these are to both the client and their family
- Respect and support these differences to the extent possible within your work role and the policies and procedures of the organisation.

It is your responsibility to get this information about cultural and individual differences. In most cases you can get it by simply asking the person or their family members. You can also talk with other workers, and in some cases, there will be files which contain relevant information.

The client has a right to be fully engaged in the assessment process, this means that you should not communicate with family members/ carers, without the involvement of the client, or at least ask their permission to talk to family members/carers about issues that directly affect them. In some situations, you may need interpreters to communicate effectively with the person or their family.

Sometimes it is very difficult to distinguish between culture and individual differences. All people, no matter what their culture, have different temperaments and personalities, and have been exposed to a variety of learning experiences during their life.

Family background, socio-economic status, educational opportunities, peer group influences and work history will all play an important part in the way an individual develops and the way they think and behave.

Carers support

The specific tasks support workers and coordinators are required to complete vary depending on:

- The sector: home and community care, residential care or community care
- The policies and procedures of their organisation
- The needs of the clients.

Typical duties for support workers	Typical duties for a coordinator
• Providing personal care, • Assisting with the activities of daily living • Helping with transportation, • Supporting the older person to participate in a range of activities, • Light cleaning duties, • Observing, reporting, and documenting signs the older person is at risk	• Conducting the initial assessment • Organising and facilitating case conferences • Matching the older person with appropriate service providers, • Coordinating the provision of service, • Monitoring the provision of service

Determining physical risk indicators

The ageing process and how it affects the risk of falls

Although anyone can fall, as a person ages falls become more common and more serious. The good news is that older adults do not need to let the fear of falling rule their lives. With some medical management, physical activity and common-sense older individuals can help themselves avoid falls and stay independent longer.

A person is more likely to fall as he or she ages because of normal, age-related physical changes and medical conditions - and the drugs that a person takes for those medical conditions. When we - age, time takes its toll on our body and individuals may find themselves taking more medications or experiencing some limitations in mobility. While the changes are unique to many aging changes are common and put a senior at higher risk.

Poor eyesight - Seniors may not see as well, which affects their coordination and balance.

Reduced reaction time - The nerves that carry information from the brain to the muscles can deteriorate slowing our reaction time and the ability to move away from obstacles quickly enough or avoid an ice patch on the sidewalk.

Decline in muscle strength - Normal decline in muscle strength and joint flexibility can change how easily an older person stands up, walks or gets out of chairs.

Limited movement - If someone does not regularly exercise, changes occurring with the aging process can be worse.

Other contributing risk factors

Lifestyle	Health	Mobility
• Unfamiliar environment within residential care settings • Activities of daily living (e.g. bed making, gardening, dressing, shopping) • Environmental hazards such as uneven or loose surfaces • Poor lighting • Slippery floors • External lifestyle factors might include: • inappropriate footwear • extended stays in hospital • people traffic	• Diet affects the client's health and strength • The consumption of alcohol can make the client more unsteady and more likely to fall • Deteriorated health making the client frail and/or unsteady • Previous health issues including strokes	• Deteriorated health making the client frail and/or unsteady • Reduced mobility and strength associated with ageing • Lack of exercise leading to impaired balance, gait, flexibility and strength • Some medications or combinations of medications • Wandering behaviour • Impaired cognition or confusion • Impaired visual acuity

Collecting information

There are a number of ways to collect information to determine older person's concerns about falling including:

Surveys - a survey is a question sheet that is used to collect a large amount of information. It can be used as a self-completed form, during face-to-face interviews or over the phone.

Focus groups - is where a facilitator guides discussion with a small group of people to gather information. Facilitating a focus group requires considerable skill, in particular in not influencing the flow of the discussion or giving their own opinion.

Interviews - is a conversation conducted by one person to gather information from another person. An interview can be conducted in a number of ways, including:

- Formally
- Informally
- One-on-one such as over the phone or by approaching people in public places such as shopping centres.

Community forums - is when one or more public meetings are held that community members are invited to share their opinions and ideas about an issue. These forums provide an opportunity to:

- Gather a lot of information about the issue
- Gain the opinion of the community members
- Increase the community's awareness of the issue
- Generate new ideas
- Test ideas
- Gain support for directions
- Identify new leaders, advocates, champions, stakeholders and other resources.

Statistics - There are many places where falls statistics are collected. These can be accessed from:

- Previous research studies found published in journal articles
- Hospital data
- Ambulance services
- Organisations that collect statistics such as the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW).

Tools and methodologies

Collaborate with supervisor and/or relevant health professional, determine the older person's risk factors based on measurements and findings which are usually categorised into low, medium or high risk.

Physiological Profile Approach (PPA) - Visual function is measured using a dual contrast visual acuity chart, the 'Melbourne Edge Test' and a device for measuring depth perception. Lower limb sensation is assessed with tests of proprioception, touch sensitivity and vibration sense.

EFST - Fall-risk screening test: a prospective study on predictors for falls in community-dwelling elderly.

Berg Balance Scale - Reliability assessment for elderly residents and patients with an acute stroke.

St Thomas's Risk Assessment Tool in falling elderly inpatients (STRATIFY) - Twenty-one possible risk factors in a case control study identified five factors that were significantly associated with falls and subsequently used these to construct a risk assessment tool. The five factors independently associated with a higher risk of falls were: falling as a presenting complaint; poor mobility, high agitation, needing frequent toileting, and visually impaired.

Falls Risk Assessment Tool (FRAT) - FRAT is a multi-professional guidance for use by the primary health care team, hospital staff, care home staff and social care workers. This guidance has been derived from longitudinal studies of factors predicting falls in older people and randomised controlled trials that have shown a reduction in the risk of falling.

Tinetti Mobility Score - The Tinetti Assessment Tool is a simple, easily administered test that measures a patient's gait and balance. The test is scored on the patient's ability to perform specific tasks.

Timed Up and Go - Doctors are asked to assess annually all patients who are sixty-five years or older using the Timed Up and Go Test:

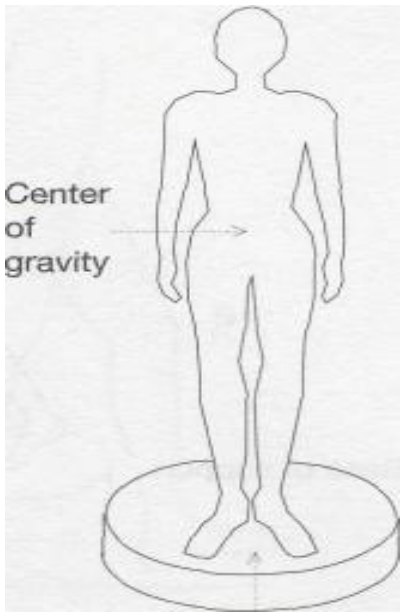
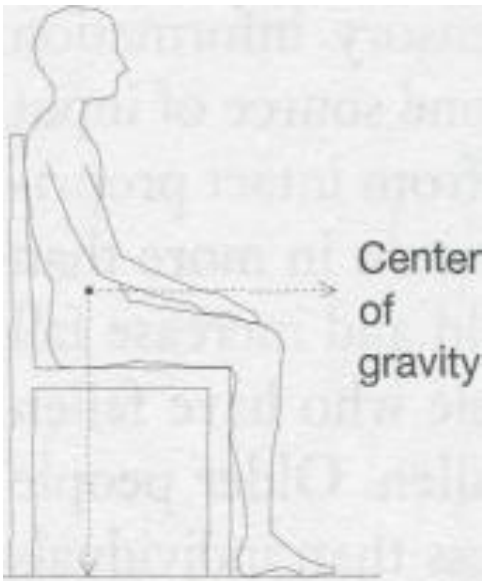
- Patient is in a seated position.
- Place a visible object 2.44m away from the patient.
- Have the patient get up and walk around the object.
- Then have the patient sit back down.
- Scores greater than 8.5 seconds are associated with high fall risk in older adults.

Mini Mental Status Exam (MMSE) - The Mini-Mental Status Examination (MMSE) is a widely used, well-validated screening tool for cognitive impairment. It briefly measures orientation to time and place, immediate recall, short-term verbal memory, calculation, language, and construct ability. Each area tested has a designated point value, with the maximum possible score on the MMSE being 30/30.

Normal posture, gait and balance

The body's ability to maintain balance depends on the central nervous and musculoskeletal systems, requiring adequate vision, proprioceptive feedback, vestibular input, muscle strength, and joint flexibility to detect and correct balance displacement. Combined, these systems culminate in postural sway, a process of antero-posterior and lateral motion of the standing or seated body that controls stability and protects against the forces of gravity (i.e., loss of balance and falls).

Balance is achieved by the body's continual positioning of its centre of gravity over a base of support: the feet, when standing, and the buttocks, when sitting.

Balance when Standing	Balance when Sitting
	
Base of Support	**Base of Support**

Multiple drug use (four or more medications), abnormalities of gait and balance on direct observation, extreme old age (>85 years), the 'senile gait disorder' and the disorders listed below, predict a particularly high risk of drug-induced falls. It is important to note that it is particularly the drugs which depress the central nervous system function that are associated with falls in epidemiological studies. Compensation for physical disability can much more readily occur with a clear brain.

Common age-related disorders which increase the risk of falling;

Special sensory dysfunction:

- Vision and hearing impairment

Neurological disorders:

- Dementia, delirium
- Cerebellar degeneration
- Stroke
- Peripheral neuropathy
- Parkinson's disease

Musculoskeletal disorders:

- Osteoporosis with kyphosis
- Arthritis affecting spine, hips and knees

Foot disorders:

- Any painful conditions e.g. bunions

Frontal Gait Dyspraxia

Frontal apraxia gait presents with short, shuffling steps on a wide base with good arm swing. There is usually no evidence of Parkinsonian symptoms. There is, however, an associated postural instability, similar to Parkinsonian postural deficits. Patients usually have difficulty in maintaining an upright posture and have no reflexes to protect themselves from falls if they are suddenly perturbed. The cause of this complaint is often due to a disconnection of the pre-frontal and frontal regions at the subcortical white matter from other parts of the motor control system.

Maintenance of Postural Stability

Maintenance of postural stability involves sensory (affector) systems, motor (effector) systems and integrating processes in the nervous and locomotor systems (See below). These components are overlapping and compensatory; a fall may not occur until several parts of the system are dysfunctional. Maintenance of an adequate blood pressure is also necessary in avoiding falls.

Sensory (Affector) Systems:

- Visual
- Proprioceptive
- Vestibular

Motor (Effector) Systems:

- Muscles
- Joints
- Feet

Central Nervous System:

- (Integrated System)

Areas outside scope of practice

At times clients will present with needs and issues outside the scope of your role. Examples of these may be;

- Mental health issues requiring assessment
- Housing assistance
- Financial counselling
- Loss and grief counselling

Where appropriate you may need to provide your client with a referral to an external agency, you should follow the organisations referral policies and procedures to do so effectively.

Element 3 Implement falls prevention strategies

Falls are a common problem for older people and are often the reason people are admitted to hospital or move to a nursing home or hostel.

The likelihood of a fall increases partly because of the natural changes that happen as our bodies' age. People often dismiss falls as 'part of getting older' or 'just not concentrating' but they are often a warning sign that something is not right, so it is important to discuss any fall with your doctor.

People fall for a variety of reasons. In some cases, a number of things combine to cause a fall. The reasons or causes for falls are known as risk factors. Some older people are more likely to fall than others. This is because they have more risk factors. These can result from illness or a less healthy lifestyle. The more risk factors a person has, the more likely they are to fall. If you know your risk factors and deal with as many as possible, you can greatly reduce your risk of falling.

Our bodies change constantly throughout our lives. Normal ageing involves:

- Poorer eyesight - we may find we can't see quite as clearly, are less able to judge distances and depth or can't cope with sudden changes in light levels or glare.
- Worse balance, weaker muscles and stiffer joints, which change the way we walk and move around.
- Less feeling in the feet and legs, increased likelihood of pain and even changes to the shape of our feet.
- Slower reaction times and more difficulty concentrating on several things at the one time.

We often don't notice these normal changes as they happen very slowly over the years.

For example, you may find it's harder to get out of that lounge chair you've had for 20 years. The lounge chair hasn't changed - you have! Your muscles have got a bit weaker and your joints a bit stiffer.

Or you may trip over a mat that has been in the same place for years. Maybe you are not lifting your feet as high when you walk, causing you to trip over the mat, or perhaps you can't see the mat as clearly anymore.

Options to minimise the risk of falls:

- Have regular check-ups with your doctor to ensure your medical conditions are well managed. Discuss any concerns you have with your doctor before they become big problems
- Keep as active as possible
- Eat a wide variety of foods and drink plenty of water, especially in hot weather. Sometimes food supplements are recommended if you are very thin – ask your doctor or a dietician
- Stand up slowly after lying down or sitting. Take care when bending down and make sure you are steady before walking. Be especially careful when you are ill, for example with the flu
- Keep yourself up to date with information about your medical conditions. Some support groups and libraries have easy-to-read information
- If you have osteoporosis, your doctor may advise calcium and vitamin D tablets, other medicines, exercise or dietary changes.

Remember that: some causes of memory loss and confusion are treatable. Also, some causes of dizziness are easily treatable.

General Principles of Falls Prevention

A range of measures can be taken in the home or residential care setting to reduce the risk of falls. General safety measures include:

- Encouraging the older person to exercise regularly to improve balance, strength and flexibility
- Encouraging the selection of shoes that are comfortable, fit well and have slip-resistant soles
- Ensuring that mobility aids are within reach and used when mobilising
- Installing good lighting in corridors, bathrooms, living areas and bedrooms
- Ensuring floors are uncluttered and free of any items that can cause trips or falls, for example electrical cords or loose rugs
- Providing support as necessary to the older person who is at high risk of falling
- Making sure that chairs and beds are easy to get into and out of
- Wiping up spills immediately
- Having safety rails and grab rails in the shower and beside the toilet
- Regular review of the older person's medications by the doctor
- Ensuring glasses and hearing aids are used
- Limiting alcohol intake.

Managing worries about falling

If an older person has had a bad fall it is natural to feel worried about falling again. Some people become fearful of falling even if they haven't fallen. This fear may be because of unsteadiness or the thought of the possible injuries from a fall.

People who are worried about falling tend to restrict their activity, gradually doing less and less. For some people this can mean less socialising and loneliness. What you can do:\

- Talk to your doctor about your feelings or concerns about falling.
- Talk to a physiotherapist about whether you need a walking aid, such as a stick or frame. This can make you more stable and improve confidence when walking. You may only need an aid for a while until you get stronger and feel steadier.
- Talk to a physiotherapist or accredited exercise or fitness instructor about how to improve your strength and balance. After building up your strength and balance you are likely to have more confidence in your abilities.
- Make your home and surroundings safer to move around in.
- Make a plan for getting help in an emergency or in the event of a fall. This will help you; your family and your friends feel confident that you can get help if you need it.
- Talking with a clinical psychologist, social worker or counsellor can also help you regain your confidence, particularly if your fear is very strong or you are lonely or isolated.

Strategies to prevent falls

Reducing a person's environmental risk factors

Making your home and surroundings as safe as possible is another important thing that can be done to reduce the likelihood of a fall.

Making these areas safer not only reduces the number of falls and accidents but can make it easier for you to manage your daily activities as you get older.

Some of the things to consider include: -

- Remove general hazards
- Appropriate and adequate lighting
- Wear appropriate footwear
- Using non-slip mats in wet areas
- Use or install handrails
- Keep walkways clear
- Tuck and hide electric cords under furniture or around skirting boards.

Stairways, hallways, and pathways should have;

- Good lighting. Provide extra lighting along path from bedroom to bathroom, by one- and two-step elevations, and by top and bottom of stairway landings; use night-light, 100-to 200-watt bulbs, and 3-way light bulbs to increase lighting levels
- A lack of glare. Eliminate glare from exposed light bulbs by using translucent light shades or frosted light bulbs
- Firmly attached carpet, rough-texture or abrasive strips to secure footing, non-skid rugs and carpet runners on slippery floors, a coating of non-skid floor wax, carpeting over threshold to create a smooth transition between rooms
- No clutter, including obtrusive furnishings
- Tightly fastened cylindrical handrails running the whole length and along both sides of all stairs, with light switches at the top and bottom

Bathrooms should have;

- Elevated toilet seat or toilet safety frame
- Wall-mounted or tub-attached grab bar or shower chair/tub transfer bench
- Non-skid mats, abrasive strips, or carpet on all surfaces that may get wet
- Night-lights

Bedrooms should have;

- Night-lights or light switches within reach of bed(s)
- Telephones that are easy to reach near the bed(s)

Living areas should have;

- Electrical cords and telephone wires placed away from walking paths
- Rugs well secured to the floor
- Furniture, especially low coffee tables, and other objects arranged so that they are not obstacles
- Couches and chairs that are of a proper height so that patients or residents get into and out of them easily (add a seat cushion to raise seat height; replace existing mattress with one that is thinner to lower bed height, or thicker to raise bed height); chairs with armrest support
- Frequently used objects sited at waist level
- A reacher device available for person to obtain objects from shelves
- Shelves and cupboards at accessible height.

The benefits of investing in falls prevention

For the individual:

- A productive life
- Health and wellbeing
- Possible delay of disability and disease
- Prolonged independence
- Confidence in mobility
- Community participation
- Reduction in negative physical or psychological effects as a result of a fall.

For the community and government:

- Monetary savings in health care services
- Reduced demands on aged care and acute services
- Savings in terms of loss of productivity of the older person and family.

Contribution and collaboration

An assessment will be carried out on initial contact with the older person, and then regularly to monitor their wellbeing and to detect any changes. In residential aged care facilities, an admission assessment will be conducted when the person moves into the facility. In home care, physical assessment may not be the primary focus, as the assessment may be directed towards the type of support offered by that service and the assistance that the older person needs. For example, assessment of an older person attending a day care centre may focus more on their social, emotional, behavioural and leisure needs.

Assessment of the older person's needs should begin with their perspective of their needs, their abilities, concerns, views, fears and what support they feel they need to maximise their independence-the client or person-centred approach to care. Encourage the older person to ask questions and take an active part in the assessment. Also, it is important to encourage the carer to participate in the process as well.

Remember that some of the questions you may need to ask during the assessment could cause embarrassment. The person has a right to privacy and should be able to share information about their problems, needs and circumstances without others being able to hear.

During assessment, discussion is gently guided to ensure all the necessary information is gathered. It is important to be professional, build trust and be aware of factors that may affect the older person's ability to communicate, such as hearing loss, inability to speak (aphasia) or the person's cultural and language background.

While assessment tools are valuable for collecting information, accurate assessment still relies primarily on the worker's observation skills and their ability to observe the older person — to notice whether there are any changes in their physical condition, their facial expression, their mood, posture, abilities and whether they are in pain. You need to continually use your senses of sight, touch, smell and hearing when caring for the older person — assessment should be an ongoing activity, not something that is only undertaken when completing an assessment tool.

When the assessment is complete and necessary information has been collected, a care plan can be developed. Again, the older person should be actively involved in the development of the care plan and help to make decisions about the care they need. Family members, carers and those close to the older person should also have the opportunity to be part of making decisions about how best to meet the needs of the older person. The aim of any intervention will be to maximise the independence, abilities and quality of life of the older person, while considering resources available and the needs of carers.

The care plan will identify appropriate support services, as well as adaptations or assistive devices that would help the older person to regain their independence and maximise their abilities.

This may not be sufficient as the older person may require the assistance of another person to manage their ADLs, in particular to meet their personal care needs.

By following the above workers and carers can:

- Providing care that is individualised, reflecting the specific needs of the older person
- Encouraging the older person to do as much as they can for themselves
- Following the care plan
- Not rushing — allowing sufficient time to permit the older person to be independent in personal care activities if possible
- Explaining what you are doing prior to implementing any care
- Maintaining safety for the client and yourself
- Being aware that it can be embarrassing to have someone assist with personal tasks
- Being respectful, ensuring privacy and maintaining the dignity of the older person at all times
- Following the policies and procedures of the organisation
- Always using standard precautions
- Following occupational health and safety guidelines using appropriate equipment, especially personal protective equipment if required
- Performing only services that you have been trained to provide, and seeking additional support when needed
- Reporting any changes in the client's condition or abilities to your supervisor
- Recording details of care and relevant information as required.

People who require assistance with personal care have many differing personal characteristics, abilities and needs. For this reason, it is essential that all assistance with personal care reflects the highly specific needs and preferences of the individual, and that care services are provided in a manner that is free from discrimination, stereotyping and judgement.

After completing the risk assessment, staff should develop a care plan for clients/residents with specific, individualised interventions matched to identified fall risk factors. The care plan should identify various risk factors that increase the likelihood of falls and restraint use, interdisciplinary interventions aimed at reducing fall and restraint-use risk, intervention goals, responsible disciplines for completing the interventions, and a time frame for evaluating the effectiveness of interventions.

If falls continue to occur, consider other possible reasons for fall risk besides those already identified. For those clients and residents who fall repeatedly and/or require restraints (i.e., where the cause

cannot be modified or controlled), identify ways to reduce the risk of injurious falls and restraint complications.

Client-focused care means that older people must be involved in decisions about their care. As an aged care worker, you will provide information and support to help the older person make choices and advocate, when appropriate, to ensure their rights are upheld.

Individualised care recognises that ageing is a unique process and each person will respond differently. As an aged care worker, you play a vital role in supporting the needs and rights of clients, and you also have a responsibility to work ethically, collaboratively and competently to achieve quality outcomes for older people in your care.

Specialists / Referrals

It is a good idea to collaborate with the following specialists where appropriate to manage fall prevention strategies;

Doctors

It is a good idea to talk with your doctor about how to prevent falls, particularly if you have one or more of the conditions linked to a higher risk of falls. Your doctor can assess and help you manage your health and any chronic disease you may have, review your medicines, or refer you for a Home Medicines Review.

(https://www.myagedcare.gov.au/getting-started/healthy-and-active-ageing/medication-management)

They may also refer you to another health professional or service.

If you've had a fall, try to give them as much information as you can about the time of day you fell, what you were doing and how you were feeling just before the fall. Make sure you tell your doctor any conditions you have and medicines you're taking.

Physiotherapists

A physiotherapist may be able to help you with balance and strengthening exercises. You can also ask them about equipment such as a walking frame or stick to help you move about more safely. It's important that any equipment you do use is adjusted to meet your needs and well maintained. For example, a physiotherapist can help make sure that your walking frame is the correct height for you and teach you how to use it safely.

Podiatrists

It may be a good idea to talk to a podiatrist if you have painful or swollen feet, tingling, pins and needles or bunions, as all of these things can affect your balance. A podiatrist may also suggest ways to improve your circulation and decrease any swelling in your legs and feet and provide advice on suitable footwear.

Occupational therapists

An occupational therapist can assess your home environment for potential hazards. They can help you with modifications to make your home safer, such as rails in the bathroom, and provide you with an exercise program.

Optometrists

It may be a good idea to talk to an optometrist because your eyes not only help you to see but also to maintain your balance. Having your eyes checked regularly, making sure you are wearing glasses with the right prescription and keeping your glasses clean are important.

Summary of terms:

Diagnostic strategies - describes a procedure or test which is performed to determine what is wrong with a client, or what illness they have. Diagnostic procedures cure anything but are more informational and exploratory nature.

Therapeutic strategies - cures diseases or relieves pain.

Preventative strategies - preventing or contributing to the prevention of diseases/falls.

Rehabilitative strategies- Clients and residents who fail to respond or improve with medical treatment and continue to remain at fall risk, particularly those with chronic neuromuscular disorders, may respond to a number of rehabilitative strategies.

Rehabilitation involves restoring a person's ability to function to their maximum potential physically, emotionally, psychologically and socially. Rehabilitation helps someone to regain function that they have lost as a result of injury, illness, surgery or accident. Rehabilitation usually involves an interdisciplinary team approach with a range of health professionals coordinating an individualised rehabilitation program.

The major goal of rehabilitation for an older person is to help them perform ADLs independently. If they are unable to manage independently, the aim is to minimise the need for assistance through the use of adaptive devices and equipment.

Many older people will have rehabilitation after a stroke, fracture, limb replacement, amputation, or if they have a disease such as Parkinson's disease or multiple sclerosis that impacts on their mobility and ability to self-care. A key focus of rehabilitation for older people is to prevent complications and further disability that could result from a disease process or injury.

Any loss of function and independence can cause an older person to feel anxious, distressed and fearful for their future. It can also affect their self-esteem and sense of wellbeing. Rehabilitation is essential to ensure that the older person has the opportunity to regain as much function and independence as possible. Each person will be assessed, and realistic goals will be set to restore their function and help them to be independent in their ADLs.

Rehabilitation is concerned with the whole person that is, a holistic approach, and looks at the physical, psychological, social and spiritual needs of each person.

General principles of rehabilitation include:

- Providing support and encouragement to the older person to help them adjust and come to terms with their loss of ability and/or increased dependence — they may be feeling a sense of loss and be grieving for their loss of independence and loss of function
- Supporting the independence of each older person by focusing on their abilities and encouraging them to do as much as possible for themselves
- Following the care plan to ensure that goals have been established for each older person, and helping to motivate and encourage them to achieve these goals
- Preventing any complications that may result from immobility and prolonged illness, such as pressure ulcers, constipation and contractures
- Ensuring you know the correct way to use any assistive device that has been recommended for the older person and following the manufacturer's instructions in the application of any prosthetic device or use of specialised equipment
- Contributing to the rehabilitation process by participating in case conferences, as well as assessing, monitoring and evaluating the progress of the older person in your care.

Rehabilitation is usually a slower process for the older person. It usually takes a longer time to achieve goals and restore previous abilities. It is common for people to become frustrated and discouraged at times when involved in a rehabilitation program. Progress may be slow, and sometimes it can be difficult for the older person to feel they are making progress.

These strategies include engaging in education, exercise therapy, wearing proper footwear, employing hip-protective pads, and using appropriate ambulation devices to assist with mobility.

Social support strategies - systems that provide assistance and encouragement to individuals with physical or emotional disabilities in order that they may become independent. Informal social support is usually provided by friends, relatives or peers while, formal assistance is provided groups such as the Arthritis Association, Commonwealth Carelink, independent Living Centres, Podiatry Association Council and the list continues.

Implement strategies in a manner that minimises the older person's discomfort

Qualitative research indicates that older people believe that falls prevention information and strategies are not relevant to themselves but to other older people, who they consider are older and at greater risk of falls. It is proposed that suggesting that falls are personally relevant to older people can be a threat to their identity. This can result in older people rejecting information and advice. Indeed, when asked about what they might do to reduce their risk of falls, many older people did not nominate any activity they would pursue.

This means that falls prevention messages delivered to older people are unlikely to succeed in engaging most older people to take up falls prevention activity. It is likely that many of the population that health professionals want to engage, particularly those who do not believe they are at risk of falls, will ignore risk reduction messages, such as 'reducing your risk of falling'.

Therefore, there is a need to engage older people in a way that older people do not reject. Messages could promote positive identities that are relevant to older people such as maintaining an independent lifestyle; staying healthy and physically active; and emphasising the promotion of activities that enhance fitness, balance and mobility and:

- That these activities would be enjoyable;
- That they are the type of people who would do this; and
- That important others (doctor, family and friends) would think they should do this

Remember that falls are not value free words as they have strongly overriding negative connotations.

Provide support to the carer to contribute to the strategy

Without carers, many older people and people with a disability may require institutionalised and long-term residential care at great cost to society. The amount and type of care provided by family and friends is diverse and each care situation is different. The level of responsibility that carers assume depends on the physical and psycho-social needs of the person requiring care and the dynamics of the relationship between the carer and the care recipient.

Carers themselves may require help and support from formal home and community care services in addition to the services provided to the person for whom they are caring. All services aim to support carers in their caring role and many formal services offer carer respite.

It is not possible to predict if, how, where and when a person might fall, or how little or much the person might be injured. Even though most falls don't result in serious injury, many people are unable to get up without help.

Therefore, it is important to think ahead and make a plan of things that can be done to safeguard yourself and the older person. This will help the older person to feel not only safer, but more confident and in control.

The damage done by any fall depends on how, where and when the older person lands, how strong their bones and skin are, and how quickly help comes.

Element 4 Monitor Falls prevention strategies

Review and measure outcomes

When assessing a resident's needs, a care plan is developed. The purpose of the care plan is to establish goals with the resident and to determine ways of delivering services that suit their individual needs and preferences. The care plan is re-evaluated regularly to check that all care is implemented and to reassess the needs of the resident. It is a crucial document for ensuring delivered care is responsive to the needs of the resident.

The role of the aged care worker in documenting what they do throughout the care planning process is very important. The care plan is an essential tool for providing evidence that the facility is meeting its contractual obligations to the government via the accreditation process, as well as ensuring appropriate care for residents.

Follow-Up

Evaluate and re-evaluate outcomes or the effectiveness of interventions included in the care plan on a continual basis and revise the client's/resident's plan of care as needed. Steps of a good follow-up plan include the following:

- Complete a fall and restraint risk assessment whenever a client/resident experiences a change of condition and/or states problems with imbalance, mobility, and so forth.
- Observe and communicate "at-risk" status (includes keeping an eye on clients/residents, particularly those individuals at risk, and communicating with physicians and ancillary providers regarding the current risk status of clients/residents).
- Document and evaluate all falls when they occur to see what other interventions can be put into place to prevent falls.

Evaluation

Evaluation involves reflecting on the process and reviewing the care plan. Aged care workers look at how the older person has responded to the care given and make changes to the care plan as required.

Evaluation asks the question 'is the plan achieving the needs/goals that were identified;" For example, if the care plan identifies that assistance with toileting is required, evaluation would include reviewing whether the older person has received assistance as required, do they still need the level of assistance provided, are they comfortable and dry at all times and if not, why the plan did not work and what should be done to achieve the desired outcome.

The care planning process involves assessment, planning, interventions or actions, and evaluation of these actions. It allows workers to communicate effectively, leads to coordinated and client-focused care, and provides ongoing documentation to ensure care is consistent and holistic.

When care plans are written, they should encompass all of the factors contributing to holistic care and in turn, inform future decisions about care delivery.

To maintain an accurate overview of the older person's current care needs, care plans should be reviewed on a regular basis to include newly identified needs, any additional interventions, and any necessary changes to interventions/care.

Aged care workers need to measure the effectiveness of what they do against the goals and identify whether their interventions are working or need changing.

As an aged care worker, you will be required to contribute to the development of the care plan by documenting care and verbally sharing information with your supervisor or other care-team members. It is essential when you are caring for someone that you are familiar with the information contained in their care plan. This information will determine how care will be delivered, and ensures all workers provide care that is consistent and that reflects the care plan documentation.

Indicators of increased risk and strategies not working

When to halt a strategy

If strategies are in place already and they are not meeting the needs of the client, this may be due to the following:

- Poorly trained staff (those with a lack of knowledge about risk assessment, procedures, and/or preventive interventions)
- Inadequate or inaccurate risk assessments
- Sub-optimal or lack of communication among staff related to client/resident risk
- Lack of chart documentation related to client/resident risk Delayed multidisciplinary referrals (i.e., further evaluation by necessary professional or trained staff of client/resident risk and/or identification of underlying problems) Staff shortages
- Inadequate staff/client and resident ratios (i.e., insufficient staff to properly care for the number of patients/residents requiring care)
- Constant staff turnover
- Delayed or insufficient medical and nursing care Reduced use of restraints without available non-restraint alternatives
- Malfunction of equipment (e.g., nurse call system, bed alarm systems, bed wheel locking systems, wheelchairs) Lack of established policies and procedures regarding falls and restraint prevention
- Staff noncompliance with protocols/procedures inadequate resources (e.g., bed alarm devices, assistive devices, non-restraint alternatives).

The key issue of concern is not simply the high incidence of falls in older people but rather the combination of a high incidence and a high susceptibility to injury (Rubenstein 2001). There is a national program called the National Falls Prevention Program, which is a national scheme in the prevention of falls. Although most falls do not result in serious injury, the consequences for an individual of falling or of not being able to get up after a fall can include:

- Psychological problems, for example, a fear of falling and loss of confidence in being able to move about safely
- loss of mobility, leading to social isolation and depression
- Increase in dependency and disability
- Hypothermia
- Pressure-related injury
- Infection.

Falls have a multifactorial aetiology, with more than 400 separate risk factors described (Oliver 2000). The major risk factors for falling are diverse, and many of them – such as balance impairment, muscle weakness, polypharmacy and environmental hazards – are potentially modifiable. Since the risk of falling appears to increase with the number of risk factors, multifactorial interventions have been suggested as the most effective strategy to reduce declines in function and independence and also to prevent the associated costs of complications.

Preventive programmes based on risk factors for falling include exercise programmes, education programmes, medication review, environmental modification in homes or institutions and nutritional or hormonal supplementation.

Interventions need to target extrinsic factors such as hazards within the home environment and intrinsic risk factors, such as mobility, strength, gait, medicine use and sensory impairment.

Checking individualised care plans is important and as a worker using your good observational skills will pick up ineffective strategies in meeting the clients' needs.

You must ensure that you communicate with your client, regarding the importance of having a medical check-up prior to them commencing any new program of physical activity. Clients with medical conditions or a disability may require a more specifically tailored exercise program and advice may be obtained from their general practitioners and allied health professionals such as a physiotherapist.

- Report any concerns you have regarding your client's wellbeing to your coordinator/supervisor/Case Manager.
- Increase knowledge and awareness of falls risks and their management
- Social contact can reduce anxiety about fear of falling
- Referral to a professional counsellor or a specialist falls and mobility clinic may assist (Depending on available services in States and Territories).

If the strategies are ineffective in meeting the clients' needs the process of risk fall assessment needs to start again. Remember the steps include:

- Problem definition-risk assessment
- Assessment/Problem Analysis- complete the fall risk assessment tools
- Problem Management-use of information gathered and plan how to best meet the clients' needs, develop a care plan
- Monitoring/Evaluation-regularly evaluate the clients' progress to see if needs are being met.

Falls are common for older people in residential aged care, and these falls usually have multiple causes. A range of falls-prevention activities can reduce falls and injuries. However, to be effective and sustainable, falls-prevention practice should be integrated into standard assessments, care planning, environment audits, and ongoing clinical and facility management.

To achieve the goal of reduced falls and falls injuries, staff members, residents, family members, and carers need to work collaboratively to develop and implement the most appropriate mix of strategies for individual residents.

Assess the outcomes of falls minimisation strategies

When working in conjunction with clients and carers during the planning, assessment and implementation processes to make individualised plans the worker builds a rapport of trust, allays their anxiety and allows them to be open about what they want and need.

The building of a positive relationship with the worker, client and carer has many benefits such as active listening; empathy; flexibility; an intimate understanding of the carers and client's needs; and an ability to read the clients verbal and non-verbal cues.

When you build a positive relationship, the strategies employed and the care plan that is implemented will mean it will be probably better adhered to and followed more closely than if you made a plan that had no or minimal client and carer input.

When evaluating a care plan the monitor its effectiveness, this can be attended to through formal and informal processes. The formal process will be an interview process of questioning and audit/observation of the home. The informal process is purely observation and listening to the client and carer.

Comply with the organisation's reporting requirements

Governing bodies such as Commonwealth Department of Health and Aged Care Documentation and Accountability Manual gives the professional requirements of responsible and accountable aged care practices. Then there is the Australian Nursing and Midwifery Council and there is a Nursing and Midwifery Board for each state and territory in Australia which have professional standards and codes of conduct/practice that need to be complied with.

Each organisation will have guidelines for completion of documentation so that consistency and continuity of care can be maintained. The National Framework for Documenting Care in Residential Aged Care Services (NATFRAME) is a manual that has been prepared by the Ageing and Aged Care Division of the Department of Health and Ageing.

The NATFRAME has been designed to help organisations communicate and deliver high-quality care for older people. It provides for initial assessment of those entering care, and for continuing evaluation, reassessment and planning of care throughout their residency.

Privacy and Confidentiality

It is essential that all staff with access to the residents' clinical records are aware of the Privacy Act 1988 and the National Privacy Principles, privacy policy and privacy code of conduct of the organisation. In addition, staff need to be aware that, under the Aged Care Act 1997 Commonwealth approved providers (and therefore their staff) also have responsibilities to protect residents' personal information which is covered by Commonwealth privacy legislation.

Therefore, it should be ensured that all staff have received education and information on the implications of privacy (and aged care) legislation and clinical care practice, particularly in relation to consent, either expressed or implied.

Documentation

There will be an organisational policy and procedures manual that will outline what the expectations are to meet legislative requirements and legal requirements in documenting care. The policies and procedures will outline how to complete forms, the acceptable abbreviations, colour of pen to write with; the guiding principles for documentation and other important information that needs to be complied with as all forms and written information are legal documents for proof of what has been done for that client care.

Organisational documentation promotes:

- Compliance with the ANMC (Australian Nurses and Midwives Council) competency standards for nurses and midwives
- A high standard of care
- Evidence of nursing and midwifery care
- Continuity of care
- Improved communication and dissemination of information between and across services providers
- An accurate account of assessment, care planning, treatment and care evaluation
- Improved goal setting and evaluation of care outcomes
- Improved early detection of problems and changes in health status.

Any and all forms of documentation by a nurse or a midwife recorded in a professional capacity in relation to the provision of nursing or midwifery care and includes written and electronic health records, audio and video tapes, emails, facsimiles, images (photographs and diagrams), observation charts, check lists, communication books, shift/management reports, incident reports and nursing or midwifery anecdotal notes or personal reflections (held by the nurse or the midwife) or any other type or form of documentation pertaining to that care.

Client Centred Care	Documentation is a tool used by nurses and midwives and other health professionals to enhance practice and client care.
Communication	Documentation is the basis for communication between health professionals. Clear, complete, accurate and factual documentation provides a reliable, permanent record of client care.
Accountability	Documentation demonstrates the nurse's or the midwife's accountability and records their professional practice. It may be used in relation to performance management, internal inquiries, Board proceedings and/or legal proceedings.
Professional Responsibility	Documentation is an integral part of nursing and midwifery practice and forms the basis for evidence of nursing and midwifery care.
Legislative Requirements	Nurses and midwives are required to make and keep records of their professional practice in accordance with practice standards and organisational policy. Legislation requires specific information to be recorded and maintained.
Quality Improvement	Documentation may be used to evaluate professional practice as a part of performance reviews, audits and accreditation processes, legislated inspections or critical incident reviews.
Research	Documentation is a valuable source of data for health researchers. It provides information in relation to nursing and midwifery care evaluates client outcomes and is a concise record, essential for accurate research data and evidence-based practice.
Resource Management	Accurate and comprehensive documentation of nursing and midwifery care provides a valuable source of evidence and rationale for funding and resource management.

Guiding Principles for Documentation (from Guideline: Guiding principles for Documentation, Nursing & Midwifery Board South Australia) gives guidelines so that reporting is consistent, this is the Who? What? When? Why? How? Approach to reporting, see below.

WHO?	Documentation should be a record of firsthand (direct) knowledge, observation, actions, decisions and outcomes. Therefore, it should be recorded by: Registered nurses, registered midwives, enrolled nurses, assistant in nursing, other health professional and other care provider. • Shared or cross agency documentation should reflect • use of consistent pro forma (e.g. shared documents across agencies) • clarification of documentation requirements by each provider • roles and responsibilities of each provider (i.e. who is responsible for review/initiation/ completion of documentation in what circumstances) • clear process for review, storage and archiving • clarification of access and communication processes
WHAT?	• All aspects of nursing and midwifery care • Collaboration and shared responsibilities with other health • professionals/care providers • Complete information • Subjective and objective information • Observation, assessment, actions, outcomes • Variances from expected outcomes or established protocol • Rationale for decision and actions • Critical incidents involving the client
WHEN?	• As a chronological record of actions and events • At the time of or as soon as practicable after (timely) • The action or event • Collaborations • Variances to expected outcomes (charting by exception) • Critical Incidents • An identified late entry
WHY?	• Basis of communication between health professionals • Informs and is a record of care provided • Used to evaluate professional practice as part of quality improvement • Demonstrates accountability • Valuable source of data for research • Tool for identifying funding and • resource allocation
HOW?	• Concise, contemporaneous, accurate and true • Clear, legible, permanent and identifiable • Chronological, current, confidential • Based on observations, evidence, assessment • Consistent with the guidelines, organisational policy, legislation • Avoids abbreviations, white space, ambiguity

Duty of care

You have a duty of care to ensure that you provide the standard of care required to meet the needs of the older person. This care is to be identified and documented in the care plan.

Continuity of care means that each worker can identify what the previous worker did when caring for the older person. Continuity of care relies on effective communication between team members. Without documentation to show what care has been provided and how the client responded, the quality and continuity of care may be compromised.

Work health and safety

Each organisation will have their own policies and procedures in the way they manage work health and safety in the workplace this will include;

- Manual handling policy
- No life policy
- Privacy and confidentiality policies
- Home visits policy
- Duty of care
- Client transfers

Falls risk assessment tool (FRAT)

The following is a sample risk assessment tool that should be completed with the client and their carer; this will be of assistance when implementing fall prevention strategies.

FALLS RISK ASSESSMENT TOOL (FRAT)	UR NUMBER: …… SURNAME: …… GIVEN NAMES: …… DATE OF BIRTH: …… Please fill in if no patient/resident label available

Part 1: Fall Risk Status

Risk factor	Level	Risk score
RECENT FALLS	None in last 12 months……	2
(To score this, complete history of falls, overleaf)	One or more between 3 and 12 months ago…….	4
	One or more in last 3 months…….	6
	One or more in last 3 months whilst inpatient / resident….	8
MEDICATIONS	Not taking any of these……	1
(Sedatives, Anti-Depressants	Taking one ……	2
Anti-Parkinson's, Diuretics	Taking two …….	3
Anti-hypertensives, hypnotics)	Taking more than two…….	4
PSYCHOLOGICAL	Does not appear to have any of these……	1
(Anxiety, Depression)	Appears mildly affected by one or more……	2
↓Cooperation, ↓Insight or	Appears moderately affected by one or more……	3
↓Judgement (**esp. re mobility)**	Appears severely affected by one or more……	4
COGNITIVE STATUS	AMTS 9 or 10 / 10 **OR** Intact……	1
	AMTS 7-8 Mildly impaired……	2
(AMTS: Hodkinson Abbreviated	AMTS 5-6 Moderately impaired……	3
Mental Test Score)	AMTS 4 or less Severely impaired ……	4
(Low Risk: 5-11 Medium: Risk: 12-15 High Risk: 16-20)	**RISK SCORE:**	**/20**

Automatic High-Risk Status: *(if ticked then circle* **HIGH** *risk below)*
☐ Recent change in functional status and / or medications affecting safe mobility (or anticipated)
☐ Dizziness / postural hypotension

FALL RISK STATUS: *(Circle):* **LOW / MEDIUM / HIGH**

List Fall Status on Care Plan/ Flow Chart

*IMPORTANT: IF **HIGH**, COMMENCE FALL ALERT*

Part 2: Risk Factor Checklist

		Y/N
Vision	Reports / observed difficulty seeing - objects / signs / finding way around	
Mobility	Mobility status unknown or appears unsafe / impulsive / forgets gait aid	
Transfers	Transfer status unknown or appears unsafe i.e. over-reaches, impulsive	
Behaviours	Observed or reported agitation, confusion, disorientation Difficulty following instructions or non-compliant (observed or known)	
Activities of Daily Living (A.D.L's)	Observed risk-taking behaviours, or reported from referrer / previous facility	
	Observed unsafe use of equipment	
	Unsafe footwear / inappropriate clothing	
Environment	Difficulties with orientation to environment i.e. areas between bed / bathroom / dining room	
Nutrition	Underweight / low appetite	
Continence	Reported or known urgency / nocturia / accidents	
Other		

HISTORY OF FALLS *Note: For an accurate history, consult patient/resident / family / medical records.*

Falls prior to this admission (*home or referring facility*) **and/or during current stay** ☐

If ticked, detail most recent below)

CIRCUMSTANCES OF RECENT FALLS: Information obtained from_____

	(Circle below)						**(Where? / Comments)**
Last fall:	Time ago _____	Trip	Slip	Lost balance	Collapse	Leg/s gave way	Dizziness
Previous:	Time ago _____	Trip	Slip	Lost balance	Collapse	Leg/s gave way	Dizziness
Previous:	Time ago _____	Trip	Slip	Lost balance	Collapse	Leg/s gave way	Dizziness

List History of Falls on Alert Sheet in Patient/Resident Record

PART 3: ACTION PLAN

(For Risk factors identified in Part 1 & 2, list strategies below to manage falls risk).

Problem list	Intervention strategies / referrals

Transfer care strategies to Care Plan / Flow Chart

PLANNED REVIEW _____**Date of Assessment**: _____

INITIAL ASSESSMENT COMPLETED BY:

Print name _____**Signed:** _____

Review

(Falls Review should occur at scheduled Patient/Resident Review meetings or at intervals set by the Initial assessor)

Review Date	Risk Status	Revised Care plan (Y or N)	Signed	Review Date	Risk Status	Revised Care plan (Y or N)	Signed

Conclusion

Implementing strategies to keep our clients on their feet is a very important part of working with older clients; this is because they are at a much higher risk of not only falls but serious injuries if they do fall. Our clients and their carers or other support people should be involved in each step of assessing the risk, deciding of the suitable prevention strategies, implementing those strategies and continuing to monitor the implemented strategies.

CHCCCS017 - Provide loss and grief support

Welcome to the learning resource for the unit CHCCCS017 Provide loss and grief support.

This unit applies to workers in a range of community services and health contexts.

On completion of this unit you will have covered the requirements for:

1. Recognise reactions to loss and grief
2. Engage empathetically
3. Offer support and information
4. Care for self
5. Review support provided

You will be able to demonstrate your ability to understand spectrum of loss situations, including:

- Primary loss
- Secondary loss
- Cumulative loss
- Integration of loss

Potential impacts at the individual, family and community level, of grief, bereavement and trauma features and expressions of grief and how these may vary, including:

- Complex grief
- Disenfranchised grief
- Reactions that may indicate risk of suicide and required responses
- How loss, grief and bereavement can impact on social and emotional health and well being
- Social, cultural, ethnic and spiritual differences in responses to loss, grief and bereavement
- Different contexts and circumstances that may be present prior to loss and their impact on grief and bereavement
- Strategies and communication techniques for formal and informal grief and bereavement support
- Grief and bereavement care services and information resources
- Stress vulnerability model and its application to loss and grief support
- Self-care strategies and support services for workers

Legal and ethical considerations and how these are applied in an organisation and individual practice, including:

- Duty of care
- Privacy, confidentiality and disclosure
- Work role boundaries – responsibilities and limitations

You will gain knowledge about the:

Responding effectively to at least 3 diverse situations of loss, grief, bereavement or trauma.
Engage with people using effective communication skills at least once that included:

- Empathic listening skills
- Verbal and non-verbal techniques
- Providing information clearly and sensitively
- Obtaining feedback to confirm understanding

A copy of the full unit of competency can be found at: http://training.gov.au/Training/Details/CHCCCS017

This learning resource is designed to support your learning and act as a guide to further research. We encourage you to access other texts which include; standards and legislation and other resources relating to your industry that can be sourced throughout the internet or library.

Element 1 - Recognise reactions to loss and grief

What is loss?

Loss is defined as the severing or breaking of an attachment to someone or something, resulting in a changed relationship.

(Guidelines for Palliative Approach in Residential Aged Care–Enhanced Version 2006).

There are two general categories of loss:

Physical Loss–is the loss of something tangible. For example; a car is stolen, a memento is misplaced, death of a loved one.

Psychosocial Loss–is the loss of something intangible, psychosocial in nature. This is sometimes called a symbolic loss. For example; a divorce, developing a chronic illness.

Sometimes a loss can be both a physical and psychosocial loss. For example; the loss of a breast due to breast cancer.

As people age they will face a lifetime of loss and grief this is a natural healing process they will go through. Those that aren't allowed to grieve or cannot process grief may experience depression which left untreated could have dire consequences.

Loss situations affect individuals over a variety of spectrums. These include;

- Primary loss
- Secondary loss
- Cumulative loss
- Integration of loss

Initial loss is referred to as the Primary Loss and the losses that follow are identified as Secondary losses. For example; a family whose father is diagnosed with Parkinson's disease. His loss of health would be the primary loss. This loss however would trigger many other losses which would be as a result of his decline in health and loss of mobility.

Another example is; where the death of someone a person cares about will be considered a primary loss. The secondary losses to this situation would include; loss of role of being a carer or a couple, loss of dreams and companionship. Secondary losses can unfold over time.

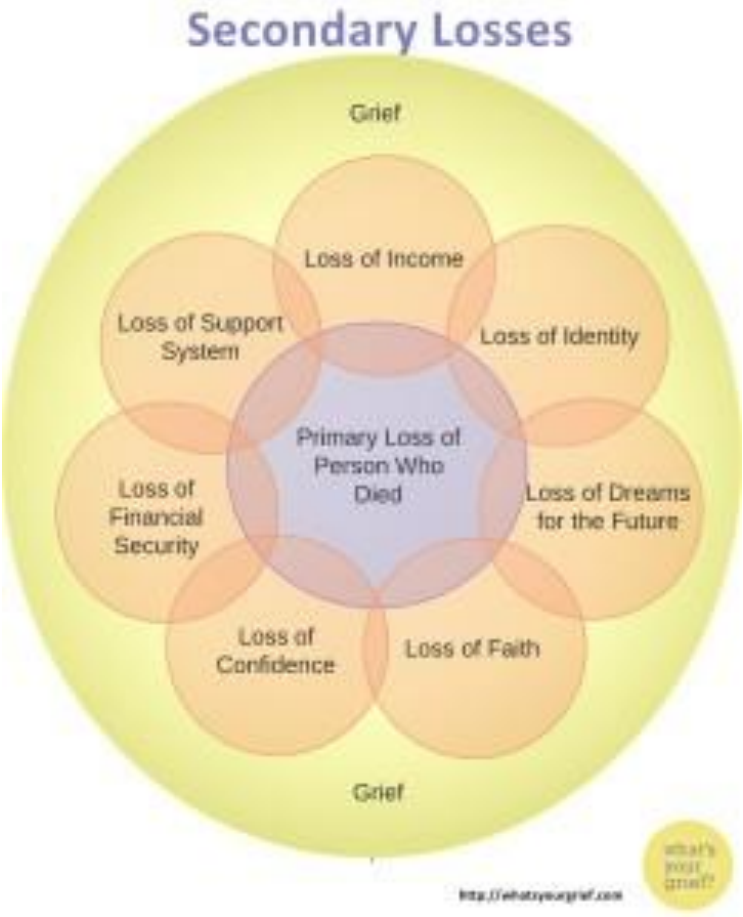
Cumulative loss occurs when someone experiences a second loss before grieving an initial loss. This term is also known as grief overload.

The situation of integrating the loss is when you have to integrate the loss into your life and continue to function as you normally would. Integrated grief does not mean that individuals forget about the loss, the loss simply becomes integrated into their memory system. The thoughts are no longer as disabling.

It does not mean a person in grief is suddenly happy, it means they are starting to move on and find some peace about the loss.

Integration of loss includes:

- Dual process
- Meaning reconstruction
- Continuing bonds
- Disenfranchised grief
- Grieving styles



What is Grief?

Grief refers to the process of experiencing the psychological, behavioral, social and physical reactions of loss. How a person grieves depends on a number of factors. How grief affects an individual is referred to as bereavement. People experiencing grief and bereavement experience emotional reactions but may also experience psychological and physical reactions. It is important that you are aware of and recognise the common features of grief and bereavement, while recognising that there is no typical response to loss and no typical way to grieve.

There are four important clinical implications:

1. Grief is expressed in four ways: psychologically, behaviorally, socially and physically
2. Grief is a continuing development. There is no timeline. It involves many changes overtime.
3. Grief is a natural reaction
4. Grief is dependent upon the person's unique perception of the loss

Grief may occur at any time, not necessarily after the event. Grief may occur:

- While the event is taking place
- Before the event takes place (anticipatory grief)
- After the event takes place

Our reaction to grief will be affected by:

- Gender
- Age
- Culture
- Religion
- Personality
- Health
- Previous life experience
- Family background
- Availability of support
- The loss and its significance to us
- Our ability to cope with stress
- Our ability to communicate emotions
- Personal issues that may be brought to the surface at this time

Stages of grief

Denial	Denial is a conscious or unconscious refusal to accept facts, information, reality, etc., relating to the situation concerned. It's a defence mechanism and perfectly natural. Some people can become locked in this stage when dealing with a traumatic change that can be ignored. Death of course is not particularly easy to avoid or evade indefinitely.
Anger	Anger can manifest in different ways. People dealing with emotional upset can be angry with themselves, and/or with others, especially those close to them. Knowing this helps keep detached and non-judgemental when experiencing the anger of someone who is very upset
Bargaining	Traditionally the bargaining stage for people facing death can involve attempting to bargain with whatever God the person believes in. People facing less serious trauma can bargain or seek to negotiate a compromise. For example "Can we still be friends?" when facing a break- up. Bargaining rarely provides a sustainable solution, especially if it's a matter of life or death
Depression	Also referred to as preparatory grieving. In a way it's the dress rehearsal or the practice run for the 'aftermath' although this stage means different things depending on whom it involves. It's a sort of acceptance with emotional attachment. It's natural to feel sadness and regret, fear, uncertainty, etc. It shows that the person has at least begun to accept the reality
Acceptance	Again, this stage definitely varies according to the person's situation, although broadly it is an indication that there is some emotional detachment and objectivity. People dying can enter this stage a long time before the people they leave behind, who must necessarily pass through their own individual stages of dealing with the grief.

Source: Elizabeth Kubler Ross

Continuing bonds

In the past, bereaved people were often encouraged to 'let go' of the deceased person by severing emotional bonds and ties with them. More recent approaches suggest that it may be more helpful for the bereaved individual to develop and maintain a continuing bond with the deceased.

A continuing bond means finding a way of maintaining a relationship with the person who died. This may include focusing on happy memories of the deceased person and remembering the positive aspects of their life, rather than the sadness of their death. By establishing a continuing bond with the deceased, the bereaved person constructs a new relationship with them that is a source of comfort and solace. By maintaining this, the grieving person can more easily integrate the loss into their ongoing life.

Meaning reconstruction

Meaning reconstruction focuses on how an individual makes sense of a significant loss. For an individual to integrate their loss, they need to find meaning in the event and circumstances that disrupted their life and sense of coherence.

Bereaved individuals need to piece together their lives by exploring the meaning of the loss through talking about it. This helps them rebuild their life without the deceased person. Integration occurs when they are able to incorporate the loss into their life.

Grief reactions can be divided into four groups: feelings, physical sensations, thought patterns and behaviour.

Feelings	Physical Sensations	Thought Patterns	Behaviour
Fatigue	Hollowness in stomach/nausea	Disbelief	Appetite disturbances
Shock	Tightness in throat	Pre-occupation	Increased use of drugs and alcohol
Freedom	Weakness in muscles/muscle tremors	Hallucinating	Under/over eating
Numbness	Dry mouth	Confusion	Avoiding reminders of the loss
Sadness	Tightness in chest	Dissociation	Searching
Anger	Over-sensitivity to noise		Absent- mindedness
Helplessness	Breathlessness		Restlessness
Yearning	Lack of energy		Treasuring objects
Relief	Exhaustion		Social withdrawal
Loneliness	Chills		Dreaming
Guilt	Sweating		Sleep disturbances
Anxiety	High Heart Rate or blood pressure		Calling out
Fear	Dizziness		Crying
Agitation			Over activity
Depression			

Common signs of trauma include:

- Little or no interest and pleasure in normal activities
- Being tearful
- Feeling low and miserable
- Feeling tired all the time
- Changes in appetite, sleep or weight
- Feeling worthless, helpless and hopeless
- Poor concentrations

Intuitive griever

The intuitive griever feels the experience intensely and can be helped by expressing their grief emotionally often with crying. The intuitive grief style is the one often associated with typical female grief. One of the best ways for the intuitive griever to cope is to express their emotions, possibly even in a group setting.

Common characteristics of intuitive grievers include:

- Openly expresses feelings
- Expresses anguish or sorrow with tears
- Is not afraid to seek support from others
- Allows time to experience the inner pain
- Might become physically exhausted or anxious
- Might experience prolonged periods of confusion and problems concentrating
- Is able to discuss the grief
- Might benefit from support groups

Disenfranchised grief

"Disenfranchised grief" is when your heart is grieving but you can't talk about or share your pain with others because it is considered unacceptable to others. It's when you're sad and miserable and the world doesn't think you should be, either because you're not "entitled" or because it isn't "worth it."

EXAMPLE

Recognise reactions to loss and grief

When Louisa's elderly mother dies after a long illness, Louisa feels sad, but also feels a sense of relief. She knows that now her mother has died, she will be able to start to live her life independently because she is no longer in the role of carer. She is surprised to find that she feels a range of fluctuating emotions and reactions ranging from feelings of depression, guilt, remorse and loneliness, to being physically unwell and doubting her ability to cope and get on with her life. Louisa decides to talk to Sarah, the community service worker who coordinates the carers' groups she often attended.

Sarah tells Louisa that her reactions are normal. She explains that although Louisa thought she would not be affected by a grief reaction because she knew and accepted that her mother was dying, she should still expect to go through a period of grief and mourning. Louisa now recognises that she has not been allowing herself to really feel her grief and still needs to do so before she can move forward with her life.

The following circumstances prior to a loss may impact the way the loss affects the client:

- Socio-economic circumstances
- Presence of mental illness in the deceased
- Age of deceased
- Family relationships

Social, cultural, ethnic and spiritual differences

In your work, you need to be able to identify and respect social, cultural, ethnic and spiritual differences that may affect grief and bereavement responses. Knowledge of these differences helps you to provide relevant and effective support. It is also important to realise that differences associated with loss and grief are not only based on cultural, ethnic or religious differences. Among individuals and families there may also be social differences in coping styles and preferences about mourning rituals; for example, whether the deceased is cremated or buried, how the service is conducted and whether children attend a funeral.

Identifying and respecting differences requires you to:

- Respond positively to differences that exist between people
- Provide socially and culturally appropriate support
- Respect the person's rights
- Build rapport and trust
- Communicate effectively
- Identify problems in grieving and assist the person to obtain appropriate help.

Our beliefs, attitudes, and values about death, dying, grief, and loss are initially moulded by societal dictates. Within societies, various religious, philosophical, and ethnic groups further determine and refine the range of appropriate responses, feelings, behaviours, and rituals. While there are certainly wide differences among individuals within any society or culture, particularly in their psychological processing of grief, they are often more subtle than the profound differences among cultures. Societal and cultural influences may be difficult to recognise. These contextual determinants are so fundamental to our way of seeing the world that we often overlook their profound impact on how we feel and behave about loss. We assume that everyone thinks like us.

Each culture will manage loss and grief in different ways it is important that we understand and respect this at all times even if it not how we personally manage loss and grief. You can see how some cultures manage grief here; http://www.griefspeaks.com/id90.html

Here is a link to the ways different religions respond to death; http://lmrpcc.org.au/admin/wp-content/uploads/2011/07/Customs-Beliefs-Death-Dying.pdf

Health and/or safety risk to the person or other people

Supporting grieving clients

When assessing a client experiencing grief and loss, for the first time or as part of an ongoing process, the worker will need to obtain information about the client through a variety of methods. This will include therapeutic communication with the client and significant others, discussion with members of the multi-disciplinary team and reviewing of current and past medical records. When engaged in communication with the client, whether during formal interview or informal interactions the worker will be able to elicit details on the client's current health status, lifestyle, activities of daily living and psychosocial history. Discussion with members of the multi-disciplinary team such as social worker, and psychiatrist will enable the worker to gain a holistic view of the client. In reviewing a client records the nurse will be able to compare their current condition/health status with previous interactions and to review the current management strategies and therapies implemented for the client and their effectiveness.

To support the worker in the assessment of the client an understanding of the concept of phases of grief can be useful in assisting the worker to recognise and support the grieving person and consequently assist in identifying the individual needs of the clients. Workers need to remember that individuals experience different aspects of the grieving process at different times and need to implement this information in their management of the client. The worker must also take into account the individual's cultural, religious and spiritual beliefs and value system as these will influence their grief reactions. Other factors that need to be considered are the stage of a growth and development of the client, support networks, familial influences, previous losses and personal coping mechanisms. Workers need to remember that all clients are unique and should be assessed as such to avoid stereotyping and inappropriate management of the client. The majority of people experience healthy, uncomplicated grief and bereavement and this process can takes months to years.

Prolonged grief

The syndrome of prolonged grief, also called pathological, complex or traumatic grief, is chronic and debilitating, results in substantial distress and impairment, worsens quality of life, and has been linked to excess medical morbidity and suicidality. As currently defined, prolonged grief consists of symptoms at least six months after the loss of a loved one that include a sense of disbelief regarding the death, persistent intense longing, yearning and preoccupation with the deceased, recurrent intrusive images of the dying person and avoidance of painful reminders of the death. There are many different tools available to assess a client's state of mind after the loss of a loved one, each organisation will you one most suitable to them.

Follow the link to see a sample of the commonly used Bereavement risk assessment tool:

https://www.victoriahospice.org/sites/default/files/bereavementriskassessmenttool2008_0.pdf

Suicidal ideation

Some people who experience a significant loss may think about ending their own lives. In most cases these are just thoughts, but some, particularly people who are having a complex grief reaction, may try to act on their thoughts.

Most people thinking about harming themselves start to make statements or behave in ways that indicate what they are planning; for example, they may say things like 'I wish I were dead' or 'What's the point?' They may also start to give away their belongings.

The mortality risk is higher for widows/widowers under age 55 when the bereavement was sudden, as from accident. For widows/widowers in the 50-to-65-year range, the highest risk is when the spouse has died of chronic illness. Several studies indicate the risk is lower when the widow/widower has family or other social support and higher when the bereaved is socially isolated.

Why are the bereaved at higher risk? The two broad explanations are grief and stress. Grief can lead to depression and its consequences. Stress can impair the immune system, increasing susceptibility to disease, and trigger dangerous behavioural changes such as higher cigarette and alcohol use. Most data is based on married couples because it's easier to obtain, but there are indications of a similar mortality increase following the death of children, siblings, and parents. Sure, grief is natural and proper, but it's healthier for the survivors to move on.

When dealing with a suicidal client, it is important to complete a risk assessment to determine the level of suicidal intent, plans and availability of means. There are no definite criteria to help a clinician choose between inpatient and outpatient care of a suicidal patient, however a patient with a plan, access to lethal means and a timeframe is considered to be at high risk and hospitalisation should be considered.

Many tools used by health professionals to assess suicide risk rely heavily upon verbal information from patients, despite the majority of interpersonal communication being of a non-verbal nature. To facilitate a more thorough risk assessment, both verbal and non-verbal cues must be assessed. Some examples of non-verbal cues may include:

- Downcast eyes
- Less attention to appearance
- Psychomotor retardation of speech or movement

Verbal cues may include comments like:

"Everyone would be better off without me."
"I don't think I can take this much longer."

Asking some probing questions may help you begin assessing the risk of suicide. Some examples:

"Other people with similar problems sometimes lose hope. Have you?"
"With this much stress, have you thought about hurting yourself?"
"Have you ever thought about killing yourself?"

Once the assessment is complete and you have sufficient input from the client on what they think will be helpful to them, you can then determine the next steps in helping the client.

Some reflective questions to consider for next steps:

- What can I do to increase this person's safety?
- Does this patient need to be hospitalised?
- Who else does this person see as being helpful and trustworthy?
- Who else can I involve in the 'helping' team for this person?
- For occasions where I am unavailable, what support is available?
- What does this person think will be helpful for them?

Referral options

Once a client has been assessed many may require further support then they have available at the time, this will mean a referral needs to be made for the client. Workers should follow the organisations referral process when referring any clients on. There are many different services that a client may be referred too. Here are some common referral options;

- A doctor
- A local community health centre, hospital or palliative care service
- A trained bereavement counsellor
- NURSE-ON-CALL – expert health information and advice, 24 hours, 7 days Tel. 1300 606 024
- Australian Centre for Grief and Bereavement – bereavement counselling and support services Tel. (03) 9265 2100 or 1800 642 066 (Australia-wide)
- Beyond blue 1300 22 4636
- Lifeline – crisis support and suicide prevention services, 24 hours, 7 days, 13 11 14
- Mercy Grief Services – for people living in the western region of Melbourne Tel. (03) 9313 5700
- Hope Bereavement Care – for people living in the Barwon region Tel. (03) 4215 3358
- The Compassionate Friends Victoria – grief support after the death of a son, daughter, brother or sister Tel. (03) 9888 4944 or 1800 641 091
- Very Special Kids (Bereavement Support Program) Tel. (03) 9804 6222 or 1800 888 875
- Parent line Victoria – 8 am to 12 midnight, 7 days a week Tel. 13 22 89
- MensLine Australia – 24 hours a day, seven days a week Tel.1300 789 978
- Victims of Crime Helpline Tel. 1800 819 817
- Road Trauma Support Services Victoria Tel. (03) 8877 6900 or 1300 367 797
- SuicideLine Victoria – for counselling, crisis intervention, information and referral (24 hours, 7 days) Tel. 1300 651 251
- Support After Suicide Tel. (03) 9421 7640
- GriefLine Community and Family Services Inc. – loss and grief telephone counselling service, 12 noon to 3 am, seven days a week Tel. (03) 9935 7400 or 1300 845 745

Element 2 - Engage empathically

Engaging with a person that is suffering loss and grief

The end of life is a vulnerable time for patients and families. The more deeply we as carers understand each family's unique needs, values, and rituals in relation to death and grief, the less likely we are to upset families and the more effective we can be in helping them through a very difficult experience.

When older people are suffering from grief, they might need professional counselling to help them through this painful period, but there is much a support worker can do to support the client through grief.

Understanding the significance of the loss to the person can also help. Although the death of a spouse might be an expected change, particularly as we age, it is a particularly powerful loss of a loved-one. A spouse often becomes part of the other in a unique way and after a long marriage; the elderly can find it a very difficult assimilation to begin anew. Furthermore, most couples have a division of 'tasks' or 'labour', for example, the husband mows the lawn, the wife pays the bills etc, which in addition to dealing with great grief and life changes means added responsibilities for the bereaved. Social isolation can also become imminent as many groups composed of couples find it difficult to adjust to the new identity of the bereaved. When queried about what in life is most traumatic, most rate death of a spouse first, although the death of a child presents more risk factors.

The loss of a sibling is a devastating event and sibling grief is often a disenfranchised type of grief (especially with regard to adult siblings), in that it is generally overlooked by society as a whole and people in general, thus negating the depth of love that can exist between siblings. Siblings who have been part of each other's lives since birth help form and sustain each other's identities; with the death of one sibling comes the loss of that part of the survivor's identity. The sibling relationship is a unique one as they often share a special bond and a common history from birth, has a certain role and place in the family, often complement each other, and share genetic traits. Siblings who enjoy a close relationship participate in each other's daily lives and special events, confide in each other, share joys, spend leisure time together (whether they are children or adults), and have a relationship that not only exists in the present but often looks toward a future together (even into retirement).

Adult siblings eventually expect the loss of ageing parents, the only other people who have been an integral part of their lives since birth, but they do not expect to lose their siblings first; as a result, when a sibling dies, the surviving sibling can experience a longer period of shock and disbelief. Overall, with the loss of a sibling, a substantial part of the surviving sibling's past, present, and future is also lost. It should also be noted that if siblings were not on good terms or close with each other, then intense feelings of guilt can ensue on the part of the surviving sibling.

Grief counselling, professional support groups or educational classes, and peer-led support groups are primary resources available to the bereaved, but a great deal of support can be given by those who support them on a day-to-day basis. Listening to the bereaved person and validating their feelings can be of great benefit. Validating means recognising and accepting the person's feelings as real and valid to them. Listening to the client's story of grief can also help the client process the grief, and in some cultures repeatedly telling the story or talking about the lost person or thing is critical and valuable part of the grief process.

When supporting a client through grief it is also important to allow the client to cry or even sob because crying is a healthy outlet for grief. Kubler-Ross advocated the establishment of grief rooms in hospitals so that people who lost a loved one could go into the padded and private room and freely and safely express their pain with tears, screams, and physical expressions of anger and frustration.

It is important to respect the privacy and right of the client not to talk if that is their choice or to talk when they choose to; not when the support person believes they should talk about it.

If the client is in grief because they have been diagnosed with a serious or terminal illness, some of their discussion or expressions might be around fear.

At such times it is good to paraphrase what you have heard to check for understanding and to confirm to the client that you are listening. Skilful questioning might also be employed in such situations to find out what the client is thinking so the thoughts can be referred back to the client when they indicate permanency, pervasiveness or personalisation.

For example, a client might say, 'I will always have pain in my knee now and I will never be able to walk anywhere anymore, and it is because when I was young and fell off my motorbike and broke my leg. The support person could remind the client that pain medication and pain relief techniques are available for arthritis, and exercise is good for the client, and it is unhelpful and unrealistic to blame oneself for what happened so long ago.

Generally, though, the best communication strategy when a client is expressing grief is listening and validation of the client's feelings. Kindness should never be underestimated as a healing attitude; to know that someone cares can make an enormous positive difference.

Very few families spontaneously offer the information, and discussions tend to occur after a problem has occurred rather than early in the process when the information can help caregivers better understand and assist the family.

In order to better understanding the socio-cultural background of your patients and families, include the following information in your assessments. Questions can be woven into various discussions with clients and family about the loss of a loved one.

Following are examples of dialogue to stimulate these important conversations:

1. **End-of-life care expectations**
   "Can you help me do a better job in caring for you and your family by sharing your expectations about my (our) care related to your mother's process of dying?"
2. **Styles and etiquette of death talk.**
   "Since everyone uses different words and has different etiquette about how to talk about dying and grieving, it would help me to know what is most comfortable for you and your family."
3. **Body-handling preferences.**
   "When (patient) dies, or now that (patient) has died, I will need to prepare the body to take downstairs. Do you have any preferences about this process?"
4. **Awareness of legal, logistical elements of body removal and disposal.**
   "I understand this is a difficult time for you, would you be willing to talk with me about some of the logistics involved now that (patient) has died (once patient dies)?"
5. **Mourning practices immediately following a death.**
   "After (patient) dies, are there some family traditions that are important to you in your grieving process?"
6. **Long-term mourning practices.**
   "When you think about the next six months or a year, what kinds of things do you anticipate doing that are part of your family traditions or will help you grieving process?"
7. **Funeral or memorial preferences.**
   "What traditions will your family use to commemorate your mother's life after she dies?"

Verbal and non-verbal communication techniques

It is important that workers are aware of the appropriate communication techniques to use when dealing with grieving clients. The following techniques are recommended;

- Active listening - 'Active listening' means, as its name suggests, actively listening. That is fully concentrating on what is being said rather than just passively 'hearing' the message of the speaker.
- Reflection of meaning- Enables clients to think differently about themselves, their feelings, and their stories.
- Open and closed questioning- A closed-ended question contrasts with an open-ended question, which cannot be answered with a simple "yes" or "no", or with a specific piece of information, and which gives the person answering the question scope to give the information that seems to them to be appropriate.
- Encouragers- Encouragers, also known as intentional listening, involve fully attending to the client, thus allowing them to explore their feelings and thoughts more completely.
- Summarising - Summarising is condensing what the client has said whilst still checking your understanding.
- Gestures - A gesture is a form of non-verbal communication or non-vocal communication in which visible bodily actions communicate particular messages, either in place of, or in conjunction with, speech. Gestures include movement of the hands, face, or other parts of the body.
- Attending behaviour - Good attending behaviour demonstrates that you respect a person and are interested in what he/she has to say. The effect of attending is an encouragement to the person to go on talking about his/her ideas or feelings freely.

Tips for engaging empathetically with clients

- Don't be impatient.
- Give clients time to gather their thoughts and express themselves.
- Don't discourage clients from going over and over what happened. This can help them make sense of their loss.
- Spend time establishing rapport and developing a trusting relationship.
- If you are unsure about something or need clarification, always ask.
- Ask concrete questions to establish areas of individual need, such as, 'Do you need someone to stay with you tonight?'
- Never make assumptions.
- Remember that not all clients from a given culture or ethnic group hold the same beliefs, values or experiences. Each client is an individual with individual needs, regardless of their culture.

EXAMPLE

Interact with individuals with empathy, sensitivity, professionalism and courtesy

Mailia is an aged care worker. Recently, one of the men using her service died of a long term illness. A number of other elderly clients who access the service are deeply affected by his death. Some of them are experiencing emotions that they are having difficulty coping with. Mailia responds to each individual, as well as supporting the group as a whole.

She encourages the clients to support one another and express their grief in a safe environment to normalise what they are experiencing. She listens to them in an empathetic way without judging them and asks individuals what they have done in the past to cope with difficult situations. This helps them to recognise their own strengths and to think about how they can move forward. Each person learns something from the others' responses. She provides information to help educate them about grief and provide them with options and choices for getting further help.

Mailia is genuine in her desire to help the clients and demonstrates this by maintaining consistency between her verbal and nonverbal communication. She helps each individual determine how they can best move forward and encourages them to find ways of coping with their grief; for example, through art, journaling and looking after their health.

Element 3 - offer support and information

To provide effective support, you must be able to identify a person's individual needs, provide information about informal and formal support options, and help the person to choose the options and strategies that best suit them. When providing support, you must adhere to organisational policies and procedures, including maintaining the person's confidentiality.

It is important for the support worker to have detailed knowledge of the common reactions to loss and the range of responses exhibited by the person who is experiencing grief or trauma. It is also important to identify the individuals that may be at risk of self-harm or suicide and who to refer them to.

Provide information clearly and sensitively

In many cases, as well as providing comfort, you need to provide grieving clients with information. The information you give them may include options for obtaining support, such as self-help groups, professional counsellors and other relevant service providers. It is important to provide this information in a clear and sensitive way. For example, instead of giving clients a lot of brochures, limit the number you give them and clearly explain what each one contains. Grieving people may feel overwhelmed by masses of written information, so it is important to be selective and clear about what you give them. It may help if they have a friend or family member present who can help them go through the information. It is also important not to give clients too much verbal information. Many bereaved people find it difficult to concentrate, and it can be stressful for a client to have to listen to someone talking at them. They do not need to be bombarded with information or things they need to do. Make sure that you give clients from culturally and linguistically diverse backgrounds information in forms they can understand. For example, they may need written information in a language other than English or to have an interpreter present.

Client's rights

All grieving clients have the right to receive information about available support services and to make choices about which best suit their needs. Encouraging a grieving client, who may feel vulnerable, confused and disorientated, to make decisions about support options can help them maintain a sense of control over their life. It is important that you provide information in a respectful, sensitive and courteous manner. Many grieving clients are dealing with raw and fluctuating emotions that make it difficult for them to focus for long periods or make decisions. However, they are more likely to want to engage with you and share information about themselves if you are patient and respectful.

Grieving clients who are rushed into making decisions or told what they should do may feel that they are not being heard or that you do not understand their situation.

When they are treated with respect and encouraged to make decisions about matters that affect them, they are more likely to:

- Feel empowered
- Choose carefully
- Be more willing to share information and participate in services that meet their needs
- Be satisfied with the service provided
- Have a greater sense of trust in workers
- Value the role of workers and the service organisation in their lives.

Informed choice Informed choice means providing a client with enough information to make decisions about what best meets their needs. For example; some clients may be experiencing a normal grief response but feel they can benefit from some additional support. In this case, you would provide information and explore options with the client for different types of support in the community, such as help with childcare or planning a funeral, as well as the social and emotional support provided by self-help groups.

Other clients may show signs of developing a complex grief reaction. In these circumstances you need to provide information about the grieving process and the need to take care of their social, emotional and physical health while grieving, in order to prevent ongoing problems. Encourage the client to visit their doctor, counsellor or other health professional to address any difficulties they are having and avoid complications associated with difficult grieving. Your role is to provide information and encourage the client to explore options rather than directing them to make particular choices. If a client is feeling overwhelmed or is having difficulty making a decision, you can help to build their confidence by taking a strengths-based approach. This means uncovering the client's personal resources and building on them by asking about losses or difficult situations they have successfully dealt with in the past and discussing their hopes for the future.

There are many options for support both formal and informal they are as follows;

- Hospices
- Psychologists
- Psychiatrists
- Social workers
- Support groups
- Friendship groups
- Telephone support lines
- Internet chat-rooms
- Art therapy groups

Obtain feedback to confirm understanding

It is important to check that the grieving client understands what you are telling them. To do this you may need to pause from time to time and ask, 'Is that clear?' or 'Is this the type of service you might be interested in? Confirming the client understanding their options is an important part of the referral process, you need the client to agree to the referral before going ahead.

Check with the client that they have understood what you have told them by asking questions such as:

- Do you have any questions?
- Would you like me to explain anything in more detail?
- Is this what you expected from a counselling service?

Each organisation has their own procedures for making referrals. The following steps are an example of general processes:

1. Discuss the need for referral with the client.
2. Provide information about appropriate referral sources and explore options with the client.
3. Help the client make a decision about the service that best meets their needs.
4. Ask the client if they are prepared to sign consent form to provide their basic details to the new service provider.
5. Make contact with the chosen service provider to check eligibility requirements and whether they have vacancies in their service.
6. Document information according to your organisation's policies and procedures.
7. Give the client contact and address details of the organisation.
8. Follow up with the client and the referral agency after the first few appointments to check all is going well for the client and for the service provider.

Tips for making referrals

- Keep an up-to date list or database of service providers and agencies that you may be able to refer clients to.
- Know the hours, eligibility criteria and basic services provided by the services you use on a regular basis. ,
- Develop a good working relationship with people from services you use on a regular basis. ,
- Seek permission from the client before making a referral and disclosing any information about them. ,
- When making a referral, take into account how easy it is for the client to get to the agency. ,
- Be prepared to offer another referral if the first one does not work out. ,
- Never criticise other workers or the services they represent. ,
- Keep accurate records about all the referrals and follow-up calls you make. ,
- Check with the client that the referral is meeting their needs.

Understanding legislation

All support workers should be familiar with the cultures of the people they care for and the people they work with, so they can respond positively to differences that exist between people, respect people's rights, communicate effectively and build a good working relationship with others. Legislations and standards help workers achieve this.

In Australia and throughout the world, it is illegal to discriminate against people for many reasons, including based on a person's culture. There are international and Australian laws that ensure all people are treated equally and all cultures are respected. Each state and territory have their own anti-discrimination laws (for example, the Racial and Religious Tolerance Act 2001 (Vic)); relevant national legislation includes the following:

- Privacy Act 1988
- Aged Care Act 1997
- Australian Human Rights Commission Act 1986
- Disability Discrimination Act 1992
- Sex Discrimination Act 1984
- Racial Discrimination Act 1975

Confidentiality

Confidentiality is the protection of personal information. Confidentiality means keeping a client's information between you and the client, and not telling others including co-workers, friends, family, etc.

Examples of maintaining confidentiality include:

- Individual files are locked and secured
- Support workers do not tell other people what is in a client's file unless they have permission from the client
- Information about clients is not told to people who do not need to know
- Clients' medical details are not discussed without their consent
- Adult clients have the right to keep any information about themselves confidential, which includes that information being kept from family and friends.

Element 4 - Care for self

Manage your own stress levels

In order to protect ourselves from the risk of compassion fatigue, and engage in work that offers meaning and purpose, we will now take a closer look at what compassion fatigue is and, through the work of Rothschild (2006), look at some strategies that can assist us to protect ourselves whilst in this work. These strategies will challenge the notions that qualifying as a compassionate or competent practitioner means giving our all — taking our clients home so to speak, and that you only need to address compassion fatigue when symptoms are evident.

Compassion fatigue

Compassion fatigue (also known as 'burnout') was a term coined to describe the set of symptoms experienced by caregivers who become so overwhelmed by exposure to the feelings and experiences of their clients, that they themselves experience feelings of fear, pain and suffering, including intrusive thoughts, nightmares, loss of energy, and hyper vigilance. It can be cumulative (from the effects of helping many clients) or occur in response to a particularly challenging or traumatic individual case. All who have the capacity for true compassion, empathy, concern and caring are vulnerable to compassion fatigue.

Symptoms of compassion fatigue include things like preoccupation with client issues or organisational issues, difficulty sleeping, loss of compassion, irritability with work, working harder to manage stress, an increased sense of inadequacy or a sense of feeling de-skilled.

We're encouraged to engage in self-care to protect against compassion fatigue and to ensure we are able to objectively support those in need. Indeed, various organisations have developed standards of practice in self-care that outline nonnegotiable ethical principles that declare unethical practice in the absence of self-care (Standards of Self Care, 2013). We are probably all good at coming up with generic lists of strategies and activities that can care for our body, mind and soul outside our professional roles. We are encouraged to have a balanced life that models good self-care. But where do we learn how to protect ourselves professionally and personally in the work, when we are regularly exposed to stories of grief, loss and trauma? How do we increase our insight on the job — an essential ingredient to assisting us in monitoring our care needs?

Self-care

Developing self-awareness is an important step in self-care. It assists you to identify your strengths and weaknesses as well as to understand why you react the way you do in certain situations. Being self-aware can assist you to manage your emotions rather than being overwhelmed by them. Develop your self-awareness by reflecting on how you respond in stressful situations and why you respond this way. Questions to consider in relation to your work include:

- Physical: What is happening to my state of health and well-being?
- Emotional: How do I feel during and after I finish work?
- Perceptions: How do I make sense of my experiences at work?
- Activities: How well do I balance my work and personal life?
- Relationships: How has work impacted on my relationships (family, friends)?
- Expertise: What am I learning in my work role?
- Spiritual: How have my faith and personal meanings changed?

Along with increasing your self-awareness, other self-care strategies that will assist you in responding effectively to grief include:

- Listen to your body
- Let others know what you need from them
- If you need counseling, do get it
- Take the time to do the things you need to do for yourself
- Pamper yourself
- Keep a journal
- Get physical exercise
- Obtain a proper diet and sleep
- Be aware of others' reactions.

It is important when you are managing suicidal clients to take care of yourself to avoid burnout.

- Obtain professional supervision
- Debrief
- Seek colleague support
- Self-reflect

A Worker's reflection

"Like so many workers I was never good at looking after myself. But I've learned to be better at it, to be more aware of it. I've learned to emotionally leave when I physically leave, to take time out, weekends off, go walking, take massages and so on. It doesn't have to cost money. It might be just making a pot of tea and putting myself in a nice environment."

Being continually exposed to the pain of others can take a physical, emotional and spiritual toll on workers. To respond effectively to the practical and emotional needs of others it is important that you find a way of monitoring your own emotional health and wellbeing.

- Educate yourself as much as possible about loss and grief. Feeling ill-informed about grieving can add to our feelings of stress during emotional encounters with carers. Similarly, knowing that anger may often be a sign of underlying grief can help you to maintain your compassion and sensitivity at difficult times.
- Try to stay in touch with your own feelings in response to the grief of the carers you work with. Be true to yourself. Do you have losses of your own that you need to acknowledge or grieve for? Are there situations that are a little too close for comfort or which you feel you would rather not tackle?
- De-brief with other workers as much as possible, particularly after a draining day or support session. If an experience has been particularly distressing, there may be an opportunity to debrief with an outside professional.
- Take breaks between interviews with carers whenever possible. Try not to take work home or miss lunch breaks or holidays no matter how pressing your work appears.
- Strive for a balanced lifestyle with adequate sleep, a nutritious diet and regular exercise. If possible, treat yourself to massages, yoga or other relaxing pursuits, especially at times when you feel weighed down by the pain of others.
- Periodically review your work goals and performance. How are you relating to clients? If you notice a significant increase in feelings of impatience and stress and a decrease in sensitivity, it may be time to take a holiday or to seek work in another area. Perhaps your workplace can offer a stint away from casework to do a specific project? A break may be all that's needed to refresh the spirit.

Supervision and debriefing

Supervision is an important component of practice but not every worker will find themselves with the quantity or quality of supervision that they need. Many challenges can arise - in the relationship, or in the availability or suitability of the supervisor. The supervisee will also need to reflect on the part they play.

Rather than accepting this as a situation that cannot be changed, it is important to find ways to articulate and respond to these challenges. A proactive supervisee, with some support, will generally be able to bridge the supervision gap once the need has been acknowledged. There are other resources in the community and, with some creative problem solving, positive supervision arrangements can be generated.

As part of this process, effective self-care is essential. Alongside supervision, our own well-being as workers can easily be compromised through the difficulties of the role. Workers can manage a lot of uncertainty and complexity in support of consumers, but no worker is 'bullet proof'. Prioritising to make self-care central is simply 'sharpening our own saw'. Self-awareness is the key.

Critical incidents sometimes occur in the workplace. There may be an accident, the sudden death of a person or rapid workplace change. Incidents like these cause stress that has the potential to affect the whole work team. To minimise the psychological effects of such events and to help staff avoid the possibility of prolonged trauma, many organisations offer carefully structured debriefing sessions. Debriefing sessions are usually group sessions offered soon after a critical incident.

The primary aim of debriefing sessions are to give people the opportunity to clarify what happened, share concerns and to unload stress and anxiety. It is important that people running a debriefing session have the skills to conduct the session in a sensitive and in a way that is helpful to the participants.

Debriefing sessions must be planned and prepared in line with organisational protocols. Organisation policies and procedures should clearly outline that debriefing is available to staff, and in what circumstances and by whom debriefing will be offered. Supervisors must be familiar with and ready to provide debriefing when required as critical incidents can happen without leaving time to plan. Delivery of a debriefing session should be run as soon as possible after the event.

Behaviour or an incident that has resulted in either injury or high levels of emotional stress can be traumatic for staff and anyone else who has witnessed an incident. Debriefing sessions are designed to prevent normal stress reactions from becoming long-term or leading to mental illness. It is normal to react emotionally to a critical incident. This may involve recurrent thoughts about the event, feeling uneasy or anxious, mood changes, restlessness, feeling tired and disturbed sleep.

Element 5 - Review support provided

Following up with clients

Part of your daily duties will be following up with clients that are receiving services from your organisation this will include clients that have been referred on. It is important that you do follow up with outgoing referrals to ensure that clients are receiving the support they need and not just falling off because the support you offered was not suitable.

Working with clients to meet their goals and monitoring their progress is a continuous process; it is therefore very important to have established indicators in place against which you can measure this progress.

The case manager needs to establish processes for monitoring which are known and agreed to by the team members, so that everyone is clear and committed to them. Written agreement is preferable, although verbal agreement (in the case meeting) is often sufficient.

Through consistent monitoring, the worker and the case manager can determine:

- Whether the goals are being achieved
- Whether they are being achieved in the timelines
- Whether there is a failure to achieve the goals
- What needs to be changed to meet the client's situation (e.g. the goals themselves, or the steps to meet those goals).

Service delivery

Quality and effective service delivery is about providing a service in the best possible way. It is about anticipating, conforming to and sometimes exceeding the clients' expectations and requirements. Effectiveness is also about service delivery being on time and resources being used effectively.

A quality service has the following characteristics:

- It is willing to, and finds the resources to, be flexible.
- It meets the needs of the clients.
- It involves the client at every stage of planning, delivery and review.
- It has policies, procedures and safeguards in place to protect staff.

It is important that agencies expend time and energy into reflecting on and evaluating their practice delivery. This includes thinking about what they do, how they do it and what they could do better.

It is also **important** to ask:

- Is there anything we are not doing that we should be doing?
- Is there anything we are doing that we should not be doing?

It is vital that they look at their outcomes of service delivery objectively.

Outcomes of service delivery can be measured in several ways:

- How the client's needs have been met
- The quality of the relationships between workers and clients
- How timely the support is
- The flexibility of the organisation and the support workers
- The quality of the communication between support workers, and clients and others in the organisation
- Adherence to the code of conduct and other standards/agreements
- The functioning and motivation of the team
- Policies and procedures.

Quantitative outcomes

Quantitative outcomes are the collection of data that shows numbers. For the organisation this may mean keeping records of how many people you supported during the month, the number of incoming and outgoing phone calls, or the number of new clients referred.

This information alone gives no indication of the quality of work performed or the level of client satisfaction with this work but may be a requirement of funding arrangements.

Qualitative outcomes

Qualitative outcome measures focus on the effectiveness of the work performed. The purpose is to start with the aims and objectives of support being provided, then gather information to see if these aims and objectives are being met.

For example, if the primary objective is 'support clients to achieve their goals', then clients may be interviewed, and files reviewed to compare goals achieved with goals identified. If a primary aim is to empower service users, then a survey may be carried out to determine whether clients feel empowered.

In terms of measuring and maintaining effectiveness of the direct support you provide to clients on a day-to-day basis, less formal methods of gathering information will be appropriate.

Below is an example of a feedback form used by services to gather client feedback;

SUNSHINE AGED CARE FACILITY

Client Feedback Form

Dear Client,

It is our great pleasure to provide you the best quality of service at all times.

Your assistance in completing this form is greatly appreciated. Your honest feedback will help us to serve you better and enable us to work on improving our service standards. Thank you.

Client Name: **[Write Customer Name Here]**

Address: **[Write Address Here]**

Destination: **[Write Here]**

Account: **[Write Here]**

	Excellent	Good	Fair	Poor
1. Contact with staff				
2. Workplace practices				
3. Staff's professionalism and aptitude				
4. Services arranged to meet needs				
5. Quality of services delivered				
6. How will you rate our overall service?				
7. How would you like to recommend us to others?				

Your comments:

_____

_____

_____

_____

_____

Signature: _____ **Date:** _____

The Stress-Vulnerability Model

As the name suggests, two main factors are involved. "Vulnerability" refers to our basic susceptibility to mental health disorders. This is determined by our genetic makeup and our early life experiences. It is affected by our use of medications and our likelihood of using alcohol or drugs. "Stress" refers to the challenges faced in our lives. It is affected by our coping skills, social support, and involvement in meaningful activities.

Biological Vulnerability

If we are vulnerable to something, it means we're more likely to be affected by it. For example, some people might be biologically vulnerable to certain physical illnesses-such as heart disease or asthma. Maybe the disease runs in the family, or maybe something in our early life "set us up" for it.

Some people are biologically vulnerable to certain psychiatric disorders: bipolar disorder, major depression, schizophrenia, or anxiety disorders (panic, post-traumatic stress), for example. This vulnerability is determined early in life by a combination of factors, including genetics, prenatal nutrition and stress, birth complications, and early experiences in childhood (such as abuse or the loss of a parent). This is why some families are more likely to have members with a particular psychiatric disorder. Although vulnerability to psychiatric disorders is primarily biological in nature, people can take steps to reduce their vulnerability, including taking medication and not using alcohol or drugs. It's also worth noting that the greater a person's vulnerability to a particular disorder, the earlier it is likely to develop, and the more severe it may become.

Similarly, some people also have a biological vulnerability to developing an addiction: they are more likely to develop alcohol or drug abuse or dependence. This is why addiction, similar to psychiatric **disorders, sometimes "runs in families."**

What Are the Elements of the Stress-Vulnerability Model?

These two main areas -- biological vulnerability and stress -- are influenced by several other factors that people have some control over. These factors include

- Alcohol and drug use
- Medication use
- Coping skills
- Social support
- Meaningful activities

This means that by addressing these factors, people can reduce symptoms and relapses and improve the course of their co-occurring disorders.

Factors recognised as lowering a person’s vulnerability threshold:

- Substance abuse
- Life events (job loss, death, divorce etc)
- Poor sleeping patterns
- Genetic predisposition for a mental illness
- Relationship problems (inter/ intrapersonal)
- Poor nutrition/ lack of exercise
- Unstable accommodation

Factors recognised as raising a person's vulnerability threshold:

- Stress management
- Adherence to medication
- Avoidance of illicit drugs
- Recognition of early warning signs
- Harnessing of social support
- Exploration of effective help-seeking strategies
- Development and/or maintenance of rewarding social and/or vocational roles
- Creation of a plan for relapse prevention and management
- Re-examination and re-evaluation of the stress vulnerability plan
- Stable living situation
- Physical wellbeing and healthy lifestyle

Alcohol and Drug Use

Using alcohol or drugs can increase a person's pre-existing biological vulnerability to a psychiatric disorder. Thus, substance use can trigger a psychiatric disorder and lead to more severe symptoms and other impairments. Because most people with co-occurring mental and substance use disorders have a biological vulnerability to psychiatric disorders, they tend to be highly sensitive to even small amounts of alcohol and drugs.

Stress

Stress in the environment can worsen biological vulnerability, worsen symptoms, and cause relapses. Stress is anything that challenges a person, requiring some kind of adaptation. Serious stressful events include losing a loved one, getting fired from a job, being a victim of crime, or having conflicts with close people.

Stress is often associated with negative events, but positive events and experiences may be stressful as well. For example, performing well in school, getting a new job, starting a new relationship, having a baby, or being a parent, all involve some degree of stress.

It is also possible for stress to be caused by not having enough to do. When people with co-occurring disorders have nothing purposeful or interesting to do, they tend to have worse symptoms and are more prone to using substances. So, a lack of meaningful involvement in life-in areas such as work or parenting, for example-can be another source of stress.

Coping Skills

Developing coping strategies can help with handling stress and reducing its negative effects on vulnerability. Examples of coping skills include

- Relaxation skills for dealing with stress and tension
- Social skills for connecting with people, dealing with conflict, and getting support
- Coping skills for managing persistent symptoms such as depression, anxiety, and sleeping problems

Stress is a normal part of life. Effective coping enables people to be engaged in interesting, rewarding activities that may involve stress, such as working or being a parent. Coping efforts can make it possible for someone with co-occurring disorders to live a normal life without suffering the negative effects of stress.

Involvement in Meaningful Activities

Having something meaningful to do with one's time gives one a sense of purpose and reduces the stress of having nothing to do. Meaningful activities can include:

- Work
- School
- Parenting or other caregiving responsibilities
- Homemaking

Social Support

Another way to reduce the negative effects of stress on vulnerability is through social support, which comes from having close and meaningful relationships with other people. Supportive people can help in a variety of ways, such as

- Helping people solve challenging Problems
- Supporting people in using coping strategies to deal with symptoms and substance-use urges
- Being open and willing to discussing and resolving personal disagreements, misunderstandings, and areas of conflict that could otherwise lead to stress
- Letting people know that they are important and cared about
- Supporting the person in pursuing personally meaningful goals

People who have good social support are less vulnerable to the effects of stress on their psychiatric disorder. Therefore, having strong social support enables people with co-occurring disorders to handle stress more effectively, and live a normal life.

Treatment Implications of the Stress-Vulnerability Model

Based on an understanding of the stress-vulnerability model, there are many ways to help people manage their psychiatric illness and co-occurring substance use disorder. In the broadest terms, the severity and course of a co-occurring mental health disorder can be improved by reducing biological vulnerability and increasing resiliency against stress.

Reducing Biological Vulnerability

Biological vulnerability can be reduced in two primary ways: taking medication and avoiding alcohol or drug use. Medication can be a powerful way of reducing biological vulnerability by helping to correct the imbalances in neurotransmitters (chemicals in the brain responsible for feelings, thinking, and behavior) believed to cause psychiatric disorders. By taking medication, the symptoms of a psychiatric disorder can be lowered and the chances of having a relapse can also be reduced.

Avoiding alcohol and drug use can reduce biological vulnerability in two ways. First, because substances affect the brain, using alcohol or drugs can directly worsen those vulnerable parts of the brain associated with psychiatric disorders. Second, using substances can interfere with the corrective effects of medication on vulnerability. This means that somebody who is using alcohol or drugs will not get the full benefit of any prescribed medications for his or her disorder, leading to worse symptoms and a greater chance of relapses.

Increasing Resiliency against Stress

It is impossible for anyone to live a life that is free of stress. However, there are many ways people can learn how to deal with stress more effectively, and to protect themselves from the effects of stress on worsening symptoms and causing relapses, including

- Developing effective coping skills for managing stress and persistent symptoms
- Getting involved in meaningful activities that structure one's time and reduce the stress of having nothing to do
- Building socially supportive relationships that help one manage the mental health disorder and maintain sobriety

Conclusion

As you have just read there are many different aspects when it comes to providing support for loss and grief. Each client is different and will cope in different ways, what might work for one client may not work for the next, workers should have different strategies that they can implement with different clients. It is important that as workers this is done correctly as clients in this state can be very fragile and often high risk. It is a good idea for workers to familiarise themselves with services that they can refer clients to, a follow up should be done as this will be useful for future referrals. It is good practice to have clients complete feedback forms for continuous improvement purposes.

CHCAGE003 – Coordinate services for older people

Welcome to the learning resource for the unit CHCAGE003 - Coordinate services for older people.

This unit applies to workers in a residential or community context, or those in personal care or support services that work with older people. Work performed requires some discretion and judgement and is carried out under regular direct or indirect supervision.

On completion of this unit you will have covered the requirements for:

1. Coordinate the delivery of the individualised plan
2. Liaise and negotiate with appropriate personnel and service providers
3. Support family and carers
4. Coordinate feedback

You will be able to demonstrate your ability to:

- Coordinate the service needs for at least 3 older people requiring varying levels or types of support

You will gain knowledge about:

- The social model of disability
- Aspects of elder abuse, including:
- Indications of neglect or abuse
- Emotional impact of abuse
- Appropriate management of issues surrounding abuse
- Manifestations and presentation of common health problems associated with ageing, appropriate actions in response to these problems and when to refer
- Role and function of various relevant health professionals
- Relevant community and support services
- Principles and practices of case management
- Organisation standards, policies and procedures

A copy of the full unit of competency can be found at: http://training.gov.au/Training/Details/CHCAGE003

This learning resource is designed to support your learning and act as a guide to further research. We encourage you to access other texts which include; standards and legislation and other resources relating to your industry that can be sourced throughout the internet or library.

Element 1: Coordinate the delivery of the individualised plan

A care plan is an individualised plan of care and gives directions for staff to follow in the provision of care.

Care plans are an essential document in the long-term care of residents. The care plan details the care requirements that a person needs on a daily basis. This type of document is generally used in long term care because it replaces the need to detail all care given each day in the resident's case notes. So, a care plan is basically a comprehensive document detailing all care considerations for example:

In the health care setting the residents notes and care plan should:

- Provide an accurate, concise notation of the residents' current condition.
- Provide information about the resident's goals and care needs.
- Provide a baseline information on which to record any improvement or deterioration in the resident's condition.

The record provides evidence of care. The records will provide information about what care was provided, by whom, when and any comments from the resident, doctor, or significant other.

The notes provide a record about any emergencies which may have occurred and how these were handled.

Individualised plans may also be called:

- Care plans
- Person centred plans
- Individual program plans
- Service delivery plans

i	**Additional resources – Individualised care plans** You can find more information on Individualised care plans here; https://www.youtube.com/watch?v=9Hm61u6qmr0

Identify and prioritise the needs, goals and preferences of the older person outlined in the individualised plan

A thorough assessment must be compiled in a variety of areas to determine the long-term care needs and goals of client care. Areas of assessment include the following:

- Physical care needs
- Psychological care requirements
- Socialisation needs of the individual
- Spiritual needs
- Assistance to maintain their personal affairs
- Relationships with family and others

All service delivery plans must document any required additional support services or expert advice. When establishing or working with an individualised care plan, special attention must be given to ensure these services or advice is provided and regularly reviewed.

Support and delivery of services to any older person should always have an individual focus; however, the additional assistance required because of complex needs could mean accessing specialised health services and external expertise. The network of advice and services available to age care workers is diverse, but firstly it is critical to identify and prioritise the precise needs for each person.

In identifying specific needs, there are policies, procedures and guidelines to follow in your organisation and a service delivery plan for each client should be established, monitored, reviewed and evaluated on a regular basis. Consultation with all staff involved in the delivery of services within the organisation must occur. These could include activity coordinators, kitchen and domestic staff, health professionals, as well as relatives.

Information that could be gained from relatives:

- Family background and dynamics
- Past employment
- Activities and hobbies of interest
- Likes and dislikes
- Religion and culture
- What personal photos of the family to hang up in person's room
- What objects have a sentimental value, like ornaments or religious figures
- Feedback on the success of the service delivery plan when conducting a review
- Daily living issues, such as the time the relative likes to get up and go to bed, bathing times, what they
- Wear, what they eat, when they have their meals, etc

Prioritise needs

Needs are prioritised according to urgency and sometimes the order of which these needs should be met may be difficult to establish. This is another reason why multiple people and services may be involved in the assessment of an older person with complex needs. A person who has dual or multiple diagnoses can be difficult to assess. On many occasions it may be up to you to decide which needs should receive priority. This may depend on medical reasons or simply which condition is causing the greatest amount of pain, discomfort or is most distressing for the client.

When prioritising the older person's needs, consider the following:

- Does the issue or need put the older person at risk?
- What is the immediate risk? For example, might the situation happen immediately or in the next few months? Issues or needs that put the person at risk are a higher priority
- Does the issue or need prevent the person from being independent?
- Does the issue or need prevent the person from interacting or participating in their community or social network?

Establish what other additional support they might need that may be outside of the service that you represent. It is vital that you can recognise these needs and be able to make suitable recommendations for things you are not trained in.

Things you should take into consideration when you are prioritising the needs of an individual are;

- Diagnoses
- Types of conditions held
- Risks associated
- Independence (is there any issues that prevent the person from being independent)
- Ability to participate (is there a care need that may impact on participation or interaction)

Identify and prioritise goals and preferences

Goals are developed in collaboration with the person you support, and they address specific needs. A person's goals are outlined in the support plan. Some of these goals may be more meaningful to the person than others, and therefore will be given priority. A person's preferences are often closely related with a person's goals and needs. Preferences may be physical, mental, spiritual, or social. They may also relate to a person's cultural or ethnic background. Some examples of needs and preferences include:

- A person prefers outdoor activities instead of indoor activities
- A person likes to see their family every Sunday in a quiet, private location
- A person is Islamic, they pray five times during the day

Social model of disability
The social model of disability proposes that if a person has a disability it is society that dictates how they are treated; in other words, society can create the disability by excluding the person. This way of thought suggests that it is the person social or physical environment that may cause them to be isolated; e.g. unable to access areas or participate in activities.

Common health problems associated with ageing

This learner guide focuses on the process of caring for individuals with complex care needs and for those entering the final stages of their lives in palliative care. When caring for older people it is important to recognise the signs and effects ageing has on people.

There is a number of common health problems associated with ageing. These can include:

- High blood pressure
- Heart conditions
- Depression
- Arthritis and joint pain
- Osteoporosis
- Hearing and vision impairments
- Dementia/Alzheimer's
- Incontinence
- Diabetes
- Frailty resulting in falls
- Cancer
- Respiratory problems

The effects of these changes also differ widely. While approximately 85% of older adults experience chronic conditions, only about 20% experience significant impairment in their ability to function. For those with disabilities this process may occur more rapidly.

Basic physiology and psychology of ageing
As we age, we undergo a number of physiological and psychological changes, which affect not only how we look, but also how we function and respond to daily living. Overall, the changes in the later life span involve a general slowing down of all organ systems due to a gradual decline in cellular activity. It should be noted that individuals experience these changes differently - for some, the level of decline may be rapid and dramatic; for others, the changes are much less significant.

Wrinkled skin and grey hair are usually what we first think of when we think of an elderly person. However, there is much more going on inside and outside the body. Let's look closely at these changes below.

Cardiovascular System
When people turn about 80 years old, they will begin to experience less blood flow. This causes a decrease in the size of the heart, and deposits of calcium to form in the heart valves, making valves hard and less flexible.

As we get older, we often experience reduced stamina, since less oxygen is being exchanged, making the person tired more often and more easily. This is obvious when we watch children at a park and compare them to people in their 50's. It's hard to remember having as much energy as a six-year-old.

Other cardiovascular risks that increase as we age include hypertension with an increased risk of stroke, heart attack, and congestive heart failure.

Respiratory System
Airways and lung tissue become less elastic, causing more restricted breathing. Your intercostal muscles, which are muscles within the rib cage that assist in breathing, become weaker making it difficult to take deep breathes and cough.

These changes that result in decreased stamina, shortness of breath, and reduced oxygen levels can increase feelings of anxiety. There is a greater tendency to develop pneumonia as a result of reduced lung capacity.

Muscles
Muscles often become weaker and are replaced with fat, causing a loss of muscle tone and strength. This can cause reduced gastro-intestinal tract function, leading to constipation, and bladder incontinence. However, regular exercise, such as walking, can greatly reduce these problems at any age.

Bones
Around age 35, men and women begin to lose bone density due to the loss of calcium. This can lead to osteoporosis, possible spontaneous bone fractures, and a reduction of height and changes in posture.

Arthritis, the inflammation of the joints, is a very common condition among the elderly. One form of arthritis is osteoarthritis, which is the wearing away of the joint cartilage. The second type is rheumatoid arthritis, which is a disease of the connective tissues. Both of these reduce mobility and can make everyday activities more difficult.

Digestive system
With aging, comes a reduction in digestive enzymes, saliva, and taste buds. This can result in impaired swallowing and slower emptying of the stomach. Food is not broken down or absorbed as effectively. This often results in vitamin B, C, and K deficiencies and even malnutrition. Such deficiencies can cause muscle cramping, bruising, and reduced appetite.

Metabolism is the rate at which food is changed into energy useable by the body. After age 25, the human metabolism is reduced by about 1% every year. Food and medication are absorbed less well.

Vision
It is estimated that the elderly requires three times the amount of illumination to see as well as a young person. An increase in near-sightedness requires more time to focus and makes small print harder to read. The lens of the eye often thickens and yellows. This results in: increased sensitivity to glare, decreased depth perception, and more difficulty seeing pastel colours, especially blue and green. There is an increased incidence of cataracts, macular degeneration, glaucoma, and diabetic retinopathy with age.

Hearing
With age, there are changes to the bones and cochlear hair cells of the inner ear cause a decrease in sensitivity to high frequency tones and less ability to distinguish between similar pitches. Hearing loss is common among the elderly. About 30% of the elderly have some hearing impairment.

Skin
- Skin loses fat layers, oil glands, and elasticity which changes its appearance.
- Skin appearance is also affected by nutrition, hormones, sun exposure, and heredity.
- Loss of fat layers causes skin to bruise more easily, causes a person to become cold more often.
- Deposits of melanin, which causes skin to turn tan from the sun, cause age spots.
- Hair turns grey because it loses pigment.

Complex care needs
Complex needs occur when the older person's disabilities or conditions affect multiple areas of their lives. Clients who have complex needs require ongoing care from a multidisciplinary team consisting of at least two to three health professionals. Complex needs can also be referred to as chronic conditions, which are conditions that are present for an extended period of time. A person with two or more chronic conditions is understood to have complex care needs.

The following table outlines some explanations of some common complex conditions.

Condition	Description
Mental-health conditions or mental illness	Mental-health problems are some of the most complex conditions faced by you as a professional in the industry. These conditions can have drastic effects on mood and thinking such as depression, bipolar disorder, schizophrenia and others. Sometimes this may mean that the older person could potentially put themselves or others at risk of erratic and sometimes dangerous behaviour. The complexity continues where many people with mental illness have periods of time where they are not symptomatic at all.
Dementia	Dementia is a disease that affects cognition / thinking and memory. Some common examples of dementia include Alzheimer's disease, vascular dementia, and frontal-lobe dementia. Many older people with dementia require ongoing support with everyday living and the condition is usually progressive. People with dementia can sometimes be aggressive or violent in situations where they feel uncomfortable or out of control.
Terminal illness	Terminal illnesses are defined as diseases or conditions that have no cure. These are sometimes referred to as life-limiting illnesses. People with terminal illnesses are expected to die. The care provided to people with terminal illnesses is referred to as palliative care. We will be discussing this in more detail later in this Learner Guide.
Chronic pain	Chronic pain is a term used to describe frequent and sometimes constant pain brought on by some conditions that affect older people. This pain is often managed through mediation and therapy but usually does not have a complete cure. Examples include arthritis, rheumatism, previous injuries, Parkinson's disease, and liver disease. Chronic pain can affect an older person's mood, behaviour, and overall attitude to life. It can be quite challenging to deal with as both the client and the carer.
Developmental or acquired disability	Developmental or acquired disabilities can be physical or intellectual. People who are born with or who develop a disability or congenital defect are known to have developmental disability. In the other cases, people may acquire a disability through illness or an accident. For example, an older person who experiences a stroke may be left with limited mobility.
Dysphagia	This is the medical term for the symptom of difficulty in swallowing. Although this is often considered a symptom, sometimes it can be a condition in its own right.
Acquired brain injury	Acquired brain injury (ABI) is as the name suggests an injury to the brain due to accident or illness. A large number of ABI are caused in car accidents. ABIs can be caused by strokes or diseases such as encephalitis or meningitis which affect and damage the brain.
Alcohol and other drug misuse/abuse	Long term abuse of substances such as alcohol and drugs can have a devastating effect on the body. Often this causes serious damage to the body's organs including the liver, kidneys, heart, and brain.
Chronic health problems	Chronic health problems include a wide range of diseases that, while often not terminal, may be lifelong. Chronic diseases include lupus, asthma, or coeliac disease. These diseases often have time periods where the person is not symptomatic and other times where they are seriously unwell.

There are some common challenges that care workers face when caring for clients with complex needs. These can include:

- Dual/multiple diagnosis
- Cultural/language barriers
- Lack of supervision/skills and knowledge
- Inadequate support
- Poor planning processes
- Unrealistic goals and expectations of the client

Caring for clients with complex needs is no easy feat. It requires a structured and holistic approach with the incorporation of support from internal and external service providers.

Coordinate services and support activities in consultation with the older person and colleagues
Providing services to older people should be done in collaboration with the person and with others providing support. The person should be the centre of all decisions made. To effectively coordinate services, it is important to consult with all people involved in an open and respectful manner. When gathering information about the issues affecting the older person, be courteous, speak clearly and use active listening skills. Information can be gathered from a number of sources which includes:

- Interviewing
- Observation
- Consultation with advocates, carers and significant others
- Review previous health records

An individualised plan should establish goals and objectives with the client and involve them in measuring successful achievement of their goals. This will also include the services and activities that are to be supported whilst following the individualised plan.

Client's goals could be documented in the plan as follows;

- **Client Name-**
- **Issues/Needs** - discussion takes place with client/ advocate to identify any issues or needs
- **Goal** - by discussing issues/needs the client/advocate determines what goals/ outcomes they want
- **Target date** - a realistic date is established and agreed on
- **Action/steps to be taken** - support/services is set up to achieve the goal
- **Responsible care worker** - who will provide the support, including external experts if required?
- **Proposed start date** - agreed start date for action/steps
- **Review date** - agreed date to review progress of action/steps
- **Goal achieved date** - agreed date on when the goal should be achieved

The client, (or their advocate where necessary) should be involved in reviewing goals and monitoring progress toward goal achievement.

Smart goals
Effective goal setting needs to be a planned approach and requires an in-depth knowledge of the influencing factors that could restrict or assist the client to achieve their goals. Goals should be **SMART.** That is:

- **S**pecific (clear and precise).
- **M**easurable (progress toward achievement can be measured and assessed).
- **A**chievable (the goal is achievable for the client).
- **R**ealistic/ relevant (the goal is realistic and relevant to the issue/need and client).
- **T**ime-based (how much time will it take and when will it be achieved) - able to be tracked in time.

Effective goals for clients should be:

- Concrete and specific (the goal targets/ addresses the problem/ issue)
- Phrased clearly (goals are written using terms and language that the client and staff understand)
- The client's own goal (the client is fully consulted and involved)
- Written down (writing down the goal in the service delivery plan provides a record)
- Realistic and attainable (it is achievable for the client and success is likely)

A technique used when documenting and setting goals is to consider the following:

- **What** - vision of the goal is clear
- **How** - actions and/or process that need to happen
- **Who** - person(s) involved in achieving the goal
- **Why** - purpose and importance behind the goal
- **When** - timeline or deadline for achieving the goal
- **Where** - location or facilities could influence the success of reaching the goal

When coordinating services and supporting activities you need to remember;

- Consultation is the key to plan success
- Encourage individuals to think about and identify their goals
- Consider what is already in place; supports; carers, family members, local community, other services
- Determine budgets and costs of services
- Apply a continuous improvement approach; review and amend
- Always consult and gain client approval before making any changes.

Seek advice to determine service issues

You may also need to seek advice from other health professionals to assist in determining service issues and to decide how services will be delivered to clients. The type of decisions that need to be made can include:

- The number of support workers rostered throughout the day
- Transport options
- Personal care help
- Help to maintain their home
- Mobility aids
- Social activities that meet their cultural needs as well as their diagnosis

When service issues arise, it may be your responsibility to find alternative options for the client. When faced with a service issue you may need to talk to a health professional, a family member, or their carer. Service issues can include:

The cost of the service is too much for the client. In this case, you may have to find a service or item that is cheaper or does not involve the additional cost of travel. Perhaps you can find a community program that will come to the person's home.

The service does not take into account the client's cultural background. For example, the carers are mainly men; the client needs an interpreter; the food is not appropriate to their culture; a service is on a day reserved for prayer. You will need to explore other options that meet the client's cultural requirements.

Your services do not offer the support required. Make sure you are aware of other appropriate services and arrange for a referral.

The service is too far away. In this case you will need to research a service closer to the client's residence.

The service is not provided on a day suitable for the client. In this case you will need to see if the client can be more flexible or whether there is a similar service provided by another agency that you can use.

As soon as you identify an issue in the service delivery for the client make sure you contact the relevant health professional or your supervisor as well as the client, their family and carer.

Outline and clarify all service providers' understanding of the individualised plan and their roles and responsibilities

The role of a service provider can be complex. To provide services to meet aged people's personal needs, the service provider needs to have highly developed quality resources, systems, procedures and highly trained and skilled care workers.

Service providers must continuously maintain a sufficient level of skilled care workers to assist individual clients in identifying their personal needs and to respond to client needs.

Plans and strategies must be flexible enough to adapt to changing needs - of the client and of the environment. Service delivery plans are living documents, that is, they are constantly changing and should be constantly updated.

As part of a team you will be required to ensure that ongoing, day-by-day and/or hour-by-hour needs identification is continuous and catered for.

Every time you interact with the client you will be in a position to make a cursory assessment of needs.

Significant feedback and information from clients should be gathered and analysed and will assist in the development of new strategies and objectives for the organisation and new plans for client care.

The service delivery plans assist the organisation to determine the following:

- Client needs
- Resources required by clients
- Type of services
- Activities and support programs
- Specialised equipment
- Financial planning and budgeting
- Labour requirements and hiring
- Organisational structure
- Staff training and development programs
- Building design and facilities

Team meetings are the ideal forum to share client information and discuss and clarify the roles and responsibilities of care workers involved in implementation of individualised plans. Care workers must have a clear understanding of the goals and objectives of plans and of their role in implementing, monitoring and evaluating the plan.

It is reasonable to suggest that it is the client individualised plans that help drive the organisation. It assists in determining clients' needs as well as the facilities, resources and services offered to them.

There will often be more than just one service provider involved in the individualised plan, it is important that each provider is aware of the other services being utilised by the client, this will allow each service provider to have an understanding of their role.

See a list of service providers below including a description of their role.

Name	Role
Activity/leisure worker (Recreation officer)	Specialises in assessing and meeting individual needs and wants. They develop individual or group activities that promote independence and provide opportunities for recreation and leisure.
Aged care worker/support worker	Provides holistic care to older people that supports and promotes their quality of life, independence, health and wellbeing.
Dentist	Provides care for the older person's teeth and gums, dentures or dental prosthetic aids.
Dietician	Specialises in the regulation, planning and supervision of diets for the treatment of health problems, or maintenance of nutritional status**.**
Diversional therapist	Plans and provides programs to support social and emotional needs and physical and mental stimulation for the older person. These programs may include group or individual activities that promote leisure, enjoyment and self-fulfilment.
Domestic service worker	Provides support in the maintenance of cleaning and laundry support services within an organisation.
Enrolled nurse	Works under the supervision of a registered nurse in the delivery of holistic, client-centred care. Responsibilities include providing support and comfort, assisting with activities of daily living, and supporting the emotional needs of individuals in a range of settings include acute care, community and aged care facilities.
Interpreter	Trained worker who translates what is said in one language into a different language so that it can be understood.
Maintenance staff	People employed (or contracted) who are responsible for a variety of maintenance roles within the facility or older person's home.
Medical officer (Dr/GP)	Provides general medical care for people. A geriatrician is a doctor who specialises in the health care of older people.
Occupational therapist	Specialises in providing assistance to maximise a person's independent living and participation in everyday activities by adapting the environment, using assistive aids/equipment and retraining clients.
Pastoral care workers	Religious support worker who provides emotional and spiritual support.
Pharmacist	Provides advice on medications to customers and health professionals. Responsible for dispensing and supply of prescription medications and over-the-counter medications.
Physiotherapist	Provides physiotherapy treatment and rehabilitation to maximise mobility and quality of life. Physiotherapy treatment includes heat, electrical stimulation, exercise, massage and application of splints.
Podiatrist	Diagnoses foot disease, problems and defects. A podiatrist conducts biomechanical assessment of the foot and lower leg, and provides treatment including nail cutting, general foot care, removal of calluses and corns, supply of orthotics, and minor surgical procedures.
Registered Nurse	Takes a leadership role in the coordination of care within a range of settings, which may include acute care, community and aged care residential facilities. The role includes promoting and maintaining health and preventing illness in individuals with a physical or mental illness, disability and/or rehabilitation needs. The registered nurse is responsible for delegating the care to enrolled nurses, assistants in nursing and aged care workers.
Social worker	Provides support, counselling and advice to help people access basic services such as housing, employment, social benefits and social networks.
Speech pathologist	Diagnoses speech and language problems and swallowing difficulties. Provides therapy to correct and manage speech, language and swallowing problems
Volunteer	Someone who works without payment in a range of roles in the community or aged care facility to support the older person; for example, Meals on Wheels, visiting or social support.

Delegate services and care activities

As a senior aged care worker, you will be responsible for coordinating different parts of the service delivery with a number of people. Effective delegation involves understanding the type of worker or service provider that is best suitable to deliver the service required. Tasks which can be delegated include:

- Allocating activities/tasks to your team
- Preparing rosters
- Referring services to other providers, where necessary
- Purchasing the service from another provider

The way you delegate depends on the service you work for. For example, if you are delegating activities to workers on you team, you may need to prepare rosters and consider whether the worker is full time or part time. The delegation of tasks might be decided through:

- Work experience
- Seniority
- Formal qualifications
- Competence
- Willingness to learn
- Availability

Below is an example where the coordinator has identified the goal, the skills needed to achieve this goal and the most suitable service provider or care worker for the job.

Goal	Skills	Service provider/worker
Regular house cleaning and laundry	**Home care skills**	**Home and community care – funded home care worker**
Development of a meal plan to maintain adequate nutrition	**Knowledge of nutrition and proper diet**	**Dietician**
Assistance and transport for weekly supermarket shopping	**Driving skills Physically able to assist with shopping**	**Home and community care – funded home care worker**

Recognise signs consistent with financial, physical or emotional abuse or neglect of the older person and respond in line with organisation guidelines

The term elder abuse is used to describe behaviour or actions which result in harm to an older person where the older person and the person carrying out the action or behaviour are in some relationship which involves trust, dependency or proximity. Elder abuse therefore includes abuse by family, friends, neighbours, paid or volunteer support workers and service providers, where the abuse happens in the context of this relationship.

Many people see the word abuse as meaning a serious, long-term and repeated action. It is, however, broader than this. Elder abuse is a complex issue; at one end of the extreme the older person may show signs of physical or mental anguish; at the other end they may demonstrate more subtle signs of abuse such as withdrawal and anxiety. The aged care worker must be alert to any sign of client distress and report it promptly; you have a duty of care to protect the older person in your care.

Abuse can range from a single episode of mistreatment through to an ongoing pattern of behaviour. In the domestic setting it is possible that elder abuse could be either intentional or unintentional, depending upon the individual circumstances of those involved.

Abuse can only be detected if workers and community members are aware and knowledgeable about abuse and understand how to respond to these situations. You must be clear about what to look for and how to respond as you have a responsibility to report and record your concerns regarding abuse.

Sometimes elder abuse manifests itself as neglect of the older person. Carers should note and document regular instances of lack of food and liquids; poor hygiene; medicines which are either not purchased or wrongly administered; and lack of supervision of the older person.

Signs of abuse

Category of Abuse	Indications of Abuse
Physical	• Weight change • Unexplained or repeated injury • Unexplained pain • Burns • Increasing withdrawing from society and usual activities • Cuts/lacerations/bruising/fractures • Dislocation • Difficulty in sitting and walking • Over sedation
Emotional- Psychological	• Sudden unexplained changes in behaviour • Depression • Confusion • Seeming distressed • Insomnia • Lethargy • Changes in eating patterns • Not wanting to join in usual activities
Financial	• No money for shopping or transport • Failure to pay bills • Disappearance of items of value • Unknown signatures on withdrawal slips or cheques • Sale of property without the approval or understanding of the older person
Sexual	• Older person is reluctant to receive physical or personal hygiene care • Bruising or bleeding in the genital or upper thigh area • Pain in the genital or anal area • Difficulty in walking or sitting • Withdrawn or depressed behaviour • Exhibits fear
Neglect	• Failure to provide adequate care and provide for a person's basic physical, social and emotional needs such as lack of food, clothing or personal hygiene

You should report any signs of abuse or neglect directly to your supervisor, if you were aware of an abusive situation and did not report this to your supervisor this may be classed as a breach of your duty of care.

Additional resources – Duty of care
You can find more information on duty of care in relation to elder abuse here;
http://www.sa.agedrights.asn.au/residential_care/preventing_elder_abuse/elder_abuse_and_the_law/duty_of_care

Elder Abuse and the Law - Mandatory Reporting
There are no mandatory reporting laws for elder abuse anywhere in Australia.

As from the 1st July 2007 Compulsory Reporting of certain assaults, inflicted on a recipient of residential care was imposed on providers of Australian Government subsidised Aged Care homes. Amendments to the *Aged Care Act 1997* (the Act) are designed to increase safeguards for residents of Aged Care homes. The Act requires approved Aged Care providers to report unlawful sexual contact or unreasonable use of force on a resident of an Australian Government subsidised Aged Care home.

As mentioned in the freedom of choice section, for other incidents of alleged abuse (financial, psychological, social and or neglect), the law assumes adults can make their own decisions, about whether or not to do anything about the abuse that they experience.

The law does not regard an older person differently from any other adult. Older people have the right to access all the current laws available. If you are supporting an older person who is experiencing abuse your role will involve assisting people through intervention strategies and the steps taken will ensure their full rights are upheld e.g. confidentiality and freedom of choice.

In circumstances where people are unable to make their own decisions, full consideration of intervention strategies needs to be undertaken prior to any actions. Capacity is a medical issue and must be determined by a doctor. A written report by a General Practitioner, psycho geriatrician or geriatrician should be obtained by the supervisor and kept on file. This helps to show that you have taken steps to meet your duty of care. In situations such as these, your supervisor might consider applying to the Guardianship Board.

Additional resources – Preventing elder abuse
You can find more information on how to report and prevent elder abuse here;
https://www.myagedcare.gov.au/legal-information/elder-abuse-concerns

Reporting abuse or neglect
If a team member reports a situation to you, make sure you collect as much detail as possible. Depending on the situation, it may be your responsibility to take action or to report the matter to your manager. Your manager may ask you to follow the situation up by reporting to an external agency such as the police or state protection authority.

Compulsory reporting of abuse and neglect is a legal requirement. For example, all government-funded residential aged care services must report all incidents or allegations of sexual or serious physical assault to the Department of Health and Ageing.

The introduction of compulsory reporting of alleged and suspected sexual and serious physical assault commenced in July 2007. The compulsory guidelines stipulate that reportable abuse is:

- Unlawful sexual contact with a resident of an aged care home; or
- Unreasonable use of force on a resident of an aged care home.

When reporting abuse to the Department of Health and Ageing, the following information is required:

- What relationship does the discloser have with the provider? (For example, key personnel, authorised person, staff member, ex-staff member or other persons.)
- Name of the alleged offender – if known.
- Alleged offender relationship to resident. (For example, staff, relative, other resident or unknown.)
- What has the approved provider done to protect other residents from the alleged offender?
- Were there any witnesses?
- When did the incident occur?
- Where did the incident occur?
- Who has been advised? (For example, police, family, medical adviser.)
- When did the approved provider become aware of the incident?
- Who else is aware of the incident?
- Where is the care recipient? (For example, still in care, hospitalised.)
- Has the approved provider made counselling or support available to relevant parties? If so, provide details.

To report abuse you must follow your organisation's procedures. Report and respond only to those signs for which you have witnessed or have evidence. Here is a list of what service providers must do when instances of suspected abuse occur:

- Inform staff about the compulsory reporting requirements for allegations or suspicions about abuse
- Report abuse to the relevant people, such as your supervisor, the director of nursing who in turn may be required to report the matter to the appropriate body
- Provide your clients with an opportunity to talk about what is happening with them and inform them about services to assist them
- Keep records of all incidents involving allegations or suspicions of reportable abuse
- Ensure staff members are protected from victimisation by keeping their identity confidential.

Element 2: Liaise and negotiate with appropriate personnel and service providers

A big part of your role will include liaising and negotiating with personnel and service providers, this is crucial to ensure your clients are receiving the care that they need. If you consider the list of service providers, we look at in the previous element this will give you some idea about the extent of liaising that will be done.

The client must be consulted and involved, as they are the key stakeholders in their own welfare. They have the most at stake; therefore, will be particular about what needs to happen to ensure quality of life.

Other stakeholders include:

- Family members
- Health care professionals
- Financial welfare professionals
- Equipment specialists
- The organisation providing accommodation and support services
- Friends and colleagues
- Cultural or religious representatives

These stakeholders can either be internal or external to the organisation and will either be full time or utilised on a needs basis during the life of the service delivery plan.

Support the older person to access and negotiate resources in order to deliver identified services

It is necessary to negotiate resources, achievement of goals, agencies and referrals (access to services and community agencies) delivery requirements, costs of services, review of services.

There are numerous community agencies and support groups who provide structured and non-structured programs and support to older people.

These agencies can be either:

- Commonwealth government (e.g. Centrelink)
- State government (e.g. Home and Community Care Programs - joint funding with Commonwealth government)
- Local government (e.g. local government community centre/ programs)
- Church organisations (e.g. church homes)
- Volunteer groups (e.g. home maintenance assistance)
- Veteran's Affairs (home care, financial assistance)

As an example, Uniting Church Homes provides Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) packages to provide low care and high care to people who wish to remain in their own homes.

These programs are subsidised by the Commonwealth government and clients need to be assessed as eligible for these services by an Aged Care Assessment Team (ACAT).

Packages of in-home services can delay or prevent the need to move to an Aged Care Facility

Examples could include:

- Domestic assistance
- Personal care
- Respite
- Medication supervision
- Home nursing

A community care coordinator meets with each prospective client to develop a care plan and negotiate the resources necessary for a client's support. The fortnightly fee for a CACP is means tested.

Accessing resources or services from an agency follows set procedures and the agency's guidelines and assessment criteria. The agency will provide the necessary assistance when applying for resources or services. It is in their interest to make the application process user friendly.

Application forms are available direct from all agencies or from their websites. As a care worker, you will be often required to assist a client in applying for agency services. This may include completing the application form or at least assisting with the completion.

Other resources that you might assist the client to access include:

- Community-based health and leisure services
- Legal advice
- Therapists
- Medical resources
- Pharmaceutical services - chemists etc
- Counsellors
- Leisure and recreational services
- Libraries
- Educational services
- Arts and crafts facilities etc

Your organisation should have a database of these types of contacts. Contact with these groups should also be included as part of your networking procedures. By developing networks and maintaining contact with network associates, you will be in a good position to negotiate resources on behalf of your clients.

Aged Care Assessment Teams (ACATs)

An aged care assessment is used to determine whether the client requires a high-level assessment. The ACAT carries out this assessment and also helps older people to meet their needs when they are no longer able to manage at home without assistance. ACATs provide information on suitable care options and can help arrange access or referral to appropriate residential or community care. The Australian Government provides funds to the state and territory governments, specifically to operate and manage the ACATs. ACATs are made up of doctors, nurses, social workers and other health professionals who can provide a thorough assessment of care needs and offer advice on suitable and available care options.

Members of the ACAT will ask a series of questions in order to find the best care options for a client's particular situation. These questions are designed to work out how much and what type of help the client needs with daily and personal activities. With the client's permission, the ACAT will also contact their local doctor to gather more information on their medical history to help with the assessment.

ACAT assessments will recommend the services that are most appropriate for the level of care needed for the client. Care needs will relate to general health, specific health issues, dual diagnoses, mobility and social needs.

Aged Care Assessment Program – Objectives

The ACAP is a crucial component of the aged care system. The objectives of the program are designed to achieve the following:

- To ensure that older persons who belong to the following groups have equitable access to Aged Care Assessment Team services:
  - Aboriginal and Torres Strait Islander people, people of culturally and linguistically diverse backgrounds
  - People living in rural and remote areas
  - Veterans and their spouses, widows and widowers
  - People with dementia
- To ensure that access to ACAT services is based on needs
- To prevent premature or inappropriate admission to aged care homes
- To help frail older people live in the community
- To facilitate access to the combination of services that best meets the needs of assessed clients
- To ensure that assessments of the care needs of frail older persons are comprehensive, incorporating the restorative, physical, medical, psychological, cultural and social dimensions of care needed
- To promote the coordination of aged care and other support services to improve the appropriateness and range of care services available to frail older people

Carry out assessment to identify needs

Carrying out assessments on clients is an important part of your job role when working in aged care. Assessments need to be made about a person's functional, cognitive, physical, mental, and emotional states in great detail in order to develop appropriate care plans. There are many different assessment tools that are used across the industry that you will come into contact with throughout your career. Each facility or aged care setting may use different tools to assess the same things. It is important for you to understand what is within your area of responsibility, and what assessment tools require someone with a different or higher qualification.

As well as tools to assess specific needs of a client, care facilities also have forms and data bases used to collect and record personal details such as name, date of birth, phone number etc. When using all assessment tools, forms and paperwork, it is essential that you take care to ensure accuracy at all times. Incorrect information could lead to incorrect treatment which could have significant consequences for the client. All of this information is used to develop individualised plans.

Assessing functional abilities

Part of an assessment is looking at the older person's functional abilities. Below is an example of the type of questions you may ask an older person when assessing their functional abilities.

Area	Screening questions
Domestic	**Do you have any difficulty, or do you need assistance at home with domestic activities?** **For example:** **To do your housework and laundry** **Prepare meals for yourself** **Shop for food and household items**
Personal	**Do you have any difficulty or need assistance with?** **Dressing or grooming** **Bathing or showering**
Mobility	**Do you have any difficulty with or need assistance with?** **Walking or moving around the house** **Do you require aids such as a wheelchair?**
Transport	**Do you have difficulty or need assistance with transport; for example, using a car of public transport?**

Questions regarding the client's cognition and behavioural concerns should not be asked directly of the client. Use observations or ask family members about a client's memory and behaviour.

Assess health conditions

Information about a person's diagnosed conditions commonly comes from a doctor or other health professionals. However, it may be necessary for you to ask the client how these conditions are affecting them. For example, a diagnosis of arthritis tells you their condition, but does not tell you how this condition affects them, what kind of pain they are in and what medication they are on.

The following are examples of questions you can ask about a person's health conditions.

1. In general, how would you say your health is?
2. In the past four weeks, has your health interfered with your normal activities?
3. In the past four weeks, how much bodily pain have you had?
4. How is your hearing (with your hearing aid)?
5. How is your eyesight for reading (with your glasses)?
6. How is your long-distance eyesight (with your glasses)?
7. Do you have a fear of failing?
8. Have you had a fall inside/outside the home in the past six months?

It is also important to ask the client if they have any health conditions. Ensure that you cover all issues; for example, allergies, acute medical conditions, disabilities, continence, dental, developmental problems.

Assess mental health and wellbeing

Assessing a client's mental health and wellbeing can be a delicate task. This task is usually done by health professionals such as a psychologist or psychiatrist. However, it may be your role to gather information to identify whether an older person needs to be referred for a mental health assessment by a professional. Some clients may be uncomfortable answering questions about their mental health and therefore you need to ensure you are tactful and show respect.

Mental status examinations are used to establish a client's cognitive and memory abilities. When it is completed by someone other than a health professional, it is usually a simplified and a general assessment of the client. The examinations require the older person to complete a number of relatively simple tasks that require memory and thinking skills. Results of the tests can provide an indication of whether or not a person has cognitive or memory problems.

Service reviews

The purpose of the service reviews is; to determine, has the support needs been met, has the goal been achieved or progressing towards achievement, what has worked and what hasn't, is the service and support providing the level of service required.

Support the older person to access community support agencies to facilitate the achievement of established goals

As mentioned in the previous topic you as a worker will have a small network of service providers that you can link your clients into and the organisation you work with should also have a database of other organisations that can assist your clients to reach their goals.

As a worker there will be different ways you can support your clients to access community support agencies along with ways to facilitate them achieving their goals, this may include;

- Provide brochures and information on relevant community support agencies
- Research and provide information on how to access/ apply for these agencies
- Explain to the client how accessing a particular agency will assist them to achieve their goals
- Provide un-identifying feedback on these agencies from other clients you work with
- Offer to assist your client to complete the application or make the first appointment
- Offer to attend or transport the client to the first few meetings if this would make them feel more at ease.

Once the client is engaged with the community support agency continue to check in and encourage the client to achieve their established goals. You can offer to attend the agency with them or liaise with a representative from the agency that works with your client.

Employing strategies to motivate, support and encourage clients is one of the major requirements of support workers. This can sometimes be a challenge, especially when clients are in crisis or are feeling depressed and lack self-esteem.

There are a number of ways to support clients who need to be motivated, to make decisions for them, and to have the confidence to act on those decisions.

You can encourage clients by:

- Asking them how they think a situation should be handled, rather than telling them how to handle it.
- Assisting them to think of options based on prior success in their individual situation, rather than options based on theory.
- Assisting them to select an option rather than telling them which one to choose.

You can support clients in this process by:

- Encouraging them to reach a decision.
- Emphasising that they have reached a decision and now they need to act on it.
- Affirming their ability to make decisions and develop steps to reach their goals.

Sharing information on other services with your client

When you have a clear understanding of your client's immediate needs, the next step is to look at the following with the client:

- What support resources can be provided?
- Who can provide the resources?
- How will they be provided?
- Will the client be able to access them? (Is the client eligible for that particular service delivery option?)
- What is the process for introducing the client to the resources? (Will a formal interview be required?
- Should you or someone else attend with the client? Is an initial phone call or email required?)
- Looking for the right program/activity/resource with a client often means you have to go outside your own agency and refer your client to another agency or service. There is little point in identifying programs and activities to meet your client's needs if your client cannot access these programs/resources.

Access community support agencies

There are many community support agencies that receive funding from the government to provide a whole range of support to older people and their carers in the community. These may include:

- Day programs; for example, activities conducted in specific day care centres.
- Personal care; such as community aged care packages that provide assistance with bathing, dressing, grooming, toileting, mobility and eating.
- Home care; including local home and community care services offering assistance with domestic cleaning, shopping and laundry.
- Professional nursing, including district nursing services that provide clinical care, assessment, education and information.
- Case management, which provides a professional to assist with planning, sourcing and coordinating the services and supports required to meet care and support needs.
- Social activities and companionship, which can include coordinating volunteers to provide services such as friendly visiting.

Access to community services is usually through direct referral. Many services have referral forms that must be completed with the older person's information. In some jurisdictions, all community services must agree to use the same referral form; in other cases, forms are to be completed electronically on a secure network.

To suggest and obtain the best service for older people you need to be familiar with the range of community support agencies and understand the criteria they have for accepting people. It is also essential to understand referral procedures in your organisation and know the cost of services.

Below is a list of community support agencies that you may come across:

- Australian Red Cross
- Centrelink
- Anglicare
- Counselling services
- Alcohol and drug services
- Crisis care
- Family Helpline
- St. John Ambulance
- Community centres
- Lawn bowls
- Medical services
- Ancillary services
- Aged Care Facilities, retirement villages
- Aged Care Assessment Teams
- Aged Care Licensing and Accreditation
- Aged care advocacy support services

Recognise when a service and/or support worker is no longer able to provide the level of service required and take action to minimise disruption to service delivery

There are many reasons why a service or support worker is no longer able to provide the level of service required, some of these reasons are;

- Skills of care worker are insufficient to service client's needs.
- A personality clash exists with care worker and the client.
- Request for a new care worker has been made by the client.
- Workload of care worker affects their ability to service client's needs.
- Staff restructure or transfer to new department/ section.
- Multi-skilling of staff and skill development.
- Staff leave.
- Changes in funding stream.
- Staff member is leaving place of employment.
- Care needs of the client have escalated.
- Staff member is dissatisfied with the organisation and its systems.
- Training/ research leave.
- Career change.

When there is a change in service or support worker it can be a good time to review the client's individualised plan as well as reassess the client's goals.

Reassessment of the service delivery plan could involve the following stakeholders:

- Client, advocate and/or family.
- Assigned care worker.
- Team leader.
- Medical/ nursing staff.
- External service providers if appropriate.
- Experts in the relevant fields - particularly where a client has multiple diagnoses.
- Options could include:
  - Assign a new care worker to the client.
  - Negotiate an agreement with the client to deliver less services.
  - Access external service providers or community programs.
  - Rewrite the service delivery plan.

If a client requires support that does not fall within the scope of your agency, you may need to investigate other options and refer them to another service provider. There are a number of important issues to consider when you choose to refer a client to another agency, or to another member of your team, be it an emergency referral or part of treatment planning. The most important consideration should be:

- Is this the best possible service provider to refer this client to?
- Will they be able to adequately meet the needs of this client?
- Are there specific protocols (cultural and/or otherwise) that must be followed to ensure effective referral processes?

To do this, you need a good understanding of the services and requirements of the agency that you are providing referrals to, and of the skills and expertise of other members of your own team.

Take action to minimise disruption to service delivery

Changes to service delivery should be addressed as quickly as possible to avoid disruption to services. If this occurs, you should report it immediately to your supervisor and discuss any further actions to take. If a service does not provide adequate support, you should:

Consult with your supervisor, the person's family, carer or advocate and any relevant professionals.

Consult with the older person about changes that have occurred and changes that need to be made:

- Clarify the issue and cause of issue.
- Identify options for making changes.
- Review the goals in the individualised plan.
- Review the individualised plan.
- Consult the older person and team about making the changes.

Considerations when changing services

- Disruption to service requirements minimised.
- Fund implications considered.
- Consultation completed, and the person involved is happy with proposed changes.
- The new service/activity fits in with schedule.
- The service meets the client's needs.

Element 3: Support family and carers

The role of carers in Australian society will increase as the population ages and the number of older people requiring care and support increases.

Who is a carer?

A carer is a person who provides regular and ongoing care and assistance to a dependent person. Often, a carer is a family member, partner, friend or neighbour who freely and willingly provides this support without payment. In saying that, a carer may be eligible for a payment from the government if they meet the carer criteria.

A carer may give care for a few hours a week or all day every day, depending on the level of support needed. Care could be provided within the person's home, a residential aged care home or at your home.

The rewards of caring

People who care for a family member or friend say there are many rewards:

- The opportunity for personal growth and the development of new skills.
- Proving to yourself that you can meet new challenges.
- The satisfaction of knowing you have you have helped someone who needs you and done the best you could to improve their quality of life.
- Strengthening the relationship with the person you care for and knowing how much they appreciate your help.
- Receiving the acknowledgement of your family and friends.

Recognise the impact of support issues on the carer/s and families and refer appropriately

Caring is a role that brings joy, togetherness, personal growth and the reward of being able to help. It can also bring challenges, stress and strain.

There are several indicators that a carer is requiring support, these are;

- Carer appears tired and exhausted.
- Confides in you that they need help.
- Change of behaviour of carer (become forgetful, irritable, short tempered).
- Carer appears unhappy and notice relationships are deteriorating.

Challenges of caring

Caring can be very demanding and often restricts the lives of individual carers and their families.

Financial hardship

50% of primary carers are on a low income and many find it hard to cover living expenses, save money or build up superannuation.

The extra costs of caring can be enormous. Caring families often have to find money for extra expenses like heating and laundry, medicines, disability aids, health care and transport.

Health and wellbeing

Caring can be emotionally taxing and physically draining. Carers have the lowest wellbeing of any large group measured by the Australian Unity Wellbeing index.

Carers often ignore their own health and are 40% more likely to suffer from a chronic health condition. Some health problems, like back problems, anxiety and depression, can be directly linked to caring.

Many carers are chronically tired and desperately need to refresh with just one night of unbroken sleep, a day off or an extended period with no caring responsibilities.

Social isolation and relationships

Many carers feel isolated, missing the social opportunities associated with work, recreation and leisure activities.

The demands of caring can leave little time for other family members or friends.

Carers often have to deal with strong emotions, like anger, guilt, grief and distress, that can spill into other relationships and cause conflict and frustration.

Disadvantage
Many carers miss out on important life opportunities, particularly for paid work, a career and education.

Caring can take the freedom and spontaneity out of life.

An important part of your role will be to work with carers, this will happen in a variety of ways however given your knowledge of the industry and services available you should ensure that carers have a good understanding of what support is available to them at all times.

As mentioned above one of the biggest challenges are the cost being a carer, this does not only include medications, specialists and potentially modifications to the home but also the loss of income from employment due to being a carer.

In Australia carers may be eligible for an allowance from Centrelink;

Carer Payment and Carer Allowance provide financial assistance if you personally provide daily care to someone:

- With an illness
- With disability, or
- Who is frail aged.

Carer Supplement is an annual lump sum payment to help you with the costs of caring for a person with disability or a medical condition.

Other ways you can support carers

- You may like to suggest the following to carers you are working with;
- Look after themselves first and foremost.
- Ensure they are eating well and getting enough sleep.
- Joining a local or online support group.
- Keeping up with a hobby or starting a new one.
- Respite to allow them some time away from being a carer.
- Referrals to any supporting agencies.

Referrals
Many services that are available to carers have a self-refer option however some services will require that you refer the carer to the agency. Where this is the case it is important to follow the organisations referral procedure.

Referral processes may be informal and require as little as a phone call or visit to the service provider, or more formal and require assessment of the person's physical, social, emotional and financial circumstances.

Many home and community services may be accessed through:

- Self-referral.
- Referral from a family member, friend or carer.
- A doctor's referral.
- Referral from a community or health care worker.

For specific information on referral processes, it is essential to contact the individual service providers.

Provide support and respite for carer/s

Support for carers has taken a turn for the better over the last few years, this includes access to many more services as well as financial assistance. You should have information readily available to carers that details the support they can get and where they can find this support.

Carers Recognition Act

The *Carers Recognition Act 2012* formally recognises the role of carers and care relationships in Victoria, including carers under 18 years of age. Carers can care for:

- An older person with care needs
- A person with a disability
- A person with a mental illness
- A person with an ongoing medical condition.

The Act applies to organisations funded by the Victorian Government that provide services for people in care relationships. Under the Act, services must respect people's wishes, involve them in all decisions and account for people's cultural identity and preferences. Under the Act, service providers must:

- Tell staff about the Act.
- Ensure staff tell carers about the principles of the Act.
- Use the care relationship principles to develop, provide or evaluate support and help for carers and people they care for.
- Describe how they have met their obligations in their annual report.

i	**Additional resources – Carers recognition Act fact sheet** You can find more information on the Carers recognition Act here; http://www.dhs.vic.gov.au/__data/assets/pdf_file/0012/738669/What-the-Carers-Recognition-Act-2012-says-fact-sheet.pdf

Respite

Direct Respite - In home care, community or outing based day centre, holiday and residential respite.

Indirect respite – Education, information, equipment and assistance with household tasks.

The purpose of residential respite care is to provide short-term residential care for frail aged people to assist them to remain in the community, as well as to assist their carers to continue to provide care for them. A break, for a few hours, days or a few weeks, helps to maintain the mental and physical well-being of both the older person and their carer. Respite care could be used for carer relief on a planned, regular or emergency basis to assist carers in times of illness or stress, holidays, or the unavailability of the carer for any reason. Respite could also be used as a short-term break by the frail and aged who are caring for themselves or in temporary situations where the person is unable to care for themselves (e.g. while recovering from an operation).

Support organisations, helplines, counselling and support services

National Dementia Helpline: 1800 100 500 Alzheimer's Australia runs this helpline and provides a range of services to support people with dementia and their families and friends, including telephone information and support, education and training programs, and a free counselling service. They can also put you in touch with local support groups. For further information please see: fightdementia.org.au

Carers Australia: 1800 242 636 Carers Australia provides specialist services including counselling, advice and information for carers of a family member with any condition. For further information please see: www.carersaustralia.com.au

Commonwealth Respite and Carelink Centres: 1800 052 222 Carelink Centres are located throughout Australia and help carers access information and training courses, such as the Dementia Education and Training for Carers Program. They may also organise appropriate respite for the person with dementia to enable the carer to attend the course. My Aged Care: 1800 200 422 My Aged Care provides information and advice about how to access aged care services, including eligibility, assessment, finding local services to meet your needs, and costs. My Aged Care is now the key entry point to the Australian aged care system. For further information please see: www.myagedcare.gov.au or phone

Young Carers: 1800 55 1800 Young Carers provides information, support or counselling for carers under 18 years old and caring for a family member with any condition. For further information please see: www.youngcarers.net.au

Counselling and psychotherapy: Australian Counselling Association: 1300 784 333 The ACA is a national association of qualified and registered counsellors and psychotherapists in Australia and has a Find a Counsellor service. For further information please see: www.theaca.net.au

Lifeline Australia: 13 11 14 Lifeline Australia provides help to anyone experiencing a personal crisis, with online, phone and face-to-face crisis support and suicide prevention services. For further information please see: www.lifeline.org.au or phone: 13 11 14

Emergency help: 000 If you or someone you are caring for is seriously injured or in need of urgent medical help phone the emergency services: 000 For emergency respite support phone: 1800 059 059

Element 4: Coordinate feedback

Significant feedback and information from clients and carers should be gathered and analysed and will assist in the development of new strategies and objectives for the organisation and new plans for client care.

Ways you could coordinate the feedback;

- Collecting feedback of service providers, the older person and other relevant people associated to the older person.
- Provide opportunities for collection of feedback (in a variety of methods) both systematically and formal and informal.
- Schedule appointments to complete monitoring of the service against the goals set.
- Take the time to review and analyse the feedback.
- Support the older person to seek advice and assistance from health professionals when their goals are not being reached.

Explain to all service providers the mechanism/s for providing feedback on the effectiveness of the individualised plan

Established mechanisms or procedures for collecting and analysing client feedback are a requirement under the Standards and Guidelines for Residential Aged Care Services It is also necessary that each resident (or representative) and other interested parties have access to internal and external complaints mechanisms.

- The organisation's management must demonstrate that:
- It actively seeks feedback from each resident (or representative) and from staff on all aspects of the services provided by the organisation
- Issues raised by a resident (or representative) relating to the services provided by the organisation are dealt with fairly, promptly, confidentially and without retribution
- A simple and easy-to-use comments and complaints resolution mechanism is in place
- All comments and complaints are recorded, monitored and acted upon in order to achieve a satisfactory resolution
- That information relating to internal and external complaints mechanisms is available to each resident (or representative)
- Complaints that are unable to be resolved internally are referred to the appropriate external agencies for resolution.

When you support or assist the older person to meet their personal care needs you will need to follow a number of guiding documents and instructions. You must never work outside the instructions given to you. Always check that the instructions are in writing, usually found in the service delivery plan itself, work instructions or procedure manuals.

All organisations must clearly understand the mechanism/s for collecting, recording and analysing feedback on the effectiveness of the service delivery plan. They should demonstrate that these are in place and that they are being used appropriately.

They must conduct regular:

- Reviews of service delivery plans.
- Surveys on service delivery clients.
- Informal discussions with clients and care workers.
- Meetings with clients, families or advocates.

Suggestion boxes could be used to provide opportunities for staff and clients to offer feedback.

Critical factors to consider when gathering and responding to feedback:

- It is the right of the client to register a comment or complaint.
- It is the right of the client to receive follow-through and an appropriate response on their complaint.
- Comments and complaints must be documented (using organisation's procedures and guidelines).
- A concerted effort must be made to address a client complaint (using organisation's procedures and guidelines).
- Client feedback is foremost in measuring the successful delivery of services for a service provider.
- Review and record all customer feedback.

Principles and practices of case management

Case management is a process in which one professional is responsible for managing care. Case managers often work for hospital or community organisations and make sure the person you are looking after gets the best possible care. Many carers act, in some way, as case managers. Case managers often work with people who need a lot of care, such as people with physical and intellectual disabilities and people with a mental illness.

A case manager can assess the person you care for, monitor their health, plan their care, look after their interests, and help them find other services. You can help them by providing information, and they can help you with any concerns you have as a carer.

Case management principles

1. Case managers should deliver as much of the "help" or service as possible, rather than making referrals to multiple formal services.
2. Natural community resources are the primary partners (e.g. landlords, employers, teachers, art clubs, etc).
3. Work is in the community.
4. Both individual and team case management works.
5. Case managers have primary responsibility for a person's services.
6. Case managers can be para-professionals. Supervisors should be experienced and fully credentialed.
7. Caseload size should be small enough to allow for a relative high frequency of contact (no more than 20:1).
8. Case management service should be time-unlimited, if necessary.
9. People need access to familiar persons 24 hours a day, 7 days a week.
10. Case managers should foster choice.

Source: Rapp & Goscha (2004)

Case management in the aged care context is the process of assessment, planning, implementation, monitoring, and review for service provided to a client. Case management aims to strengthen outcomes for both the client and their family. The elements of case management are:

Screening and assessment of individual/family capacities and needs*:* a continuous process of analysing available information leading to a judgement of risks, strengths, and needs of the client. This information and analysis is used to determine whether clients are in the target group for support programs and to inform a realistic plan of action.

Case planning to determine the goal and objectives: identifying the strategies that will address the physical, emotional, educational, social, religious, and cultural needs of the client. Case planning is an interactive process involving participation of the client, their family, and carer. Case plans must be documented and identify goals, objectives and tasks with clearly identified responsibilities and timeframes. Goals must be realistic and achievable within available resources. Goals should be communicated to the client as well as other key stakeholders.

Implementation*:* delivering or arranging services within available resources to meet the identified case plan goal. This should include regular communication with the client to ensure their needs are being met.

Coordination of services and supports: arranging, coordinating, and following up on the delivery of services and supports.

Monitoring: obtain regular feedback from the client, carers and service providers to determine whether services are being provided in the manner determined by the case plan and whether needs have changed.

Review: assessing whether the case plan goal has been effectively and efficiently met and whether modification or change to the plan is required.

There are a number of principles that drive case management practice. Case management should:

- Concentrate on strength based, client centred practice. It includes the active involvement and participation of the client (and their carers and families) in the process.
- Address and meet the needs and goal of the client, facilitate their development and be culturally appropriate.
- Achieve continuity of support through appropriate referral, transition and follow up
- Promote and reinforce partnerships between service providers where this will facilitate the achievement of the planned goal.
- Support self-determination for clients
- Ensure the goal, objectives and strategies are recorded and monitored for progress/achievements and arrangements reviewed to ensure their continued appropriateness.

Obtain feedback from service providers on the effectiveness of the individualised plan and report to supervising health professional

Feedback should be sought from all the service providers involved in care plans, particularly where changes are proposed. Changes to one area of a plan can have an impact on other areas. If the services offered by one provider are to be changed, then it is possible that those provided by others might need to change or adapt accordingly. It is, therefore essential, that all of the service providers share feedback and maintain open communication channels.

Service plan conferences, to which clients and the various involved service providers are invited, can be used to elicit feedback, generate discussion and design and develop improvements.

Clients should also be offered the opportunity to attend if they desire.

Regular monitoring and evaluation of plans is essential as people's needs are not static, nor are the environmental conditions that might affect care plans. Monitoring processes and feedback information can be used to identify improvement needs, the need to re-prioritise care needs or the need to source more appropriate resources.

Without complete feedback from all service providers there could be an incomplete picture of how well the plan is performing.

Regular meetings will be held where all relevant service providers will either be in attendance or provided meeting minutes to ensure everyone involved in the clients care plan are on the same page and aware of any issues, changes in the client's goals and any other changes or updates.

Seek feedback from the older person and/or their advocate and report to supervising health professional

- Often a decision may be difficult to make. For example, when a decision involves the client's right to choose to take a risk, the aged care and health support workers may wish to seek support as well as advice from their supervisor.

Seeking advice and direction from a supervisor is crucial to the role of monitoring the effectiveness of the care plan. For example, the care plan for Mr. Millthorpe states that he had a hip replacement and should use a walking frame for four weeks, but he tells you that he does not use it or need it any longer. It would be appropriate for you to respond to Mr. Millthorpe in helpful way, informing him that you need to obtain advice and direction from your supervisor and that a reassessment may be required. In this way you will be directly working within the care plan and contributing to the evaluation and development of ongoing and changing needs of Mr. Millthorpe.

Reporting changes in a person's condition

Observing clients is a vital part of the aged care and health support worker's role. To be able to report changes in a client's condition or needs, the carer must be a good observer. To observe people in your care, you must use ALL your senses. Observing is much more than just looking at the person.

- Anything unusual or out of the ordinary should be noted and reported to the supervisor. For example, you may smell a strange odour, hear a moan or groan or feel an unusual swelling or lump on the skin.
- It is important to know your client to be effective in the care you give. 'Care' includes being attentive to change and reporting any changes to the relevant person. The worker must first know what is 'normal' before they can recognise what is not normal.

Gathering feedback

Elements to consider about feedback include:

- Development of a service culture that encourages open and honest communication.
- Encouragement of feedback through a variety of channels.
- Anonymity for people providing feedback.
- Records of client feedback and levels of satisfaction.
- The process for compiling, analysing and using information arising from feedback.

Feedback tools

- An entry and exit survey at the beginning and end of receiving care from a service provider.
- A series of verbal feedback questions to be asked at different stages of a client's journey through the service.
- A brochure explaining how to feedback and how to make a complaint.
- A feedback record that guides workers on what feedback questions to ask, and what information (verbal and written) to give at different stages of a client's journey through the service. This record also records a client's response to verbal feedback questions.

By adopting different kinds of feedback modes (i.e. written, verbal, formal, informal etc) at different stages of a client's journey through the service, will allow for client and/or advocate input to amend any deficiencies in care or to meet the ever-changing needs of the client.

Feedback is so that continuous improvement can take place and work towards improvement of facilities, care and procedures. Active participation in continuous improvement will also improve team work, and encourage a sense of ownership of the process, which will in turn create a greater sense of satisfaction in services and pride in achievement.

Complaints by clients
Elements to consider about complaints by clients include:

- Internal and external complaints mechanisms
- How complaints are recorded, considered and appropriately dealt with in a timely manner
- The outcome of the complaint
- Options to appeal decisions
- Options for taking complaints to agencies beyond the organisation
- How people may be supported by a representative of another organisation or advocate
- Processes to ensure that the complainant is not disadvantaged by making a complaint
- Culturally appropriate processes for making complaints
- How the outcomes of complaints are taken into account in improving the organisation.

Support the older person to seek advice and assistance from relevant health professionals when their goals are not being reached

Knowing whether a service is providing the desired outcomes and quality of life for the client is critical. This is particularly important if a system of services claims to provide quality services.

Methods of collecting, analysing, and reporting on client feedback have already been covered. Client feedback is important, as the most appropriate people to determine what aspects of a service plan are meeting client needs are the clients themselves. The consumer or client's perspective is crucial and most relevant, if service providers are going to support their clients completely. It is therefore necessary to question what is best for the client, in terms of outcomes and benefits. To do this the input of various experts will be required, as will feedback from those experts, on how well the plan is meeting identified objectives and how well it is contributing to the health and well-being of the client.

When determining where the organisation is in relation to the Standards and Guidelines for Residential Aged Care Services and to identify best practice in health and personal care, input from all involved or interested parties will be necessary.

Organisational policies, procedures and quality control systems should be scrutinised, questioned and adapted to meet needs that are identified as a result of feedback. Client feedback (or from their advocate) and feedback from relevant health professionals will, as already discussed, contribute to the adaptation of plans and to improvements to organisational policies, procedures and systems.

The older person should be central to their service delivery and the decisions that are made. It is important that their independence is encouraged and supported when their goals are not being reached. If the person feels empowered to seek assistance themselves, they are more likely to show independence.

To support the older person to seek advice you should:

- Know how to contact health professionals
- Provide the older person with relevant contact details
- Ensure the older person is able to use an appropriate mode of communication
- Organise a case conference to discuss the service plan

Conclusion
Coordinating the services of older people is a very important task and needs to be well managed and documented. Each client will usually have a range of service providers working with them and this is why the individualised care plan is as beneficial as each service provider can clearly see what the other services are doing to achieve the client's goals as well as continue to update the plan when required. Gathering feedback from the client regularly is paramount to ensure they are happy with the care they are receiving and able to make changes where they feel is needed. As always if there is any time you cannot support your client it is important to refer them to a service that can. Supporting the client's carer is also a big part of your role and has many aspects; it is often a good idea to check in with not only the client but also the carer to see how both people are going and if any additional support is required.

CHCPRP001 - Develop and maintain networks and collaborative partnerships

Welcome to the learning resource for the unit CHCPRP001 Develop and maintain networks and collaborative partnerships.

This unit applies to work in all industry sectors, and to individuals who take pro-active responsibility for improving collaboration between workers and organisations.

On completion of this unit you will have covered the requirements for:

1. Identify networking and collaboration needs and opportunities.
2. Develop collaboration strategies.
3. Work collaboratively.
4. Represent the organisation.
5. Maintain and enhance networks and collaborative partnerships.

You will be able to demonstrate your ability to:

- Develop strategies for networking and collaboration for at least 1 organisation.
- Work collaboratively with external individuals or groups in at least 3 different service delivery situations.

You will be gain knowledge about the:

- Copyright and intellectual property.
- Legal and ethical considerations for collaborative practice, including:
  - privacy, confidentiality and disclosure
  - principles of networking and collaboration
  - different types of networks and collaboration:
- Organisational.
- Individual.
- Virtual.
- Formal/informal.

Benefits of networking and collaboration:

- For clients.
- For the organisation.
- For the worker.
- Values, limitations and dynamics of networks and collaborative partnerships
- Industry structure and interrelationships between different organisations, both public and private
- Established networks in relevant area of work:
- Structure.
- Key stakeholders.
- Vision and purpose.
- Opportunities for participation.

A copy of the full unit of competency can be found at: http://training.gov.au/Training/Details/CHCPRP001

This learning resource is designed to support your learning and act as a guide to further research. We encourage you to access other texts which include; standards and legislation and other resources relating to your industry that can be sourced throughout the internet or library.

Element 1: Identify networking and collaboration needs and opportunities

Evaluation of organisational performance

Collaboration

Collaboration generally refers to individuals or organisations 'working together' to address problems and deliver outcomes that are not easily or effectively achieved by working alone. Collaborative practice is now central to the way we work, deliver services and produce innovations. Collaborative relationships are attractive to organisations because the combination of effort and expertise produces benefits greater than those achieved working alone

Collaborative practice involves community service organisations working together to achieve shared goals.

In the community services delivery system, collaboration is achieved when organisations develop mechanisms, structures, processes and skills - for bridging organisational and interpersonal differences, and together arrive at outcomes that they value.

Community service organisations generally collaborate to:

- Improve the quality or scope of service to their clients, and/or
- Provide administrative or service delivery efficiencies.

Dynamics of networks and collaborative partnerships:
http://mams.rmit.edu.au/mnnqqhodgc76.pdf

Organisational collaboration

Collaborative practice can be seen as a continuum of relationships. The relationships formed between organisations can vary in terms of the formality of arrangements and how activities or functions are shared or integrated. Arrangements can range from informal agreements for information sharing, such as inter-agency or other network meetings, through to amalgamations and mergers, where a formal process fully integrates two organisations into a single operation.

Relationships may also differ in terms of:

- Length of relationship (one-off activity, time limited or ongoing)
- Degree of risk and commitment
- Type of outcomes sought, and
- Level of organisational autonomy retained.

A Collaborative organisation review:
http://community.aiim.org/blogs/angela-ashenden/2013/04/16/what-is-a-collaborative-organisation-anyway

Networks

Networks involve individuals and groups working together to share information, ideas and resources to help them meet common goals. The term 'networking' is often used to describe the process of making contacts with others to foster mutually beneficial and supportive relationships.

Different sectors within community services have their own networks. For example, aged care, disability, mental health, youth and alcohol and other drugs (AOD) services have established networks that link all the agencies and services within each sector.

Some networks are based on a cross-section of organisations within a particular community, while others focus on a particular issue, such as housing.

Here are some of the ways that networks can benefit you and the service you work in.

Networks are a means to:

- Connect
- Communicate
- Learn
- Interact
- Share
- Expand
- Access

Collaboration and networking provide positive opportunities to explore where improvements can be made to the service provided by the organisation along with the organisation itself. Continuous improvement is a process that most organisations that are involved in delivery of services adopt. Networking and collaboration can provide various useful information and resources that lead into continuous improvement.

Identify and prioritise organisational and individual needs

Meeting the needs of the individual whilst meeting the needs of the organisation can at times be a balancing act. Prioritising these needs is the key to success. The need of the person who you support is your primary source of information and collaboration and will provide much guidance around how you can support them within the capabilities of the organisation and surrounding services and ultimately how you determine the most suitable network and collaborative partnerships.

Organisational needs

The organisations objectives and the needs of the people who utilise its services need to be identified. For example, your organisation may work primarily with individuals who have dementia. Therefore you will research and seek networks and partnerships with organisations and people that work with people with dementia

Individual needs.

The individuals needs and goals are your first focus. Having a clear ideas of the persons needs will enable you to develop a project plan that guides you to certain networks and people.

Prioritising

Identifying and understanding the organisations and individual needs you will have necessary information to research how best to meet these needs and what services, networks and collaborative partnerships will provide the most benefits.

Once you have identified the most appropriate networks, individuals and other organisations and services you will be able to determine the sequence of activities to engage networks and collaborative partners, prioritise how and when communication and actions will take place and assign time frames based on specific needs and urgency of the situation.

Gaps in networks and collaborative practice

Work practices are reviewed and monitored to ensure practices and activities are efficient and are working to meet the best interests of the organisation. The same process can be taken for collaboration and networking. Collaboration and networking need to be achieving positive outcomes for the business to ensure it is a useful way to spend time and resources.

Through regular monitoring ,assessment, review and reflection, you will determine how well the collaborative activities and networking are meeting the needs of the client and the organisation.

Questions to ask yourself;

- Do we need to continue with this collaboration, has it served its purpose?
- Is the network and collaboration still providing benefits to the organisation and the individual?

If you have identified a gap in the ability of the collaboration or network meeting the organisation, individual or workers need it is best to have an open discussion about how to proceed. An alternative network or collaborative group may be required to be engaged. Goals and service requirements change and with that external services and people will need to change with them. Adapting and changing to meet the service needs will provide all parties with the opportunity to gain further information and build on networks.

Limitations of networks and collaborative partnerships

Whilst there are many advantages and positive outcomes that can be achieved through collaboration and networking there are also limitations.

Limitations can include;

- Accessibility – Regional areas may have limited opportunity to collaborate and network.
- Time – Networking and collaboration takes time which can put pressure on individuals additional work responsibilities. Time allocated to participate in these activities might not always fit in with everyone's needs and capabilities.
- Availability of networks to suit the needs of all parties.
- Access to services.
- Costs – Financial ability of the individual to pay for the services.

The power of leadership networking :
http://www.emergingrnleader.com/networkinginnursing/

Element 2 : Develop collaboration strategies

Gather and review information

One of the first steps towards create positive networks is to establish and maintain a database of all the people, agencies, services and organisations that you and your workplace deal with and then move on to reviewing what services, people and agencies that you or your workplace hasn't built a relationship with and add this information to a database.

This information should be recorded in a format that is easy to update as details and contacts may change over time particularly, if you deal with large government agencies. The database must reflect these changes.

The information must also be accessible as this ensures appropriate resources are easily identified as soon as they are needed, resulting in organisations operating more efficiently. Organisation and maintenance database records may vary between each organisation. For example, in organisations where data is not easily accessed, people tend to maintain their own records and list of contacts. This is inefficient as it leads to duplication and increases the risk of information being incorrect or out of date.

A single, shared database is more efficient. The responsibility for keeping records current in a central database may vary; however, in many organisations, the responsibility belongs to all who use the data. A coordinator or supervisor may share the responsibility of entering information into the database with colleagues and other work professionals.

Some organisations may have a formal process where a person is designated the responsibility of maintaining this information. However, all users of the database should contribute information, in order to maintain the data's currency, and a coordinator is often the person who finds out that a contact, or other information, has changed.

Required information

The type of information that is collected and kept depends on the nature of the organisation you work for and the services it provides. It may also depend on the background and experience of the people who use the database and their experience within the industry.

If you work for an organisation providing services that are mainly funded through government programs, such as Home and Community Care (HACC) programs, the database may include information about contacts for those services, web site and e-mail addresses including a nominated liaison person.

If your service is self-funding or relies heavily on donations and fundraising, your database may include information about corporate and private donors and philanthropic trusts. Usually, a database contains details of your organisation's clients and the providers your organisation uses.

If an organisation provides direct care and support, the information collected may include details of medical experts and other health professionals, agencies and services.

The following table provides examples of various organisations and agencies and the information that an organisation may regularly require, which should be included in a database.

Figure 1:

Organisation/Agency	Information required	Example
Government agencies	Service guidelines, funding, funding applications, eligibility, programs and contacts, legislation and legal requirements	• HACC programs • Veterans' Affairs programs • Carers' Action Plan Programs • State Disability Plan or Disability • Action Plans • WHS requirements
Insurance providers	Guidelines about funding or programs and contacts	TAC
Other service providers in the same field	What services they provide, where and at what cost	Providers of: in-home care residential care recreational facilities case management
Not-for-profit community groups	Who their members are, what their purpose is, what services they provide and to whom	Vision Australia Paraquad SCOPE Epilepsy Foundation
Philanthropic trusts	What trusts exist, what they fund and how much they fund	Helen Macpherson Smith Trust James Brown Memorial Trust Corporate organisations, including the major banks and Telstra, have philanthropic trusts that support programs to enhance the lifestyle of people who are disadvantaged
Government-funded residential facilities	What facilities exist, where are they located and the guidelines for occupancy	Aged care facilities Hostels
Service providers	What service providers exist, what services, recreational activities and day programs they provide and their costs	Service providers may specialise in: residential care home care home maintenance working with special groups such as Aboriginal or Torres Strait Islander people counselling support programs professional development
Equipment suppliers	The type of equipment and products that are available for people with special needs	Independent Living Centres Australia Guide Dogs Australia
Agencies for relief staff	What agencies exist, where they are located, what staffing needs they can meet and the costs involved	Service providers may need to use agency staff for emergencies when they can't meet client needs with their own staffing resources

Training organisations	What TAFE colleges and Registered Training Organisations (RTO) offer courses in your area and the costs involved; what apprenticeships are offered RTO	RTO TAFE
Specialty groups	What specialty groups exist, what their purpose is, where they are located and what programs they run	ADEC - Action on Disability in Ethnic Communities U3A - University of the Third Age
Rehabilitation hospitals	What hospital programs are available to rehabilitate people with acquired disabilities	Public or private rehabilitation hospitals for people with stroke, spinal injury, vision and hearing loss, ABI, etc.
Gym and sporting organisations	Where gyms and swimming pools are located, their accessibility and their programs	Local gyms Public pools that may offer hydrotherapy or specialised programs, like aqua aerobics, for older clients
Advocacy groups	The services that exist to assist clients to speak up for themselves individually or as a group	ARAS Aged Rights Advocacy Service DAIS - Disability Information and Advocacy Service Inc
Venue providers	The cost and availability of rooms, facilities or venues	Community halls Local recreation centre facilities

Information about organisations, service providers and contacts may come in many forms. The organisation you work in, your role and the type of forums you have exposure to will determine the information you have access to. A common way of receiving the information is by liaising and meeting with people and other organisations.

The following list provides examples of key contacts, including people, organisations and groups, which should be considered as potential sources of information, and ways to gather the information.

- Work colleagues.
- Former work colleagues.
- External customers.
- Suppliers of services, products and consumables.
- Funding body, program contacts or liaison officers.
- Medical experts.
- Allied health professionals, such as a physiotherapist or dietician.
- Owners of facilities you have used.
- Landlord of a property your organisation operates.
- Policy makers and advisors within government departments.
- Political parties and advocacy groups.
- Patrons.
- Government ministers and their support staff.
- Teachers, trainers and training bodies.
- Recruitment and employment agencies.
- Trusts and philanthropic bodies.
- Advocates and lobbyists.
- Client reference groups.
- Professional support and networking groups.
- Board members or steering committee members.

Industry structure and interrelationships between different organisations both public and private

The community services organisations exist on the national, state/territory and local levels. Some organisations are publicly funded and others are private businesses who may or may not operate with some public funding. Some organisations are not for profits or charities, how may function purely on private donations and or government funding. Other organisations are founded to serve a particular demographic or community whilst some specialise in a particular type of service provision. The wide range of organisations, structures and activities undertaken in the industry open up opportunities for organisations and individuals to work together on a range of activities.

Interrelationships can include;

- Creating policy
- Meeting needs
- Advocacy

Public organisations often work together to achieve outcomes and share information, resources, projects and people on a variety of levels.

Private organisations often work with others to expand the reach of their services and often do so in a more formal capacity.

Initiate relationships

Once you have created a database of current, thorough information about potential collaborators and networks, you can begin approaching them.

Learning how to initiate productive relationships involves understanding the structure of the industry and how organisations relate to each other. Community services work involves both public and private organisations, who work together to provide best practice supports and care. While your workplace will have established partnerships and relationships with other inter and intra-sectoral professionals and organisations, being pro-active about forming new relationships supports best practice standards and allows for evolving, flexible service provision and innovations in care.

'Intra-' means 'within', so intra-sectoral relationships are between you and your colleagues within the community services industry.

'Inter' means 'between' or 'among', so inter sectoral relationships involves collaboration with organisations, services and people outside of your specific field or the community services industry that have a common interest in supporting an individuals or organisation's needs.

Building relationships is about your ability to identify and initiate working relationships and to develop and maintain them in a way that is of mutual benefit to both yourself and the other party.

Work colleagues

- Ask colleagues to establish a shared database and brainstorm the contacts you have.
- Place database discussion on the agenda at staff meetings.
- Organise regular meetings.
- Strike up informal conversations, introduce yourself in common areas of work.

Former work colleagues

- Keep in touch with former colleagues and what they are doing.
- Form a support group of your own.
- Meet for coffee and a chat.

External customers

Seek feedback about your services and follow up to see what current needs they have

Suppliers of services, products and consumables

- Maintain a list of all services you have used.
- Keep brochures, business cards and product details.
- Contact the suppliers to determine products specifications, availability etc.

Funding body, program contacts or liaison officers

- Make formal contact to introduce yourself.
- Check their websites for information.
- Ask if you can meet up with them or invite them to see your services in action.

Medical experts

- Keep a record of any medical experts you have used.
- Check what research is being undertaken and note the details.
- Demonstrate interest and ask questions throughout collaboration.
- Organise time to meet one on one.
- Attend forum, discussions where medical experts are present or speakers.

Allied health professionals, such as a physiotherapist or dietician

- Attend professional networks.
- Explore opportunities to work with other health professionals.
- Consider inviting them to talk to you about their services at a staff meeting

Owners of facilities you have used

- Visit facilities and introduce yourself.
- Ask clients what facilities they have used and why. Record this information on a central database.

Landlord of a property your organisation operates

- Take part in reference groups and network groups for special housing- introduce yourself and ask what others do.

Policy makers and advisors within government departments

- Attend briefing or information sessions offered by funding bodies. Introduce yourself, give them your business card and if possible make a follow-up call.

Political parties and advocacy groups

- Collect details of the advocacy groups your clients have used.
- Undertake an Internet search.

Patrons

- Research who the patrons of your organisation are.
- Invite them to functions, such as the opening of new residential houses or employee award ceremonies.
- Send them an annual report and phone to make sure they received it.
- Research to see what other organisations they support and in what way.

Government ministers and their support staff

- Contact the Minister's office and ask for details of their support staff.
- Invite your Minister to any special events you have planned.

Teachers, trainers and training bodies

- Contact your local TAFE and ask for details to be sent out of the courses they run.
- View the TAFE course directory online.
- Ring and discuss professional development.
- Attend training expos and conferences and introduce yourself to the people there.

Recruitment and employment agencies

- Contact recruitment agencies and introduce yourself.
- Invite them to visit you to discuss your needs.

Trusts and philanthropic bodies

- Research the funds, then make contact and discuss any projects you have in mind.
- Take down the details of who you speak to.
- Ask for information to be sent out regarding their funding.

Advocates and lobbyists

- Search the Internet.
- Talk to clients to see what advocacy services they have used.
- Make contact and ask about their services.

Client reference groups

- Attend or chair client reference groups to get to know your clients.

Professional support and networking groups

- Join a support group.
- Offer to host a meeting.
- Take your business card along and introduce yourself to as many people as you can.

Board members or steering committee members

- Attend board meetings or annual general meetings to show your interest.
- Introduce yourself and explain what you do.
- Ask what special interests the board members have.
- Develop a rapport with them so you are known.

Once you have collected all the information about services, organisations and established the key people, the information should be regularly reviewed. Reviewing the information can assist you in ensuring that all information is complete, up to date, accessible to others in need, relevant to the organisations and client's needs. This will also assist you in determining where there might be gaps in information.

How to nurture professional networks;
http://www.businessinsider.com.au/10-tips-for-appreciating-your-network-contacts-2012-8?r=US&IR=T

Sharing information and resources

In order to provide accurate and timely information to other organisations, you must have a thorough knowledge of the services your organisation offers. You must also understand the nature of the services, the benefits and the costs associated with each service. All information must be current and if you are able, describe new services you are planning to provide, to gain interest for when the services commence.

To determine this information, you need to network with others in your organisation. Ensure you have access to all relevant written material such as brochures and price lists, which may be passed on to prospective clients. These must be current, error-free and in good condition.

It is beneficial to both parties to always communicate how services your organisation offers benefit prospective clients. This may entail explaining exactly what is involved in a way that your prospective client understands.

Information that other organisations may request depends on the nature of your organisation and the services provided. The following table provides examples of information inquiries your organisation may receive and possible reasons for the request.

Type of information	Reason requested
Details of services offered	The person is a prospective purchaser of services
Information packs	To learn about the services and have information to place on file
Cost list	Cost is a major factor when selecting services
Brochures and advertising material	To place on file and share with others
Business cards	For easy storage of contact information
Website details	For future contact and research
Annual reports	To assess the past performance of your organisation and to find out more about your organisation, its mission and values etc
Contact details of others within your organisation	To purchase services that are outside your expertise but available from a colleague
Professional expertise of staff members	To ensure the standard of services
Special events your organisation runs	To take part or attend
Details of projects your organisation has previously undertaken	To assess your past performance and contacts
Professional networks	For opportunities to meet and discuss options
Professional development/ conference opportunities that your organisation offers	To learn more about your field of expertise or for general professional development
Location of services	To match the location of services to client needs
Networking opportunities	To meet with you and get to know what you can offer
Other services your organisation is affiliated with	There may be other services that they can purchase
Organisation structure; for example, a company, not-for-profit organisation or government department	To determine the sort of organisation they are dealing with
Your organisation's needs and what services it may wish to purchase from their organisation	To sell services back to you

Sharing resources with other organisations

As a coordinator in the aged care industry, you should maintain and conserve resources, where possible, to ensure that through networking and cooperation you avoid expensive duplication of services and unnecessary competition between similar organisations. This in turn leads to better service to your clients and better financial management across the sector.

Rationalising resources, to ensure there is no duplication of services, has significant advantages.

The following table provides some examples of how to conserve resources and the associated benefits.

How to conserve resources	Benefits
Share a physical resource that is owned by another organisation but not used full-time; for example, a minibus. This may incur a small hire fee rather than the cost of purchasing a vehicle.	Helps keep within budgets By sharing resources, expertise, equipment and venue costs and expenditure is reduced across the industry
Your organisation doesn't offer a counselling service but you can offer one through your network contacts	For the client, a sharing of information and expertise among service providers means better links between services and a wider range of choices Service delivery is seamless
Use a contact who specialises in daytime recreational activities rather than creating your own similar programs.	Service providers working cooperatively results in less wasteful repetition of services
Share 'people' resources such as physiotherapists who can offer advice.	By combining information and expertise across organisations, it means a greater pool of advice available to each individual organisation A higher level of expertise is drawn upon

There are a number of different types of resources that can be shared including:

- Physical resources such as aids, equipment and facilities.
- People such as program coordinators or health professionals.
- Expertise such as in aged or disability care.
- Skills and knowledge.

All resources are valuable to a network; therefore, sharing resources often results in greater efficiency for all parties. Why resources are shared;

Resource	Why the resource can be shared	Example	How it helps client delivery
Aids	The aids your clients use are rarely in use full time. They may sit unused for much of the time.	Some organisations may establish a library of aids that can be hired out. This is suitable for a client with temporary or changing needs who only requires the aid for a short time. For example, clients with a progressive disability may require a manual wheelchair for a short time and then an electronic wheelchair.	Provides clients with faster and cheaper access to the aid they require
Equipment	Expensive equipment is seldom in use full time. Increasing the number of organisations that have access to a piece of equipment reduces the costly need of each company acquiring equipment.	Many organisations have equipment such as minibuses, high-low beds, and various lifting devices that are not in use full time.	Cheaper and immediate access to equipment
Venues	Most organisations have venues, training rooms, meeting rooms, respite accommodation or recreational facilities that are not in use full time.	Some organisations may only use training rooms and meeting rooms on certain days of the week, so they are available at other times including weekends and evenings. Other organisations may have respite accommodation which is not used at 100 per cent capacity.	More options are available in more locations
Training	Many organisations run the same training such as WHS or first aid. Where class numbers are small, groups may be combined.	Most organisations require certain training before employees commence work. If organisations pool this training they can run it more often and start new staff sooner.	Better trained staff available sooner
People	Support staff seldom work full time and are often looking for more work opportunities.	Support staff may work for several different organisations offering similar services. If these resources are shared between companies it can reduce cost of training etc.	More staff available to choose from
Expertise	Specialist services and expertise is required across the industry not just for one organisation	Specialist staff such as counsellors, case managers and other health professionals may provide services across various organisations	More specialised services available
Services	Many services are not fully used in any one organisation. Services, such as recreational activities, peer support or meals preparation may be shared.	If a recreation groups already exists in the region, clients from several different organisations may be encouraged to attend. A daytime meals program is an example where there is a cost saving by catering to a large number of people.	More services available to all

Debriefing	Health professionals, require the opportunity to debrief. This can be done with people from other organisations.	Case managers or counsellors who are the only such health professional in their organisation may debrief with a colleague from another organisation.	Opportunities for staff to debrief and improve the way they deliver services
Mentoring	Often it is best to have a mentor who is not in a management relationship with the person they are mentoring.	A mentoring program may be established across different organisations to share experience and knowledge.	Exchange of knowledge and experience

Issues to consider when sharing resources

There are many advantages in sharing resources; however, there are still logistical and cost issues that should be considered. These include:

- Service fees.
- Borrowers' registers.
- Intellectual property.
- Research and joint projects.

Service fees

A fee or cost structure should be established to ensure that your organisation runs efficiently within the budget. Fee-for-service arrangements must always be put in writing to avoid misunderstandings. This may be done by establishing a price list for the services offered and then invoicing clients on use. The fees may already be determined, or you may need to consult with your supervisor or the organisation's accountant.

Borrowers' registers

When sharing equipment or aids, a booking or timetabling system is usually required. Some organisations may establish a borrowers' register similar to a library system where equipment and aids are signed in and out. If any costs are involved, they should be agreed in writing and invoiced through the organisation's finance system

Intellectual property

Where resources are of an intellectual or knowledge-based nature, for example a brochure or a training guide, copyright and ownership must be observed. It is also necessary to ensure that company guidelines such as privacy and confidentiality are observed.

Research and joint projects

If the sharing of resources involves a joint project, subcontracting or research, terms of reference should be established to define the roles, responsibilities, relationship and the scope of the project. In the case of subcontracting, a formal agreement should be determined and signed by all parties.

It is important to consider these issues and establish appropriate procedures before the sharing of resources commences.

Maintain currency and accessibility of information

Once the organisation's database is established, information must be updated regularly to maintain its currency. Having out-of-date information may significantly reduce the benefits of being part of a network and may affect the efficiency of your organisation. Time and effort may also be wasted using information that is out of date.

The following table describes a range of reasons why you should update information and how you should do this.

Information	Reasons for updating information	What to do
Contact's detail	People in key positions may leave or their areas of responsibility may change. Contact details may change due to relocation or key contacts may be absent or on extended leave.	Existing and well-established relationships may need to be re-established with someone else when the previous person is promoted, relocated or goes on leave. Allocate responsibilities to new staff members to establish relationships.
Services	Services may change due to increased or decreased demand. Funding guidelines and legislation may change. Other changes may include changes to national standards, addresses and delivery methods and service delivery partnerships. New services may be introduced and new client groups may emerge. Infrequently used services may cease. Services may be improved due to client feedback.	Services may be put to public tender at each new funding cycle. You need to know who has been successful in each funding round and who now provides the services. For example, the Department of Veterans' Affairs and several local councils do this annually or biannually. Provide an avenue for all staff to be able to advise of any changes. Assign responsibility of ensuring services information is up to date and current.
Agencies	Agencies may be taken over or combined and new agencies may emerge. Agencies may relocate or new government departments may be created. New regulatory authorities may be created and new strategic directions may take place. Agencies may form new partnerships.	As part of its strategic planning cycle or half yearly review of data and information, an organisation may commit to contacting agencies and ensuring information is up to date. A dedicated staff member may be responsible for maintaining the data based with agency information and will update the information as new advice is provided.

Define and document collaboration and negotiation

Successful collaboration involves aligning yourself with other organisations that have aligned values and practices, have a clear understanding of challenges and limitations and have a positive communicative approach to relationships.
It is important to define the level of collaboration that is required. There are a variety of levels of collaboration which include;

- Collaboration – working with others to meet a specific need.
- Networking – sharing information, developing relationships, increasing profile or organisation and worker.
- Cooperation – supporting colleagues sharing resources both internally and externally.
- Partnership – aligning with another organisation to achieve set outcomes through negation of activities.

Given that collaboration and networking is both beneficial and crucial when ensuring service delivery success, it is crucial to define what objectives are, what you want to get out of it, how you are able to contribute and what you need from others.

Once the network or collaborative group is determined define your objectives and identify and define the objectives of other parties. Decide at the beginning on who will work on what, carefully establishing the purpose of the collaboration and delegate responsibilities.

Negotiation

Negotiation in community services can be required throughout many relationships and situations. For example;

- Clients entering into aged care homes.
- Entering into agreements with service providers.
- Partnering with external providers to achieve specific outcomes.
- Accessing services.
- Shifts to be worked.
- Allocating tasks and responsibilities throughout role.

Throughout many of these situations a process collaborative negotiation will take place. When approaching collaborative negotiation it is important to treat the relationship as an important and valuable element while seeking an equitable and fair agreement. You will aim at creating win win situations where both parties can feel they have gained something valuable and it is a fair process. Creating win lose situations takes the competitive approach to negotiation and is often less successful. Most people have a deep need for fairness and we can achieve this when everyone's needs are met fairly. When another person becomes competitive and is seen to try and take advantage of your collaborative approach, clearly explain your intent on creating and establishing a fair environment that enables win outcomes for the organisations and individuals.

i	For information relating to the skills needed for effective negotiation, visit; http://smallbusiness.chron.com/top-ten-effective-negotiation-skills-31534.html For further information on creating a constructive negotiation climate visit; http://changingminds.org/disciplines/negotiation/activities/constructive_climate.htm

Documenting collaboration

All collaboration decisions, actions and conversations need to be recorded. Recording these points will provide evidence of responsibilities, discussions, agreed decisions, negotiations held, collaborative partnerships details and plans of action.

Documents can be required for legal purposes so it is a good idea to ensure the information is clear, relevant and covers all crucial points.

Documenting collaboration can be in the form of;

- Case notes for client.
- Meeting minutes.
- Letters/email.
- Client records.
- Memos.
- Reports.

It is important to remember that for collaboration to be successful clear communication and defining of responsibilities and objectives are important activities and efficient documentation is vital to this process.

Element 3: Work collaboratively

As a support worker, you have the opportunity to share your skills and expertise with others and learn from other people's experience by working collaboratively. This topic explores some of the elements involved in working collaboratively in a productive, efficient and rewarding manner.

These include understanding how to use collaboration to meet your own goals, your organisation's goals and those of people with support needs. Additionally, you need to know how to plan and deliver excellent services arising from collaborated projects, and explore how to liaise with colleagues in collaborative projects

Identify opportunities

While some networking and collaborative activities serve the purpose of general support, connection and access, other collaborations are undertaken to serve particular purposes and to meet specific goals. To use networking and collaborative activities in a targeted way, begin by defining specific goals that could be met through collaboration. Defining your goals, the goals of the people with support needs that you work with and your organisation's goals allows you to identify specific opportunities where collaborations may assist in meeting or exceeding these goals.

Many relevant networking and collaborative opportunities arise from engaging with established networks in the community services industry. However, to be able to use these networks to meet specific goals, you need to understand the vision and purpose of these industry networks and recognise how you can participate in them.

Organisational goals & collaboration

Each organisation will have a vision or mission. In order to meet the organisation's goals, plans are made, targets and objectives are set and performance standards are determined. All staff should be involved in these processes and have a clear understanding of what they are and why they are necessary. People who are involved in planning processes are more likely to actively support goal achievement. People who are given information and understand how and why things are necessary are more likely to actively work efficiently and effectively. By providing information and including staff in the design and development of the processes with which they work, both the organisation and the staff will benefit.

Participating in network opportunities can assist you throughout contributing to the development of organisational goals, by sharing information learned and providing examples and information of how other organisations achieve or implement processes.

Individuals goals

The individual who you support relies heavily on your knowledge and ability along with the organisations ability to assist them in achieving their goals. Assisting individuals with setting goals involves collaboration with multiple parties; internal staff, families and carers, external health professionals and service providers. Throughout participation in networking activities your knowledge of available services and solutions to service needs can increased and broadened.

Personal goals

Professional development and job satisfaction are important goals to establish for yourself. You may become inspired to attend further education or apply for career development from attending and meeting individuals in networks.

With a clear idea of goals of key stakeholders who surround you, you can begin to give thought into what networks and collaborative opportunities will support the goals. There are a variety of networks that can assist you and the discovered goals which include established networks, such as; National disability services, at www.nds.org.au

When considering the opportunities to network or collaborate, it is a good idea to ask the following questions;

- Is this opportunity or network likely to support the achievement of my goals, or the organisation or support my client's goals?
- What do I intend or need to get out of participation? By participating in this collaboration or network will I gain the outcome that I need?
- Does the organisations values, mission and vision statements align to mine, the client and the organisations of where I work?
- From my research what has the collaboration or network achieved with other organisations?
- Do they seem innovative, helpful, person focused, informative?
- Is there any bad reviews or areas that are concerning which would question outcome of association?

Plan and integrate projects and service delivery

Working in collaboration can include working closely with others on special projects and delivering services to clients. As stated above many organisations can work closely together to meet the needs and goals of individuals and organisations.

In order to plan and implement integrated projects and service delivery firstly you need to determine what the goals and needs are, so you are able to identify which network suits the best and who is the best people to collaborate with in order to achieve the desired outcomes.

There are five steps you can take towards successful project management

Step One – Identify and define

- What are the goals?
- What is the need and desired outcome of the project?

Step Two – Create a plan

- Gather information.
- Invite all stakeholders to participate.
- What is the time frame?
- Who else needs to be involved.
- Responsibilities and accountabilities realised.

Step Three – Coordinate the project

- Allocate resources.
- Confirm with individuals who will perform certain functions and activities.
- Provide support, training.
- Monitor the resources.

Step Four – Monitor

- Is the networking beneficial and supporting meeting the needs and goals?
- Observe, monitor, listen, document.
- Communicate.
- Identify and act on issues.
- Provide any new information to all parties.

Step Five – Evaluation and Review

- Have the results been delivered?
- Has the project been a success or failure?
- Collaborate and reflect on the challenges and successes of the project, networks and collaboration.
- Document results and outcomes.
- Apply continuous improvement.

Liaise with staff from relevant organisations

Throughout your role, you will have many opportunities to communicate and collaborate with others from both within your organisation and with others from external organisations. Communicating effectively will increase the success of the relationship. Creating good relationships with staff from other organisations can be a slower process and will take time and commitment. Many of these interactions will occur over limited time frames due to many occasions of bringing people together are in more formal settings.

Informal and formal

Opportunities to promote your organisation may occur regularly in formal or informal settings.

Formal

Formal settings may include;

- Staff meetings.
- Board meetings.
- Arranged meeting and appointments.
- Regional meetings.
- Briefings.
- Networking groups.
- Seminars or conferences.
- Professional associations.
- Reference groups/steering committees.
- Community groups.

Staff meetings

You may have the opportunity to present information at a staff meeting of your peers. While these are internal rather than external contacts, it is still a valuable opportunity for you to present and promote the services that you are involved with. Don't assume that your colleagues have the knowledge that you do; use the opportunity to ensure their knowledge is up to date.

Board meetings

Some organisations have a board of directors, who provide direction and advice regarding the running of the organisation. It may be possible to make a formal presentation, about a project or service you have undertaken, to the board. This provides you with the opportunity to promote the services you are involved in to make board members and senior staff aware of them.

Arranged meeting and appointments

Often you may need to attend a formal meeting or appointment, such as a meeting with a person from a funding body. These meetings provide an excellent opportunity for you to promote your organisation and what it offers.

Regional meetings

In some parts of the aged care sector, there are regional meetings for service providers. These provide opportunities for you to present to other organisations what you can offer and how your organisation may benefit them.

Briefings

Funding groups and service providers often hold briefings about their programs. This provides an opportunity to present a formal case study of what you have achieved or to network more informally and promote your services that way.

Networking groups

Networking groups are designed specifically for the promotion of organisations and services and often have a guest presenter at each meeting. This provides a valuable opportunity to present to an audience that you know are interested.

Seminars or conferences

Seminars and conferences often have structured group sessions, which you may participate in. These opportunities allow you to introduce yourself and provide a brief overview of your organisation.

Professional associations

Professional associations often have regular meetings, for example breakfast meetings, which provide the opportunity to promote your organisation and its range of services to other health professionals.

Reference groups/steering committees

Some projects may be organised by a reference group or steering committee. You may be able to make a presentation to the group or committee to showcase what your organisation offers.

Community groups

Community groups or clubs, such as Probus or the Lions Club, often have guest speakers at their meetings, which provide the opportunity to inform them about your organisation and promote its services.

Informal

Opportunities for networking in informal settings include;

- Client visits.
- Seminars, conferences and trade fairs.
- Meetings with client's family members.
- Casual meetings with people from other organisations.
- Meeting suppliers.
- Casual meetings with people from other organisations.
- Dealings with funding bodies.
- Conversations with your own friends and family members.

Client visits

When you are working in the community with your client, you are promoting your organisation by example. What you say to others and how you provide services promotes the image of the organisation you work for.

Seminars, conferences, trade fairs

While a seminar, conference or trade fair is a formal event, there are numerous informal opportunities to meet people from the aged care industry. You should promote your organisation and exchange business cards during breaks in the program.

Meetings with clients' family members

Clients' family members may be interested in knowing more about the organisation and the services it offers. When talking to them, use this opportunity to represent the organisation in a positive way.

Casual meetings with people from other organisations

You may use casual meetings with colleagues from other organisations as an opportunity to talk about the services your organisation offers. This is not the time for a hard-sell approach, but rather to impart general information.

Conversations with suppliers

While talking to your suppliers about purchasing products or services, you create an impression of your own organisation. If you are courteous and professional in your dealings, it creates a positive opinion of your organisation.

Dealings with funding bodies

Each contact with your funding body is important, no matter how casual or informal. You must present a professional image in all communications, in both verbal and written form. Ensure that all requirements are met in an efficient and timely manner to promote a positive image.

Conversations with your own friends and family members

When you meet with your own friends and family, you may talk about your work and the organisation you work for. When doing so, you are representing the organisation. Remember, a positive report makes a positive impression. Ensure that organisational issues, which should not be made public, remain confidential. People won't trust you if they think you are unethical or disloyal.

Virtual

There are many advantages and some disadvantages to collaborating and working in groups virtually. Advantages include;

- Covering all areas: A group is able to divide and conquer and tackle large scale subjects.
- Sharing of information; When working together virtually, it is much easier for members of the group to share their information and sources because it is already on their computer.
- Working around schedules; Everyone in a group is not going to have the same schedule, therefore it is much easier to work around a schedule virtually, because everyone does not have to be working and communicating at the same time; emails and instant messages do not disappear into thin air after they are sent, they will be waiting patiently in someone's inbox.
- Transportation: In addition to not having to be working all at the same time, everyone does not have to be working in the same place. Group members do not have to worry about getting to wherever the group plans on working, because most members are able to work from their own house or workplace.

Disadvantages include;

- Motivation: Because group members do not have to physically gather together, they have to encourage themselves to do what is asked, instead of being pushed by their fellow group members. All members are faced up against their own work habits, which can be especially difficult for individuals in management positions.
- Communication inconvenience: Collaborating virtually does not allow for easy communication, only because you are not physically placed in a room together. Once again this means that students have to be self-motivated and reach out more to other group members, rather than just letting the situation take care of it automatically.

Element 4: Represent the organisation

Promote a positive image

All staff, particularly coordinators/supervisors act as ambassadors for their organisation, which may be judged on the way they represent the organisation and what they communicate directly and indirectly. Promoting a positive image increases the potential for others to want to network with you and use your organisation's services. It also boosts the morale and self-esteem of those who work within the organisation.

Positive image means:

- Always presenting the organisation to its best advantage by the way you present yourself, the behaviour you model and the things you say.
- Emphasising the organisation's achievements and the things it does well and is proud of.
- Not complaining in public about colleagues, workloads or other issues.
- Considering each contact as someone you want to encourage to do business with you in the future.

In order to promote a positive image, you must always be a professional and competent representative of your organisation. Provide an accurate account of the organisation, which conveys a sense of purpose, interest in others and a genuine belief in the organisation's positive aspects.

Not promoting yourself and your organisation may result in loss of business, fewer contacts and increased stress as you try to recommend your organisation to others.

You can promote a positive image by;

- Dressing appropriately and be well groomed.
- Display a cooperative and helpful demeaner.
- Being enthusiastic.
- Being prepare.
- Giving yourself time.
- Keeping a good stack of business cards with you.
- Providing others organisational information both through your own knowledge and hard copies of information they can take away.
- Ensuring that the material provided is of high quality.

Communication

In the aged care industry, good communication skills are essential because you will be communicating with a wide range of people in a number of different ways.

In order to network efficiently, you must fully understand your organisation's operational policies, procedures and practices. These define how the services your organisation offers are delivered and outline the responsibilities and requirements of all parties when entering into a working relationship.

Communicating policies and procedures

Communicating policies, procedures and practices therefore enables other organisations to understand the services you offer and the requirements of your organisation.

Your organisation's policies are the rules for the organisation, its employees and its clients, which explain the way services should be provided. Policies explain:

- What the organisation must do to conduct business responsibly.
- What employees should and shouldn't do when delivering services.
- Client's rights and responsibilities.

All organisations in the aged care sector are obliged to comply with legislation. You don't need to know the details of various legislation. However, you should know what it means and how the organisation you work for meets its legal obligations. Legislation relating to aged care covers:

- Occupational Health and Safety (WHS)
- Freedom of Information (FOI)
- Privacy and Confidentiality.
- Equal Employment Opportunity (EEO)
- Disability Discrimination.
- Guardianship.
- Medical records.
- Public health.
- Access and equity.
- Standards in Residential Care.
- Home and Community Care (HACC) Service Standards.
- Disability Service Standards.

Communicating practices and implications

Every organisation has work practices or instructions that individuals must follow to meet the organisation's policies and procedures. Many of these practices may have implications for your clients and other organisations you deal with.

Practices	Implications
Every client must undergo an individual assessment	All clients should be assessed before services can be rostered for them; this means a representative visits the client in their home or residence
Clients in their own homes must provide their own cleaning products and equipment	Clients must acquire suitable cleaning products for cleaning services to commence. Support workers should not use unsuitable products, like bleach, even upon client request.
Three days' warning is needed for change of service times	The organisation or service is unable to reschedule at short notice.
Clients must sign support workers' time sheets	Clients should agree with the hours that they are billed for.
All staff should attend three days' training before they commence work	Staff must be adequately trained and shouldn't commence employment without training to ensure clients receive the correct care.
All clients should be given information about the complaints process	Clients' complaints are listened to and valued and dealt with appropriately
All incidents reported should be investigated	If an incident occurs, clients and family members may be interviewed.
Support worker should use their own cars to take clients shopping	The quality and availability of transport may vary.
Support workers may shop for clients but should not withdraw money for them	Clients must make arrangements to have finances available when shopping.
Support workers must provide a current police check and first-aid certificate before they commence working with a client	Clients receive correct and safe care.
All quotes for services must be in writing	Verbal quotes are not accepted
Residents of residential houses may be involved in staff recruitment	Clients have a say in assessing support staff's suitability

Communicating issues

In addition to communicating policies and practices, issues may occur that are specific to your organisation, which need to be communicated to others, depending on the audience or forum. The following table lists some examples of issues that may occur and their implications.

Issues	Implications
Your organisation may only be able to offer certain services in metropolitan areas and not in regional areas	Regional clients are not being catered for.
Staff retention is an issue in the aged care industry as pay is often low and there are not a lot of hours available	You may not be able to guarantee that a support worker can stay with a client long term.
Staff from diverse backgrounds are not employed in order to meet different cultural and language needs	Clients from diverse backgrounds are not catered for.
Increased petrol costs affect the cost of providing service	In regional areas petrol costs make it difficult to provide affordable support outside town areas.
You have just won a tender to take over services in a certain area within a short time frame	As the new service provider, you should work with the former provider to ensure a smooth transition to the new services.
Your company has an EEO exemption for personal care	Clients have the right to choose the gender of the support worker who showers them.
Your organisation lacks experience looking after clients with dementia	Dementia clients are not catered for.
Your organisation has gone through a restructure and offered redundancies	Contacts and personnel have changed.
Your organisation provides services to other key organisations in the sector	Organisations may perceive a conflict of interest if you work with their competition
Your organisation is owned by a religious order and you must uphold its principles	Attitudes towards certain issues like euthanasia, stem cell research or sexual practices may be predetermined. Find out whether these values apply to your organisation

Once you understand your organisation's policies, work practices and issues, it is important that you are able to communicate this information clearly and promptly to the people and organisations you deal with. This information may be communicated verbally, in writing or often a combination of the two.

Coordinators in the aged care industry must be able to communicate information to a range of people and organisations with different needs, including:

- Internal clients.
- External clients.
- Professional networks.
- Funding bodies.
- Political groups.
- Community groups and associations.

The appropriate means of communication depends on the audience you are communicating with and the information you are communicating. It also depends on the relationship you have with the other party; for example, whether it is formal or informal. In many cases, the communication method may be determined by a work instruction. For example, you may be required to report electronically to a funding body or present regular face-to-face briefings to staff.

The following table details various communication methods.

Who you communicate with	Example of information regarding a policy, practice or issue to be communicated	Possible communication method/s
Internal clients	Policies and practices regarding the purchase and supply of goods, including the need for all suppliers to be on a preferred suppliers list. For example, you may need to explain to the finance department why a certain supplier or product is chosen.	This information is best kept in a policy and procedures manual and a set of work practices located on a shared database or in hard copy A brief presentation at a staff meeting. A telephone conversation followed up by an email.
External clients	External clients receiving direct care require information about WHS requirements, what products they must supply for cleaning and the need for infection control procedures. External clients in regional areas may require information about what services are available in their area and any issues regarding travel and petrol costs.	A discussion with the client at the initial meeting and then providing it in writing for their reference at a later date Details of the services you provide may be communicated in an information pack and then followed up with a discussion This information may also be posted on a website
Professional networks	Professional networks require information about policies that may affect service provision and any specific issues that may distinguish your organisation from other service providers. For example, your organisation may have staff experienced in providing services to people from Aboriginal or Torres Strait Islander backgrounds.	A formal presentation at a meeting with associated written information A telephone conversation may also provide a means of checking details
Funding bodies	Information regarding performance guidelines and if your organisation is meeting targets Information about work practice and polices that relate directly to their funding provisions	Formal reporting procedures should be followed - usually in writing and submitted electronically Regular phone contact may be used to establish a more personal relationship
Political groups	Political parties are likely to be interested in achievements and issues such as if there are any gaps in government policy and whether current practices are working; for example, an issue may relate to a specific group of clients whose needs are not being met systemically.	Formal written communication Conversations to invite people to discuss or experience firsthand any problems or issues
Community groups and associations	Information about current work practices and issues; for example, community-based, regional and local issues. What services your organisation offers in the community and how they are offered.	Written communication to a local paper or editorial content for local media A presentation at local community clubs or associations At an open day where people are invited to see what you do first hand

Each industry has unique protocols and characteristics for networking and it is essential that coordinators understand those of the aged care sector and of their own particular area. Networks/networking is the process of using one contact to gain others.

Confidentiality

As the aged care industry is client based, confidentiality is of paramount importance. Although you have a need to share information in the interests of the industry, you also have the responsibility to preserve the privacy and confidentiality of your clients.

Within your client group, there may be people who have been diagnosed with chronic or terminal conditions. You may have clients who suffer from debilitating conditions, for example dementia, where they struggle to preserve their dignity. Clients may also have conditions such as HIV that may be stigmatised within the broader community. The sensitivity of these details must be respected, and you must protect these clients' personal information for both legal and ethical reasons.

Privacy laws

The Privacy Act 1988 directs how individuals and organisations deal with personal information. Organisations are to provide information to both clients and networks that outlines their commitment to adhering to privacy laws and that this is demonstrated throughout internal policies and actions.

Review the privacy act by visiting;
https://www.legislation.gov.au/Details/C2016C00979

Confidentiality and disclosure

Maintaining confidentiality means not disclosing personal / private details of individuals, without their permission, to parties outside the situation concerned. As well as being illegal for an organisation to disclose someone's personal details to a third party, client confidentiality is the key and common element to all professional codes of conduct. However, there are some contexts when personal confidences must be disclosed for reasons of legal obligation, child protection or health and safety, certain assaults, when a person is a danger to themselves or others or where this is consent from the older person. In such contexts, it is important to follow organisational policies / procedures and to ask for advice and guidance from senior colleagues or appropriate specialist advisers, if uncertain.

Being sure of confidentiality is vital to create trust within a relationship and while trust is a major component within any successful relationship, it is absolutely fundamental within a context that involves any element of personal risk, especially with vulnerable individuals.

For an example of privacy, confidentiality and disclosure in practice view Bupa's privacy and security policy at;
https://www.bupaagedcare.com.au/privacy-and-security

Element 5: Maintain and enhance networks and collaborative partnerships

Maintain networks

It is to your advantage to foster networks and collaborative partnerships to ensure the networks are as effective as possible.

An effective network is one you can readily utilise and feel free to contribute to when the need arises. Network members are committed to cooperation and trust; they believe in sharing skills and knowledge to better service the industry.

Key principles of an effective network are:

- Share and do not withhold information.
- Share resources and expertise.
- Communicate regularly.
- Be committed to working together.
- Be committed to remain in contact.

In addition to these principles network members should demonstrate:

- Trust and honesty.
- Good communication skills.
- A preparedness to engage in critical debate.
- An ability to accept and give advice.
- An ability to declare any conflict of interest.
- Respect.
- Confidentiality.
- An ethical approach.
- It is important to remember never to use a network for business advantage at the expense of network relationships.

Identify benefits

There are many advantages of networking and building good work relationships. The following table lists purposes and advantages of networking.

Purpose of networking	Advantage	Example
To be able to call on help when it is required	A network provides a larger group of people to draw on for help, support and advice	You may contact a member of your network to ask if they are able to assist with sharing equipment and transport, etc
To promote partnerships instead of competition	Partnerships increase market share without undercutting each other for contracts and tenders	When a new tender is made for services, you may tender as a partnership, working together instead of in competition with each other
To share current information	Shared responsibility for keeping abreast of new information	Your network may decide that one person should go to a funding briefing and then report back to the whole network
To promote best practice	Allows honest comparison of service standards	You may benchmark against others in your network to establish best practice
To share resources	Reduces spending and increases utilisation of resources	Venues, equipment and even training may be shared to save money
To share specialist services	Provides a broader range of specialist services across agencies	One organisation may have counselling services while another may provide a case management service; by networking you may be able to share both specialist services
To increase market access and exposure	Partnerships increase market share and profile	By working together, organisations may provide information about each other's services to prospective clients
Provide a one-stop shop approach	Easier for clients to access a full range of services	Where your organisation is unable to meet all of a client's needs, you may be able to by working in partnership with others in your network; for example, clients may access an organisation that provides a respite facility

There are numerous benefits of networking with both clients and organisations, as detailed in the following information.

Benefits for clients

All in one

Clients may utilise one organisation, which is then able to put them in touch with other organisations to meet any additional needs. For example, a person receiving home care may also want some gardening work done or a client may need to go into respite, while their partner receives home support. Through your network, you can put them in touch with organisations providing all the services they require.

Choice

Networking provides clients with a larger choice of services. For example, in regional areas, networking may allow people to choose between low-level residential care or home support in their region.

Person Centred

Individual, person-centred planning requires coordinators to identify a variety of services that meet individual clients' range of needs. For example, one client's specific needs may be that they require an advocate to lobby for them and also home care and Meals on Wheels. Networking gives coordinators access to a wider range of services to meet these individual needs.

Coordination of services

As a result of networking, the service providers within the network are able to coordinate their services. For example, personal care may be timetabled to fit in with community transport to a local club.

Transition as needs change

As a client's condition changes, they may need to move from home care to residential care. Alternatively, people coming out of hospital may require home services in place for when they return home. Networking provides options for these changing needs

Cheaper options

By sharing venues and equipment through networking, the cost of services may decrease. For example, a client temporarily needing a wheelchair may be able to borrow one from an organisation that has an equipment library.

More flexible services

Working with a network provides more flexibility in services. For example, a client going on holiday may require personal care when they are away, and a network may provide them with options to achieve this

More accessible information

Organisations in a network are able to provide more information to clients about the range of options that are available in the community. For example, people receiving home care may not know about respite opportunities or people may be assessed as eligible for services but not know where to purchase them

Benefits for the organisation

The benefits of networking also extend to the service providers (organisations) and are especially apparent when maximising the resources available.

Cost efficiencies

Sharing resources, venues and equipment results in less capital purchases for each organisation in the network, as organisations may lend resources such as minibuses, hoists, specialist staff, etc.

Benchmarking

Coordinators may use their network to benchmark aspects of service such as the caseload a coordinator can manage, to see how they compare with other services, so improvements or changes may be made.

Best practice

Networking allows coordinators to share examples of best practice and duplicate ideas that have worked. For example, one organisation trained people who delivered Meals on Wheels to also monitor clients' welfare by observing any decline in their condition. This procedure worked successfully so it was implemented by other organisations in the network.

Industry standards

Networking allows coordinators to have an industry perspective when implementing industry-standards into work practice. Organisations may share policy and work instructions that have been developed to best meet industry standards.

Debriefing

Networking provides coordinators the opportunity for debriefing outside of their own organisation. This allows coordinators to get together with other workers to discuss issues they have with clients or practices and to seek assistance to resolve these issues.

Lobbying

Lobbying the government is more effective when undertaken by groups of service providers, like those in a network. For example, a group of service providers may highlight the issue of younger people living in nursing homes.

Community profile

Partnerships created through networking may create a profile for the industry in the community and increase people's awareness of the services your organisation provides. For example, a group of service providers in a region may organise an expo to promote all their services and raise their profile.

Marketing

Marketing together as a network, rather than separately or in competition with each other, is more cost effective. For example, a group of services may advertise the range of services or options they offer to make them more attractive to prospective clients.

Fundraising

Fundraising jointly and working together, rather than competing for funds, allows more funds to be raised, which may be shared across the network

Benefits for the worker

The workers can benefit from networking and collaboration through increased opportunity for both personal and professional development along with providing an opportunity to share information and strengthen relationships.

Networking can also provide an opportunity for you become known in the industry, raise your profile and assist in career growth. Expanding your contacts can open doors to new opportunities for business, career advancement, personal growth, or simply new knowledge. Active networking helps to keep you top of mind when opportunities such as job openings arise and increases your likelihood of receiving introductions to potentially relevant people or even a referral.

Fresh ideas

Your network can be an excellent source of new perspectives and ideas to help you in your role. Exchanging information on challenges, experiences and goals is a key benefit of networking because it allows you to gain new insights that you may not have otherwise thought of. Similarly, offering helpful ideas to a contact is an excellent way to build your reputation as an innovative thinker.

New information

Networking is a great opportunity to exchange best practice knowledge, learn about the business techniques of your peers and stay abreast of the latest industry developments. A wide network of informed, interconnected contacts means broader access to new and valuable information.

Advice and support

Gaining the advice of experienced peers is an important benefit of networking. Discussing common challenges and opportunities opens the door to valuable suggestions and guidance. Offering genuine assistance to your contacts also sets a strong foundation for receiving support in return when you need it.

Maintain networks and collaborative partnerships

Once you have developed successful networks and collaborative partnerships it is important to maintain the relationships.

The following outlines tips to maintain strong relationships and networks;

1. Stay visible & relevant.
2. Stay in touch.
3. Refer clients and others.
4. Identify the resources you need to support the group or partnership.
5. Schedule catch ups and communication.
6. Share information regularly.

Maintaining networks and collaborative partnerships requires commitment from all parties. The following table provide an overview of what is considered effective networkers and ineffective networkers.

Effective networkers	Ineffective networkers
Keep in touch regularly	Contact people only when they need something
Are committed to sharing information	Are focussed only on collecting information and extending their knowledge through others
Apply a giving approach	Are only interested in what they can get out of the relationship
Are respectful	Are disrespectful and not considerate of others time
Take their time in building relationships	Do not place importance on longevity of relationships

Monitor benefits to worker, organisation and client group

For the majority of situations that involve, collaboration and networking in aged care, there are significant outcomes required to be achieved and the success of the activities are vastly important and benefit a specific individual.

Participating in networking and collaborating with others also takes time and effort. In a lot of cases the time to participate in these activities is outside of normal work hours or taking individuals away from their work without someone completing their work in the meantime.

With these two points in mind, it is fair to say that monitoring the outcomes achieved from networking and collaborating is a valuable process.

Schedule time to regularly evaluate the network, group, partnership to ensure that this is a beneficial activity and partnership.

You may need to reflect on how this partnership or network is benefiting both yourself and the organisation. This will ensure that you are spending the time on an activity that will provide you or your organisation with some advantage.

Reflective questions may include;

- Is this network or partnership providing positive outcomes for individuals and the business?
- Have I or the organisation benefited directly from this network?
- Could another network or partnership provide more benefits?
- Is this network or collaboration meeting a specific need?
- Am I able to contribute effectively?

Examples of ineffective and effective networks are listed in the below table:

Effective networks	Ineffective networks
Have a clear purpose	Has no clear purpose
Encourages communication	Has a listen and not talk or contribute approach
Are informative	Does not have strong vision
Set in convenient locations and time frames	Has unachievable goals
Are not time wasters	Hold irregular meetings and activities
Encourage input	Has poor attendance
Is constructive in its process	Is unable to achieve set goals

Evaluate strengths and weaknesses of collaborations

There are many areas where collaboration is required within aged care. Collaboration can provide great advantages to all parties, however collaboration can cause disadvantages when unsuccessful. When evaluating collaborations, the aim is to assess these relationships and processes and how they facilitate both the collaboration and its outcomes.

The effectiveness of a collaboration is not simply seen in tradition outcomes, as any successful collaboration is reliant upon a range of relational or non-traditional performance measures to assess;

- The relationships and processes that enable collaboration.
- The level of participation and engagement of collaboration members.
- How well the structure of the collaboration allows participants to contribute.

Advantages and strengths of collaboration include;

- Provides opportunity for giving and receiving for both parties, whether its access to skills and resources or just working towards a common goal/aim/outcome.
- Both organisations will have a broader reach.
- Access to new skills can be gained.
- Opportunity to widen networks.
- Favourable to government funding bodies.
- Collaboration leads to ongoing relationships.

Disadvantages and weaknesses of collaboration can include;

- Partnering with companies that do not carry the same values can be detrimental (i.e. information shared in confidence and used it for competitive advantage).
- Restricted to making fast decisions, may not be agreed on by other members in the collaboration.
- Individual agendas overshadowing common goals and outcomes.

When evaluating the effectiveness of collaboration, the question is not so much whether by working through them participants are able to do a better job of delivering services. Instead, it is whether by working through collaboration participants can build the new capacities and relationships needed to work in different ways.

The development of a shared vision and values between collaborating organisations, have been highlighted as crucial to successful collaboration.

A successful collaboration or partnership also needs to be approached systematically. Without clear goals and careful planning, collaborating organisations risk misunderstandings, disagreements or other problems arising.

Improve networks and partnerships

There are many different strategies that can be employed to maintain and improve networks and collaborative partnerships.

For example;

- Feedback – Collecting feedback will help all parties determine where the relationship is successful and positive and identify the areas that are not as successful or lacking.
- Surveys - Using qualitative and quantitative data to determine patterns, gaps and trends in past and current relationships.
- Research – Conducting research on what other network opportunities are available and benefits of participating in these, competitors and reviewing what network and partnering opportunities they have entered in to.
- Opportunity and recognition – providing staff with the opportunity to participate in collaboration and networks and providing rewards and recognition for the participation.

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