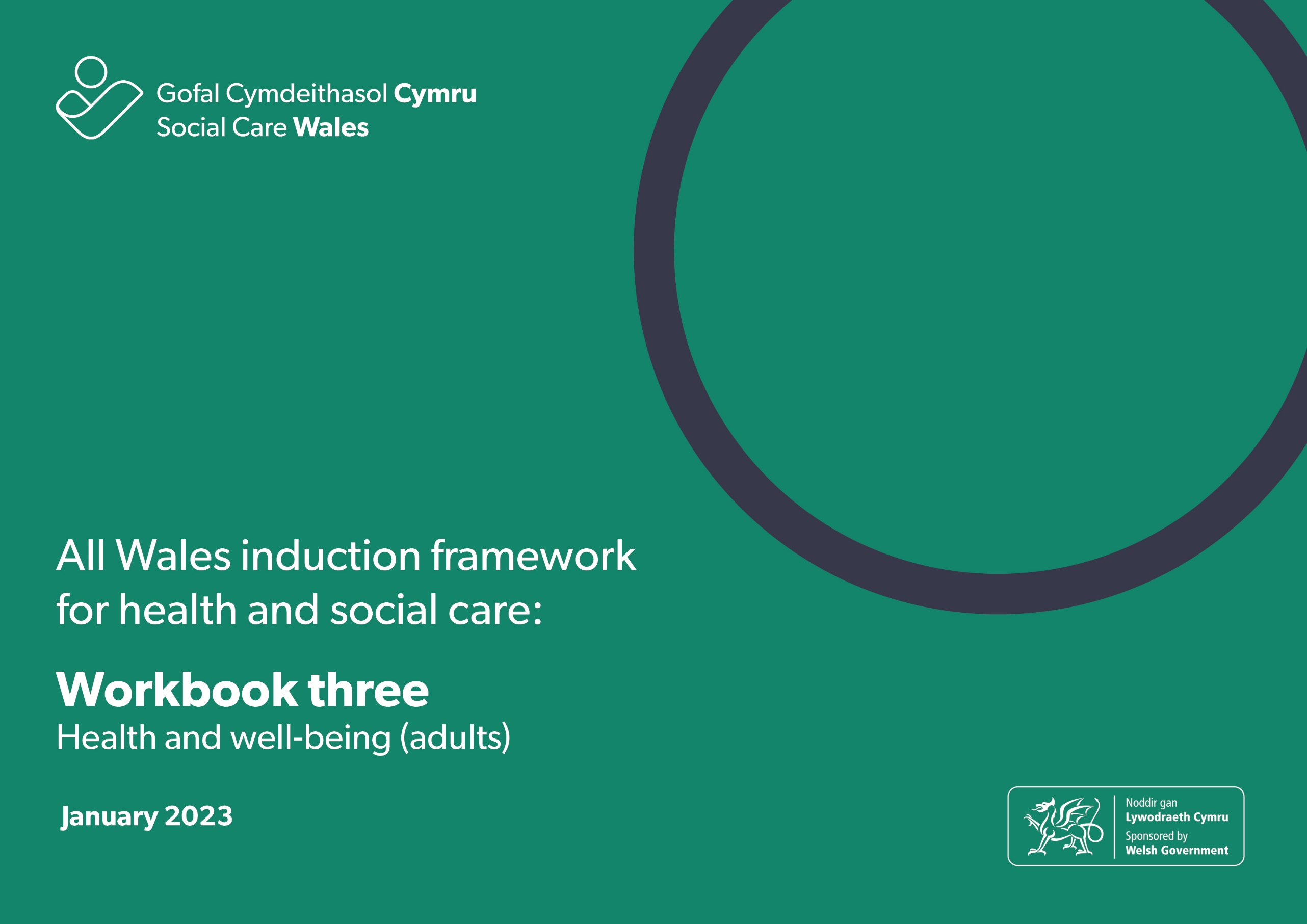
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# All Wales induction framework for health and social care workbook 3: Health and well-being (adults)

This workbook will help you explore the relationship between your role in promoting health and well-being in the care and support provided to individuals. The workbook can either be downloaded and completed electronically or printed and completed by hand.

You can also use the completed workbook activities:

* towards achieving the *All Wales induction framework for health and social care* (Induction framework)
* to help you get ready to complete the core qualification for health and social care
* as evidence towards your practice qualification.

Some words are highlighted in **bold** in the progress logs. There’s a glossary at the end of this workbook if you want help to know what these mean.

Throughout the workbook we refer to ‘health and social care workers’. This means the person providing care and support or services to individuals.

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## 3.1 Well-being

Well-being is central to the Social Services and Well-being (Wales) 2014 Act. If you’ve completed *Workbook 1: Principles and values of health and social care*, you will have started to think about what this means in your work. This section will help you explore your understanding a bit more.

Everyone’s entitled to well-being and everyone has a responsibility for their own well-being, but some people need extra help to achieve this.

Well-being is about more than just being healthy. It can also include:

* + being safe
  + having somewhere suitable to live
  + being involved in decisions that impact your life
  + having friends
  + being part of good, strong communities
  + having every chance to do well in education
  + feeling good about your life
  + for adults – being able to work
  + for children – being able to grow up happily and successfully, and being well-looked after.

Welsh Government has developed a national outcomes framework[[1]](#footnote-2) that it has co-produced with individuals and carers. The framework includes a ‘well-being statement’.

The statement builds on the Act’s definition of well-being in relation to eight aspects of a person’s life:

* physical and mental health and emotional well-being
* protection from abuse and neglect
* education, training and recreation
* domestic, family and personal relationships
* contribution made to society
* securing rights and entitlements
* social and economic well-being
* suitability of living accommodation.

National well-being outcomes for individuals and carers have been developed for each of the eight aspects of well-being. Some outcomes describe the responsibilities that people must carry out themselves to help them achieve their own well-being.

The following information from the framework shows the definition of “what well-being means”, from the Act and the national well-being outcomes.

**Securing rights and entitlements**

Also for adults: control over day-to-day life

* I know and understand what care, support and opportunities are available and use these to help

me achieve my well-being

* I can access the right information, when I need it, in the way I want it and use this to manage and improve my well-being
* I’m treated with dignity and respect, and treat others the same
* my voice is heard and listened to
* my individual circumstances are considered
* I speak for myself and contribute to the decisions that affect my life, or I have someone who can do it for me.

**Physical and mental health and emotional well-being**

Also for children: physical, intellectual, emotional, social and behavioural development

* I’m healthy and active and do things to keep myself healthy
* I’m happy and do the things that make me happy
* I get the right care and support, as early as possible.

**Protection from abuse and neglect**

* I’m safe and protected from abuse and neglect
* I’m supported to protect the people that matter to me from abuse and neglect
* I’m informed about how to make my concerns known.

**Education, training and recreation**

* I can learn and develop to my full potential
* I do the things that matter to me.

**Domestic, family and personal relationships**

* I belong
* I contribute to and enjoy safe and healthy relationships.

**Contribution made to society**

* I engage and make a contribution to my community
* I feel valued in society.

**Social and economic well-being**

Also for adults: participation in work

* I contribute towards my social life and can be with the people that I choose
* I don’t live in poverty
* I’m supported to work
* I get the help I need to grow up and be independent
* I get care and support through the Welsh language if I want it.

**Suitability of living accommodation**

* I live in a home that best supports me to achieve my well-being.

**Learning activity – well-being**

There are many things or factors that can have a positive or negative affect on our sense of well-being. Using the table from the framework that shows what well-being means, find one thing that has a negative effect on an individual you support and one that has a positive effect. Make some notes here:

|  |
| --- |
|  |

Working in ways that put the individual at the centre of their care and support and focus on helping them achieve ‘what matters’ to them is key to your role in supporting their well-being.

**Learning activity – well-being**

Read this case study and answer the questions.

**Case study – Gwyneth**

Gwyneth is 80 years old. Her husband died a few years ago and her daughter lives in England. Gwyneth has always been very active in her local community, helping out in the local church lunch club and singing in a choir. She’s been going to a computer class in the village hall and has learned how to use social media, which has helped her keep in touch with her family.

Gwyneth recently had a nasty fall, breaking her arm and leg. She was discharged from hospital to a residential care home for rehabilitation before going home but her recovery has been slowed down by an infection in her leg.

She has become very low in mood. She doesn’t want to get dressed or leave her bedroom and has little appetite. She isn’t doing the exercises the physiotherapist has set for her.

Her daughter has been keeping in touch by telephone and is worried about her mother.

Answer these questions:

|  |
| --- |
| 1. What do you think is affecting Gwyneth’s well-being? 2. What could improve this? 3. How could you work with Gwyneth to support and promote her well-being? 4. Who else could help? 5. Which section of the [Code of Professional Practice](https://socialcare.wales/cms_assets/file-uploads/Code-of-Professional-Practice-for-Social-Care-web-version.pdf) relates to well-being? |

**Manager’s comments for section 3.1**

|  |
| --- |
|  |

**Progress log – to be completed by the manager**

**3.1 Well-being**

**What well-being means in the context of health and social care**

|  |  |
| --- | --- |
| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| What is meant by the term ‘well-being’ and why this is important |  |
| Factors that affect the well-being of **individuals** and **carers** |  |
| The importance of families, friends and community networks on the well-being of individuals and carers |  |
| Ways of working that support well-being |  |

## 3.2 Factors that impact upon health and well-being

In this section, you’ll show your understanding of the factors that affect individuals’ health, well-being and development.

**Human growth and development**

Knowledge of human growth and development is important because it will help you understand individuals’ needs at different stages in their lives. You should be aware of the factors that can have a positive or negative effect on an individual’s development and how this links to their health and well-being. This workbook will give you an introduction to this topic.

Human growth and development will vary depending on the individual’s life stage. The life stages are broadly described as:

* infancy: from birth to two years
* childhood: three to 12 years
* adolescence: 13 to 19 years
* young adulthood: 19 to 40 years
* middle adulthood: 40 to 65 years
* later adulthood: 65 years and over.

Human growth and development relate to our skills, abilities and emotions. All areas of development are equally important and have an impact on one another. Human development is holistic, with many things happening at the same time. To understand this, we’re going to look at something referred to as ‘PIES’ across the life stages:

* **P – physical development**
* **I – intellectual development**
* **E – emotional development**
* **S – social development**

The transition of a child to an adolescent, then to an adult, goes along with a lot of changes in their personal, physical, emotional and social areas. Coping with these changes can be a strain as not everything can be taught and many things are learned through experience. It’s only when we experience social situations that we can build our way of responding to them.

There are theories about the stages of social development in adulthood. Erik Erikson, a well-known psychologist, put forward the ‘psychosocial theory of development’. According to Erikson, there are stages of social development a person goes through in their transition from an adolescent to a young adult, a middle-aged adult, then an older adult. We have used Erikson’s theory to describe social development through the life stages, but this theory is generic and each individual may have different experiences in childhood that will mark their journey into, and experiences of, social development into adulthood. The process of social development is different for everyone and depends on their personal experiences.

**Infancy: from birth to two years**

* **Physical** – from birth to age two, physical growth and brain development are rapid. Motor skills are developed, with the infant using muscles to sit up, stand and walk
* **Intellectual** – infants learn by doing, that is, looking, hearing, touching grasping and sucking, and they will start to interact with their environment on purpose
* **Emotional** – the infant will start to bond with the people who care for them, such as their mum and dad. They will try to develop a sense of being nurtured and loved. They will need to form a strong attachment to their main care giver as this will help give them a sense of security now and through all their life stages
* **Social** – at this age the infant will be learning how to play with other children and will start recognising faces and names. They will also try to start sharing things with others.

**Bonding and attachment**

Before we look at the other life stages, we’re going to explore bonding and attachment, as this has a significant impact on how we develop throughout our life.

Bonding is the intense attachment that develops between parents and their baby. It makes parents want to shower their baby with love and affection, and to protect and care for their little one. It’s a parent’s feeling of unconditional love for their newborn child. For some parents it can happen straight away, while for others it can take some time to feel that bond. Post-natal depression can affect how a mother bonds with her baby. Experts say that early bonding between a parent and baby affects the baby’s response to stress, their learning behaviours and their social skills.

Attachment is the emotional bond that’s formed between infants, young children and their main caregiver. A baby’s attachment to its main caregiver begins immediately after birth as it responds to the love and attention it receives. Babies need warmth, cuddles, play, rest and food to build an emotionally strong attachment, which will benefit them in later life. Attachments are key to an infant or child’s emotional well-being.

In early infancy, infants form one primary attachment. This is important as secure attachment provides a baby with the best foundation for life – an eagerness to learn, a healthy self-awareness, trust and consideration for others. An insecure attachment fails to meet an infant’s need for safety and understanding, and can lead to confusion about their own identity and difficulties in learning and relating to others in later life.

If an infant has formed a strong attachment, they will be secure in the knowledge they have a safe haven to return to in times of distress. This helps with the development of trusting relationships later in life.

Studies suggest that children need to feel deeply attached to their parents to grow into successful independent adults. If children feel they can rely on their parents for love and support if things go wrong, they are more likely to develop a positive self-concept, have good self-esteem and feel confident trying new things for themselves as a child and later in life as an adult.

**Self-concept, self-esteem and self-confidence**

So, what do we mean by the terms self-concept, self-esteem, and self-confidence?

Self-concept is how we think of ourselves based on our feelings, experiences and what we learn from others about ourselves. It’s our understanding of who we are and includes our own beliefs about our personality, character and values.

Self-concept can be positive or negative. It changes the way we behave and has an impact on our self-esteem.

Self-esteem is how much we value ourselves. It includes how we feel about ourselves and is our opinion about things such as:

* what kind of person we are
* how successful we think we are
* the status we have, for example, our job or role such as a parent or homeowner
* how we think others see us
* how much we think we deserve to be loved.

So, self-concept is the thoughts that make up the mental image or the idea we have of who we are, and self-esteem is about the thoughts and opinion we have about ourselves, for example:

* self-concept –I’m good at my job because I’m a good communicator, or I’m not good at my job because I’m not good at communicating
* self-esteem – I deserve a good job because I’m very experienced, or I don’t deserve such a good job as I don’t feel experienced enough.

Self-confidence is our belief in our ability to succeed at something. So self-concept tells us who we are, self-esteem is a judgement we make about our value in the world and self-confidence is purely the belief that we can succeed.

The humanist psychologist Carl Rogers believed that the earliest roots for the difference between the way we see ourselves and reality stem from our childhood. This is particularly true for children who are brought up with the idea they have to earn affection from their parents. Children then begin to associate memories, which make them feel unloved and not good enough, and this can often carry on into adulthood.

People who haven’t formed a strong attachment during childhood often go on to have a negative self-concept, low self-esteem and lack confidence as adults.

**Childhood: three to 12 years**

* **Physical** – by the age of five children can start to walk up the stairs without help and hold a crayon or pencil to draw and write. By the age of eight, children can throw and catch, and develop a good sense of balance
* **Intellectual** – children go through a lot of learning between the ages of three and 12. Communication and language skills improve, they develop an understanding of time, learn to read and use reasoning from knowledge to form opinions. They will also watch the behaviour of others around them
* **Emotional** – from the age of three, children start to learn how to control their emotions, but they will test limits and boundaries. They will start to show and express emotions, such as love or anger, and express their feelings through words
* **Social** – children become more interested in friendships. They will lead imaginative play and ask lots of questions. They will also play co-operatively and take turns.

**Adolescence: 13 to 19 years**

* **Physical** – hormones cause the body to change shape as young people go through puberty. By 18, the human body has reached its full height and physical abilities are at their peak, including muscle strength, fine motor skills, reaction time, sensory abilities, cardiac functioning and sexual response
* **Intellectual** – adolescents start thinking for themselves and using a logical way to solve problems. They will form new ideas and questions, and consider many points of view
* **Emotional** – many experience mood swings, frustration, insecurities and confusion. This is a time when sexuality is explored
* **Social** – the transition from a child to an adolescent is defined by the search for one’s own identity, and the perception of ourselves in relation to society. Adolescents often find themselves asking questions, such as “who am I and where am I going?”

This stage creates a certain amount of confusion about the young person’s expected role as they grow older. At a stage where they are allowed to make certain decisions on their own, adolescents are likely to start experimenting with their behavior and may engage in activities that help them discover their roles and identities. This is a stage marked by what Erikson called the “identity crisis”.

These changes are intensified by the physical changes that adolescents are going through because of puberty. They tend to see the world as a hostile place to live in, and their sense of self-concept and self-esteem are challenged. As they develop their ideas, adolescents may also face conflict with adults.

This stage is also marked by the need for adolescents to ‘fit in’ to a particular norm or type because of peer pressure.

**Early adulthood: 19 to 40 years**

* **Physical** – from around the age of 30 the body’s functions start to decline, but this may not be noticed for some time. The first signs of ageing may be fine lines and wrinkles, and skin taking longer to heal. Hair may also start to turn grey
* **Intellectual** – during this stage, people begin to understand things from different perspectives, building on practical experiences and information gathered over time
* **Emotional** – people become less egocentric, develop control systems to reach the best conclusion, and become more caring and respectful toward others. One of the reasons for the development of these traits is self-reflection
* **Social** – certain aspects of the previous stage continue into this stage as these young adults try to fit into the roles they desire. Career choice, networks and relationships impact on our self-concept and self-esteem during this stage.

**Middle adulthood: 40 to 65 years**

* **Physical** – physical capabilities decline, skin loses elasticity and starts to wrinkle. Muscle tone slackens and eyesight and hearing declines. Men’s fertility will decrease from around the age of 40 as their testosterone levels drop, leading to the production of less sperm. Women can’t conceive after the menopause, but men can still produce children well into later adulthood. The muscle-to-fat ratio for both men and women also changes, with an accumulation of fat in the stomach area. Fine motor skills are more difficult, and coordination and reaction times are slower
* **Intellectual** – there’s a slowing down of our cognitive functions, such as paying attention to a task or multi-tasking. But, the ability to use intelligence from our experiences, skills and strategies developed throughout our lifetime, increases
* **Emotional** – emotions aren’t as strong during this stage, and we tend to focus on more positive and less negative things
* **Social** – the biggest social contribution of an adult in this stage is to help the growth and development of the next generation. This is done by starting and raising a family, which then leads to a sense of accomplishment. Erikson thought that if this stage lacks this aspect of growth, an adult is likely to feel inactive and inconsequential.

It’s during this stage that adults experience their children leaving home, causing a sense of emptiness and leading to what’s known as the mid-life crisis. At this time, the adult looks for other changes, such as their career, or a new direction, such as spirituality.

**Later adulthood: 65 years and older**

* **Physical** – during later adulthood, the ageing process becomes more apparent. Some people have hair loss, and others have significant greying of the hair. Hearing and sight also decline further and the other senses, such as taste, touch and smell, are also less sensitive than they were in earlier years. Skin continues to dry out and get thinner, age spots and blood vessels become more apparent, joints stiffen, muscles weaken and bones become brittle. The immune system is weakened, and many older people are more at risk of illness, cancer, diabetes and other ailments. Heart and respiratory problems become more common in old age. Older people also experience a decrease in physical mobility and a loss of balance, which can result in falls and injuries
* **Intellectual** – the slowing down of our cognitive functions, such as paying attention to a task or multi-tasking, continues, but the ability to use intelligence from our experiences, skills and strategies developed throughout our lifetime can still increase
* **Emotional** – there are some theories of successful ageing. The *disengagement theory* says that as people age, their withdrawal from society is normal and desirable as it relieves them of responsibilities and roles that have become difficult. The *activity theory* says that activity is necessary to maintain a “life of quality,” that is, that one must “use it or lose it” no matter what one's age and that people who remain active in all respects – physically, mentally and socially – adjust better to the ageing process.
* **Social** –this stage is marked by a reduction in productivity and is when a person enters the retirement phase. In this stage, adults tend to look back on their lives to see if they’ve had a successful life. If so, a feeling of contentment and what Erikson called “integrity” happens. This reflection, if not positive, leads to a state of despair where nothing can be done to turn back time and change. It can also be marked by regrets. A prominent aspect of this stage is the fear of death, which contributes to the hopelessness that can become apparent. An adult’s values at this stage are set and firm, and nothing can change the thought process or the way in which he or she now views the world.

**Learning activity – human growth and development**

Read this case study and answer the questions.

**Case study** – **Ryan**

Ryan is 38 years old. He has been married twice and has four children, with whom he has no contact. Ryan misuses substances and is supported by the community mental health team for depression. He has difficulty controlling his emotions and forming positive relationships. His self-esteem and confidence are low.

Ryan’s father left his mother before he was born. He has never met him. His mother had post-natal depression and did not bond with him. She continued to have mental ill health and Ryan experienced neglect. He never formed an attachment with his mother.

Answer these questions:

|  |
| --- |
| 1. Which factors had a negative impact on Ryan’s human growth and development? 2. Which aspects of Ryan’s emotional and social development differ from the ‘norm’ for early adulthood? |

**Let’s review what we have learnt so far**

**Quiz**

1. How many broad life stages are there?
2. four
3. six
4. eight
5. The ‘P’ in ‘PIES’ stands for
6. personal development
7. psychological development
8. physical development
9. True or false?

Self-esteem is about how much we value ourselves

**The Senses Framework**

Mike Nolan[[2]](#footnote-3) developed a framework to help people think about creating an ‘enriched environment’ not only for individuals and their families or carers but for health and social care workers as well.

The Senses Framework has six elements and each is equally important to individuals, their families or carers and workers:

* **security** – to feel safe physically and emotionally
* **belonging** – to feel part of a valued group, be able to maintain or develop important relationships
* **continuity** – to be able to make links between the past, present and future
* **purpose** – to enjoy meaningful activity, to have valued goals and know that what you do matters
* **achievement** – to achieve valued goals and ‘what matters’
* **significance** – to feel that you matter and have value and status.

Creating the right environment for everyone to grow and develop is important.

**Learning activity – the Senses Framework**

Think about your role and write some notes about how you feel about the following in your work:

|  |
| --- |
| 1. security 2. belonging 3. continuity 4. purpose 5. achievement 6. significance |

Now reflect on how you support each of the senses with the individuals you support and write notes here:

|  |
| --- |
|  |

**The importance of engaging in meaningful activities**

Engaging in meaningful activities can benefit us all in many ways:

* physically, by helping to maintain and improve our body, such as through movement of the joints
* intellectually, by helping to develop the mind and improve memory
* emotionally, by helping to improve mood, supporting relaxation and encouraging positive self-concept and self-esteem
* socially, by encouraging relationships with others, promoting communication and interaction.

**Learning activity**

Read this case study and answer the questions.

**Case study – Margaret**

Margaret lives in Sunnyhaven Care Home in Barry. She moved there six months ago after a stroke. Margaret’s been making a slow recovery but is depressed and has lost weight. She doesn’t want to join in any activities in the home and tells her daughter Ruth she feels life isn’t worth living any more. Margaret’s really fed up and misses her friends from the Women’s Institute (WI).

Before her stroke, Margaret was a keen cook and often swapped recipes with her friends from the WI. The care home employs a cook and Margaret isn’t allowed in the kitchen as it’s thought to be “too much of a risk”. Ruth suggests they talk to the manager to see if there’s a way Margaret can use the kitchen to do some baking when it isn’t busy.

The manager agrees to give it a try in the afternoons once the lunches have been cleared. She asks one of the workers, Donna, to look at what would need to be in place for Margaret to do this safely.

Donna and Margaret spend time in the kitchen together talking about what she would like to make and assessing the environment. The countertop is too high for Margaret to reach from her wheelchair, but the table is the right height and there’s a trolley they can use for the ingredients. Margaret would like to cook some of her favourite, recipes but is having trouble remembering them because of her stroke. It’s also affected her sight and she’s having difficulty reading.

Donna asks Ruth if she can find her mum’s recipe folder and record herself reading out the ingredients and the steps for cooking. Ruth does this and sends the videos to Donna. Donna sets up an iPad in the kitchen and shows Margaret how to start, pause and stop the video so she can follow the instructions at her own pace. Margaret needs lots of help at first but is getting more confident each time she uses it.

Donna helps Margaret get the equipment out for her first cooking session and weighs the ingredients for her as Margaret can’t see the numbers on the scales. At teatime, Margaret proudly presents a sponge cake to share with the other residents.

Ruth brings in her mum’s old fashioned weighing scales with weights so she can prepare the ingredients with less help from Donna. Margaret now has support from Donna to bake a cake once a week to share with the other residents.

The WI have a WhatsApp group and Margaret shares photos of her cakes with her friends. One friend, Betty, contacts her to see if she can come into the care home to help her with her baking. Donna talks to her manager, and it’s agreed that Betty can come in twice a week to support Margaret with her baking. Margaret is delighted and the other residents love her cakes. She has been able to reconnect with her old friends and feels she has a purpose in life again. She’s also developing new friendships with other residents because of her teatime treats.

Answer these questions:

|  |
| --- |
| 1. What was the impact on Margaret of not being actively involved in anything that mattered to her? 2. How did baking cakes change this? 3. Thinking about the Senses Framework, describe how you can relate each of the six elements to Margaret’s story:  * security * belonging * continuity      * purpose * achievement * significance  1. How do you think it made Donna feel? 2. How do you think the way Margaret was supported by Donna had an impact on her self-concept, self-esteem and self-confidence? 3. How did social media and technology help Margaret engage in this activity and connect with others? |

There are lots of activities that can support the well-being of the individuals you work with, from cake making like Margaret, to listening to live music, singing, dancing, drama or sports. All enrich our lives by helping us connect with others, do things we enjoy and by providing us with mental and physical stimulation.

**Learning activity**

Think about the individuals you support and write down some of the activities they take part in and how you feel these support their mental and physical well-being:

|  |
| --- |
|  |

**Medical and social models of disability**

We will now introduce you to the medical and social models of disability.

Attitudes towards disability affect the way people think and behave towards disabled people. They also impact the way disabled people are treated and can take part in society.

**Social model of disability:**

The social model was created by disabled people and looks at the barriers put in place by society in terms of disabled people being able to fully take part in day-to-day life. The social model seeks to remove the barriers that stop disabled people from taking part in society, accessing work and living independently. The social model asks what can be done to remove barriers to inclusion.

The social model identifies the problems faced by disabled people because of external factors. For example, the way organisations produce information, for example, by not offering formats such as Braille or large text, or venues that aren’t accessible.

The social model recognises the difference between ‘impairment’ and ‘disability’. Impairment is described as a characteristic that may or may not result from an injury or health condition and that can affect a person’s appearance or functioning of their mind or body, for example, sight loss or cerebral palsy.

The social model says a person doesn’t ‘have’ a disability – disability is something a person experiences. The disability experienced is usually caused by the approach society or people take, which doesn’t take account of people with impairments and their associated needs. This can lead to people with impairments being excluded from mainstream society. For example, an individual isn’t prevented from reading a magazine because of blindness, but because there are no alternative formats. A person isn’t prevented from going to see a play because they’re a wheelchair user, but because of a lack of accessible transport and access to venues.

The social model of disability also focuses on people’s attitudes towards disability and recognises that attitudes towards disability can create barriers for disabled people in the same way the physical environment can. These attitudes are many and varied, ranging from prejudice and stereotyping, to unnecessary, inflexible practices and procedures by organisations and seeing disabled people as objects of pity or charity.

**Medical model of disability:**

The medical model looks at a person’s impairment first and sees the impairment as the reason why disabled people can’t access goods and services or take part fully in society. Saying “he can’t read that magazine because he’s blind” is an example of someone being influenced by the medical model of disability.

The medical model focuses on the impairment and what can be done to ‘fix’ the disabled person or provide special services for them. The medical model views the individual as the problem, rather than society.

Here are examples of how the medical and social models of disability differ in everyday situations:

**Issue – transport**

* **Medical model:** specialist transport is provided for people who can’t access mainstream transport
* **Social model:** mainstream transport is made accessible for everyone.

**Issue – at home**

* **Medical model:** homes are adapted and specialist products are recommended by professionals, such as occupational therapists, to meet disabled people’s needs
* **Social model:** mainstream retailers, for example, kitchen and bathroom shops, offer more options, such as different heights and depths of units, as standard. Products around the home are designed with accessibility in mind so specialist products aren’t needed.

**Issue – education**

* **Medical model:** disabled children receive specialist provision in special schools and do alternative qualifications
* **Social model:** disabled children are educated in accessible mainstream schools alongside non-disabled children. Education provision is accessible to all, with the same qualifications and opportunities open to everyone who wants to access them.

**Issue – at work**

* **Medical model:** sheltered workplaces are created for disabled people to work alongside other disabled people in a specially adapted environment doing specific work
* **Social model:** workplaces are made accessible for disabled people and there’s training and development available to enable them to apply for a range of job roles.

**Issue – communication**

* **Medical model:** communication takes place in ‘standard’ ways, for example, letters are in font size 12. If someone can’t read them, they can be given magnifiers or ask someone to read the information to them
* **Social model: c**ommunication is tailored to meet the needs of the individuals and information is available and offered in a range of formats.

**Issue – language**

* **Medical model:** language usually refers to a person’s medical condition, what is ‘wrong’ with them and what they can and can’t do
* **Social model:** language is focused around the barriers an individual faces and what can be done to remove them.

**Issue – attitudes**

* **Medical model:** people make assumptions about what someone is capable of based on information about their medical condition
* **Social model:** people talk to individuals about their needs, wishes and preferences.

**Learning activity – medical and social models of disability**

Read these case studies and answer the questions.

**Case study – Rachel (part 1)**

Rachel catches the train to work every day. She has sight loss and has missed her stop a few times because the conductor doesn’t always announce when they arrive at stations.

Answer these questions:

|  |
| --- |
| 1. What would the medical model of disability say here? 2. What would the social model of disability say needs to happen |

**Case study – Rachel (part 2)**

Rachel is waiting to cross the road to get to her office, a man she doesn’t know approaches her and says “I will help you across the road dear”. He takes her arm and pulls her across the road.

Answer these questions:

|  |
| --- |
| 1. Does the man’s attitude reflect the medical or social model of disability? 2. Why did you decide this? |

**Health checks**

We all have checks for our health at different stages of our lives, for example:

* cervical screening is offered to all women and people with a cervix aged 25 to 64 to check the health of cells in the cervix
* breast screening is offered to women aged 50 to 70 to detect early signs of breast cancer
* everyone aged 60 to 74 is offered a bowel cancer screening home test every two years
* we go to the dentist for a dental check-up and they’ll also check our oral health
* we go to the optician for a sight test and they also check our eye health
* we may be tested for diabetes if we’re showing symptoms, such as feeling thirsty all the time, feeling tired and going to the toilet more than usual
* our GP may ask us to have a cholesterol level test if we’re overweight or have another condition, such as high blood pressure or diabetes.

Individuals receiving social care and support will need the same health checks, but they may need extra health checks depending on their age or impairment.

**Learning activity – health checks**

Check the care and support plan of an individual you work with and note some of the routine health checks they need to have. Write a summary here, making sure you don’t share anything confidential:

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|  |

Health checks and health screening are a way of identifying people who may be at risk of different conditions. In addition to health checks, we use health promotion to support healthy behaviours, such as increasing physical activity, and reduce health harming behaviours, such as smoking.

There are lots of services, such as Public Health Wales, Age Cymru and National Stop Smoking Centres, that support health promotion.

**Learning activity – supporting health promotion**

An important part of your role as a health and social care worker is promoting an individual’s health and preventing illness where possible. What information would help in these situations and where could you get more advice?

|  |  |
| --- | --- |
| You work with a family that’s struggling to eat a balanced diet |  |
| You support a young adult with a learning disability who doesn’t like going to the dentist and hasn’t been for several years |  |
| You support an older person who has trouble swallowing her tablets and doesn’t want to take them |  |
| You work with a family with young children and the parents want to give up smoking |  |

**Changes in an individual that would give cause for concern**

There are some important changes that may give us cause for concern for the health and well-being of individuals, such as:

* weight loss or lack of appetite
* excessive tiredness or drowsiness
* dizziness or blurred vision
* constant headaches
* going to the toilet less or more frequently.

You know the people you work with best. It’s important to record and report any changes you observe or concerns you may have. This is particularly important for those who have known medical conditions such as diabetes, high blood pressure or cancer.

**Links between health and well-being and safeguarding**

Safeguarding is about protecting individuals from harm, abuse or neglect and educating those around them to recognise the signs and dangers. It also involves promoting individuals’ health and well-being, and making sure they receive safe and effective care, such as making sure health checks are carried out, supporting health promotion, and reporting and monitoring any changes.

**Links between health and well-being and the Mental Capacity Act**

The Mental Capacity Act is designed to protect and empower people who may lack the capacity to make their own decisions about their care and treatment.

We should never assume a person doesn’t have capacity to make decisions about their health and well-being. To be deemed not to have mental capacity, they must have been formally assessed as not being able to:

* understand the information relevant to the decision
* remember that information
* use or weigh up that information to make the decision.

If a person has been assessed as lacking capacity, this will be recorded in their care and support plan. But if you have any doubt, check with your manager.

**Let’s review what we’ve learnt so far**

**Quiz**

1. Security, belonging, continuity, purpose, achievement and significance are important for:
2. just individuals
3. just individuals and their families
4. individuals, their families and workers
5. Which of these statements reflect the social model of disability?
6. New public toilets have opened in a shopping centre in Cardiff. They include two accessible toilets for disabled people. The toilets are locked to stop others using them. A key is available from the information centre
7. New public toilets have opened in a shopping centre in Cardiff. They are all accessible so can be used by everyone.
8. True or false?

No one with dementia has mental capacity

1. True or false?

Health promotion aims to reduce health harming behaviours

**Manager’s comments for section 3.2**

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**Progress log – to be completed by the manager**

**3.2 Factors which impact upon the health and well-being of individuals**

**Factors that impact upon the health and well-being of individuals**

|  |  |
| --- | --- |
| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| Human development and factors that can affect it |  |
| The range of **factors that may affect the health, well-being and development** of **individuals** and the impact this may have on them |  |
| The difference between the medical and social models of disability |  |
| What is meant by good physical health and good mental health and how these are interdependent |  |
| The impact of prolonged inactivity on physical and mental well-being |  |
| The social, mental and physical benefits of engagement in activities and experiences |  |
| The different ways that people can engage in a range of personal activities including the use of social media and technology |  |
| How engagement in the ‘Arts’ can support health and well-being |  |
| The meaning of the term ‘attachment’ and the impact that this can have on individuals in adulthood |  |
| The importance of self-identity, self-worth and sense of security and belonging for the health and well-being of individuals |  |
| How the way that individuals are supported will impact on how they feel about themselves |  |
| The range of health checks that individuals need to support their health and well-being |  |
| The range of services and information that support health promotion |  |
| The types of changes in an individual that would give cause for concern for their health and well-being |  |
| The importance of observing, monitoring and recording the health and well-being of individuals affected by particular health conditions |  |
| The importance of reporting concerns or any changes in the health and well-being of individuals |  |
| Links between health and well-being and safeguarding |  |
| Links between health and well-being and the Mental Capacity Act |  |

## 3.3 Support for personal care and continence

**What does personal care mean?**

Personal hygiene and how we look is important to most people. It’s essential to find out what’s important to the individuals you’re supporting, for example, the routine people like to follow if they’re taking a shower or having a wash. Think about your own morning routine and the order you do things such as brushing your teeth, washing or bathing and doing your hair. Imagine what it would be like if you needed some support with this, but the person supporting you didn’t ask about your normal routine and did things differently. The standards each of us wants for our personal hygiene and appearance, our culture and beliefs will also have an impact on how we want to be supported.

An individual’s personal plan will have some of this information, but it’s important to talk to the individual and their families or carers to find out what matters to them.

Having privacy and dignity when we’re being supported with our personal care is also important to us – who wants other people to see us getting bathed or being helped to the toilet or to get dressed? Simple things matter, such as making sure:

* the door is closed so others can’t see into the room if you’re helping someone get dressed
* you have the person’s consent, for example, asking, “Is it okay if I help you get dressed now Gloria?”
* people are covered up as much as possible.

**Learning activity – personal care**

Read this case study and answer the questions

**Case study – Amelia (part 1)**

Amelia is 32 years old. She lives at home with her husband in Llandysul. Amelia has an acquired brain injury because of a bleed on the brain a year ago.

Amelia receives support in the mornings to get up, wash and dress, and have breakfast. She is also supported at lunch time. Her husband supports her in the evenings when he gets home from work.

Amelia is making progress in her recovery and wants her support workers to only help her with the parts of personal care and meal preparation she can’t do on her own.

This morning, Sarah arrives on duty. She rings the doorbell to let Amelia know she’s there and lets herself in using the key safe. Sarah goes upstairs, knocks on Amelia’s bedroom door and enters straight away. Amelia has just woken up and is still drowsy. Sarah says good morning and she starts running the shower for it to warm up.

Sarah helps Amelia out of bed and guides her to the bathroom to shower. She helps her undress and Amelia sits on the shower seat. While Amelia is washing herself, Sarah props the bathroom door open, goes back to the bedroom and gets a tracksuit for Amelia to wear. Sarah’s in a rush because she’s running late. She thinks a tracksuit will be easy for Amelia to put on and will help her make up some time.

Answer these questions:

|  |
| --- |
| 1. How well do you think Sarah has treated Amelia with dignity and respect? 2. What could Sarah have done differently? 3. What impact would Sarah’s approach have on Amelia? |

**Continence management**

From an early age, most people can control their bladder and bowel. This is known as continence. Continence is being able to pass urine or faeces voluntarily in a socially acceptable place. A person needs to be able to:

* recognise the need to pass urine or faeces
* identify the right place to pass these
* reach the toilet in time to pass urine or faeces
* pass urine or faeces once there.

Incontinence is the unwanted or involuntary leakage of urine or faeces. Many people will be affected by incontinence at some time in their lives. People may experience urinary incontinence or bowel incontinence. Memory problems caused by dementia or an acquired brain injury, physical problems, such as poor mobility, poor dexterity or eyesight, and conditions, such as diabetes, can lead to urinary or bowel incontinence. Bowel incontinence can also be caused or made worse by constipation.

**Learning activity – continence**

Read the next part of Amelia’s story and answer the questions

**Case study – Amelia (part 2)**

Amelia has problems with her balance and mobility because of her acquired brain injury. It also means she isn’t always able to get to the toilet in time to pass urine. Amelia feels embarrassed by this and hasn’t told anyone. She’s wearing sanitary towels, which help a little, and she keeps spare underwear and trousers in the bathroom airing cupboard in case she accidentally wets her clothes. She doesn’t drink anything after 6pm as she’s afraid of what may happen in the night if she can’t get out of bed in time to reach the toilet. Amelia is also nervous about going out for too long in case she can’t get to the toilet in time to pass urine.

Answer this question:

|  |
| --- |
| 1. What impact is incontinence having on Amelia’s self-esteem, health and well-being, and her day-to-day activities? |

Another of Amelia’s health and social care workers, Glenys, has noticed the trousers Amelia wears at lunch time are often different to those she puts on in the morning. She asks Amelia if there’s anything she needs more support with as she’s noticed the different trousers. Amelia tells Glenys what’s been happening and says she hasn’t told anyone as she’s really embarrassed and feels ashamed.

Glenys asks Amelia if she would be happy for her to ask for a referral to the continence nurse as she’s sure they would be able to help her find some solutions. Amelia agrees. Glenys talks to her manager and Amelia is referred to the local continence team.

The continence nurse carries out an assessment. She carries out a urine test to make sure Amelia doesn’t have a urine infection and arranges for more tests to make sure there isn’t an underlying problem. Glenys gives Amelia some continence pants and agrees to check in with her in four weeks’ time to see how she’s managing. She also makes a referral to the occupational therapy team to carry out an assessment of the home to see if there are any more adaptations that would help Amelia with her mobility. Amelia is also referred to the physiotherapist for some pelvic floor exercises.

Answer this question:

|  |
| --- |
| 1. How do you think this extra support may help Amelia? |

If you need to support individuals with their personal care, it’s important you do so in a way that keeps you both safe. You’ll need to make sure you follow good infection prevention and control measures, such as using PPE and hand hygiene. You’ll also need to think about how you carry out intimate personal care in a safe way. You should always make sure you:

* follow any risk assessments and the personal plans for individuals
* let a colleague know what you’re doing, if you’re working in a residential setting
* never have a phone with you when carrying out personal care
* record in the daily log that you have supported someone with their personal care
* record and report any concerns, for example, marks or bruising on the body, inappropriate comments or sexualised behaviour from the individual or incidents of challenging behaviour.

**Let’s review what we’ve learnt so far**

**Quiz**

1. True or false?

Incontinence is the unwanted leakage of urine or faeces

1. True or false?

Bowel incontinence is made better by constipation

**Manager’s comments for section 3.3**

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**Progress log – to be completed by the manager**

**3.3 Support for personal care and continence**

**How to support individuals with their personal care and continence management**

|  |  |
| --- | --- |
| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| What is meant by the term 'personal care' |  |
| How to establish with an individual their preferences in relation to how they are supported with their personal care |  |
| How to protect the privacy and dignity of an individual when they are being supported with their personal care |  |
| What is meant by the term ‘continence’ |  |
| Factors that may contribute to difficulties with continence |  |
| How difficulties with continence can affect an individual’s self-esteem, health well-being and day to day activities |  |
| How an individual’s personal beliefs, sexual preference and values may affect the management of their continence |  |
| Aids and equipment that can support the management of continence |  |
| The range of professionals that may help with continence management |  |
| How to support individuals with their personal care and / or continence management in a way that protects both the individual and the **worker** supporting them |  |

## 

## 3.4 Pressure area care

It’s important health and social care workers understand how to keep skin healthy and stop skin from breaking down by carrying out pressure area care after an individual’s personal plan and risk assessment.

Pressure ulcers develop when pressure or friction is applied to the skin and causes damage to the soft tissue underneath. Pressure against the skin can limit blood flow, which is needed for delivering oxygen and other nutrients to tissues. Without these, skin and soft tissues are damaged and can eventually die. Bony areas of the body, such as the spine, hips, heels, elbows and shoulder blades, are most at risk of pressure damage. Eventually this can lead to deep tissue damage, infection and severe pain. Pressure ulcers can also be caused by moisture on the skin.

Pressure damage can be caused by a lack of mobility, for example, lying in bed or sitting in a chair for long periods of time.

You can avoid most pressure ulcers with good pressure area care. You can do this by:

* changing position
* keeping skin dry and clean through continence management
* checking skin for signs of ulcers
* having a healthy balanced diet
* not smoking.

Health and social care workers may be the first people to notice pressure damage when supporting individuals with their personal care.

There are four main stages in the development of pressure ulcers:

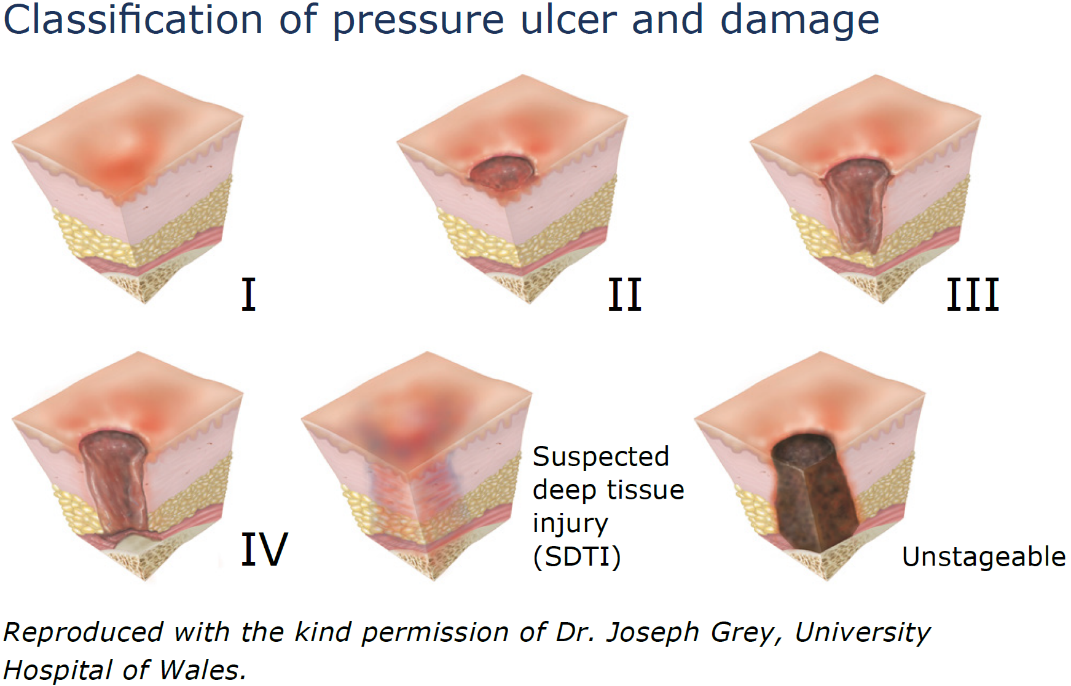
* Stage one: Closed wounds. This is where the skin is painful but there aren’t breaks or tears. The skin is reddened and doesn’t lose colour if a finger is pressed on it. The skin temperature is warmer. A stage one sore may go in two to three days.
* Stage two: The skin breaks away and forms an ulcer. The sore expands into deeper layers of the skin and looks like a crater, abrasion or blister. At this stage some skin may be damaged beyond repair or die. Stage two ulcers can heal in one to six weeks.
* Stage three: The sore gets worse and extends into the tissue beneath the skin and forms a small crater. Fat may be visible in the sore but not muscle, tendon or bone. Stage three ulcers may take several months to heal or may never heal, especially in those with ongoing health problems.
* Stage four: The wound is deep and reaches into muscle and bone, and causes damage. There may be damage to deeper tissues, tendons and joints. Dead tissue may need to be removed to minimise further infection. Stage four ulcers may take several months to heal or may never heal, especially in those with ongoing health problems.

In stages three and four, tissue damage may mean there’s little pain. But if the injuries progress, there can be serious complications such as infection of the bone (osteomyelitis) or blood (sepsis).

There are another two descriptors for pressure area damage: suspected deep tissue injury and unstageable.

In ‘suspected deep tissue injury’ the depth is unknown and there’s a purple or maroon area of intact skin or blood-filled blister.

In ‘unstageable’, the depth isn’t known as it’s covered by ‘slough’ This isn’t a scab and will slow down healing. Slough can be yellow, white, or grey in colour and it can cover all or part of the wound. It can be thick or thin and may appear sticky.



A serious incident report must be made to Welsh Government about anyone receiving Welsh NHS care who has avoidable grade three, four and/or unstageable pressure damage. This includes individuals who are admitted to health care from residential care homes. Residential care homes also have a duty to report pressure damage to Care Inspectorate Wales.

Any worker, regardless of the setting, should immediately report any concerns about pressure damage to their manager.

**Learning activity**

Read the case study and answer the questions.

**Case study – Operation Jasmin**

A coroner has ruled that neglect on the part of a care home owner contributed to the death of one of the elderly residents.

The judgment came after an inquest heard the owner and manager of a residential home failed to seek medical help for an 80-year-old woman despite 19 references in the home’s records to her having a pressure sore.

The woman, who had been living at the home for five years, died in hospital on 5 August 2016, two weeks after being admitted with a grade four sore, the worst grade possible, on her bottom. The cause of death was respiratory failure caused by sepsis.

The owner told the inquest the sore was not there two days earlier. But a consultant geriatrician said it was the worst he had ever seen and it could have started as early as April, with “redness” noted.

The coroner said the woman’s death “was contributed to by neglect in not seeking medical attention for the pressure sore in the appropriate manner”.

Members of staff at the home told the inquest that when they drew the owner’s attention to the sore, which sometimes bled, she was reluctant to call a nurse or doctor.

Answer these questions:

|  |
| --- |
| 1. What actions should the owner have taken? 2. What actions should the care workers have taken if they had ongoing concerns? 3. How does this relate to responsibilities in relation to safeguarding and duty of care? |

**Let’s review what we’ve learnt so far**

**Quiz**

1. The areas of the body most at risk from pressure damage are:
2. the spine
3. heels of the feet
4. elbows
5. toes
6. stomach
7. shoulder blades
8. True or false

Pressure damage can be caused by sitting in a chair for long periods of time

**Manager’s comments for section 3.4**

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**Progress log – to be completed by the manager**

**3.4 Pressure area care**

**Good practice in relation to pressure area care**

| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| --- | --- |
| What is meant by the terms ‘pressure area care’, ‘pressure damage’ and ‘pressure ulcers’ |  |
| Legislation and national guidelines in relation to pressure damage |  |
| Factors that cause skin breakdown and pressure damage |  |
| Stages of pressure ulcer development |  |
| Common parts of the body for pressure damage |  |
| Interventions that can reduce the risk of skin breakdown and pressure damage |  |

## 3.5 Oral health care

A healthy mouth is an important part of our well-being. Your role as a health and social care worker involves helping individuals maintain and improve their oral health and get timely dental treatment.

**What do we mean by oral health care and mouth care?**

Oral health is sign of our health, well-being and quality of life. The World Health Organization (WHO) defines oral health as “being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other diseases and disorders that affect the oral cavity”.

Mouth care refers to oral hygiene and ways to maintain good oral health, which includes teeth and dentures. Mouth care can prevent problems, such as infections and pain, and difficulties, such as bad breath, dry mouth and thrush.

The policies and guidelines to support good oral health and mouth care include:

* *Together for Health: A National Oral Health Plan for Wales (2013 to 2018)*. This is a plan to improve oral health and reduce inequalities in Wales
* 1000 lives. This is the national improvement service for NHS Wales provided by Public Health Wales to help improve outcomes for individuals using services in Wales
* The All Wales Dental Public Health Team (AWD PHT). This service provides advice and support to the health boards, NHS Wales Shared Services Partnership, Healthcare Inspectorate Wales, the Welsh Government and dental teams.

Older people and individuals who need care and support may suffer from a range of oral and dental problems. Some common problems for older people and individuals who need care and support include:

* gum disease caused by bacteria in plaque and tartar. Symptoms include irritated, red and bleeding gums
* cavities and decay, which can cause pain, infection and tooth loss
* receding gums, which is a gradual condition that means gums shrink away from teeth. It’s caused by gum disease, poor dental hygiene and smoking, and increases the chances of developing serious gum disease and tooth loss
* dry mouth caused by producing less saliva, which may happen with age or as a side effect of medication, including medication for high blood pressure, high cholesterol and depression. This means sugar and acids may build up in the mouth and increase the chance of cavities and decay. It can also lead to dry and cracked lips and a swollen tongue that makes it difficult to speak and swallow
* bacteria on the tongue
* mouth sores
* tooth sensitivity
* oral cancer. The chance of oral cancer increases with age and there’s an increased risk in those who smoke or drink alcohol
* poor fitting dentures can make eating difficult and affect nutrition.

Oral health and mouth care is important to:

* support overall health and well-being
* prevent tooth decay and gum disease. Regular brushing and care, such as flossing, helps keep teeth and gums healthy
* prevent infection. Gum disease and infection can lead to infection in other parts of the body
* support a positive image and self-esteem because dental problems can make people self-conscious about their appearance
* support good nutrition because poor dental health can make it difficult to chew and eat
* support communication because missing teeth can cause speech difficulties.

Good oral health is important for general health and nutrition, well-being and quality of life. Diets that are high in sugar can lead to dental decay. Healthy teeth and gums help people chew and digest food properly and maintain a balanced diet throughout their life. Having poor oral health, tooth decay, gum disease or ill-fitting dentures can impact food intake and enjoyment of food. If a person doesn’t have healthy teeth, it can be difficult for them to enjoy foods that need to be chewed, such as meat, fruit and vegetables.

Vitamin D is important for oral health as it allows calcium to be absorbed. Without it, there can be underdeveloped teeth, gum disease and tooth decay. Not enough vitamin C will lead to bleeding gums and loose teeth.

Where nutrition is poor, the first signs are often seen in dental health.

Many professionals support oral health care such as:

* dentists, who will diagnose issues and manage and treat general oral care needs such as fillings, root canal treatment, crowns and gum care
* dental hygienists, who will clean teeth and give advice about hygiene issues
* community dental professionals, who will provide support in the community or home for people who can’t access dental surgeries
* orthodontists, who will specialise in the prevention, diagnosis and treatment of dental problems that affect the teeth, jaw and their structures. They will identify if a person needs braces or their teeth straightened.

**Learning activity**

Read this case study and answer the questions

**Case study – Denise**

Denise is 45 years old and lives alone. She’s experienced mental health problems for many years. As her support worker, you’ve been visiting twice a week to go with her to an anxiety management programme because she’s reluctant to go alone. You’ve noticed she has ‘bad breath’ when talking in the car and when you look at Denise in the class you can see she’s shielding her mouth when talking to the person next to her.

Answer these questions:

|  |
| --- |
| 1. How might Denise’s oral health be impacting on her well-being? 2. What action would you take to help Denise? |

When supporting individuals with their mouth care it’s important to do this in the way they want. You may want to ask someone to brush your teeth to see how it feels!

**Manager’s comments for section 3.5**

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**Progress log – to be completed by the manager**

**3.5 Oral health care**

**How to support good oral health care and mouth care for individuals**

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| --- | --- |
| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| What is meant by the terms ‘oral health care’ and ‘mouth care’ |  |
| National policy and practice guidance on oral health care |  |
| Common oral and dental problems in older people and other individuals who need care and support |  |
| Why oral health care and mouth care are important |  |
| The impact of poor oral health care and mouth care on health, well-being, self-esteem and dignity |  |
| Links between oral health care and mouth care and nutrition |  |
| The range of professionals that may help with oral health care |  |

## 3.6 Foot care

Foot care is important for us all, but it’s particularly important as we get older. Foot problems can lead to issues such as infections, which can spread, and poor mobility, which can lead to falls.

Foot care is especially important for people with diabetes because they’re more likely to have **poor blood circulation and nerve disease** in the extremities such as the feet. People with diabetes are also likely to develop infections in the feet and even small sores can turn into serious problems quickly.

Good foot care has benefits such as:

* reducing pain
* helping mobility and ability to engage in physical activity
* reducing the risk of trips and falls.

Common conditions that can cause foot problems include:

* fungal nail infections, which usually affect your toenails, but you can get them on your fingernails, too. Fungal nail infections sometimes start at the edge of the nail and the infection often spreads to the middle of the nail, making the nail discoloured and sometimes thicker in parts. The nail becomes brittle, and pieces can break off. Sometimes the whole nail lifts off. This can cause pain and swelling in the skin around the nail
* Athlete’s foot is a common fungal infection that affects the feet. One of the main symptoms of Athlete's foot is itchy white patches between the toes and it can cause sore and flaky patches on the feet. Sometimes the skin on the feet may become cracked or bleed. If it's not treated, the infection can spread to the toenails and cause a fungal nail infection
* bunions are bony lumps that form on the side of the feet. They can cause pain along the side or bottom of the feet. This is usually worse when wearing shoes and walking
* diabetic neuropathy. Raised blood glucose levels, also known as blood sugar, can damage sensation in the feet. There’s a greater risk of cuts and minor injuries not being noticed because of a lack of feeling. Raised glucose levels can also affect circulation, which can lead to less blood supply getting to the feet. Lack of a good blood supply can cause problems with cuts and sores healing. If these foot problems aren’t treated, they could lead to foot ulcers, infections and, at worst, amputations. Most foot problems can be prevented with good, regular footcare. Some of the symptoms of foot problems are:
* tingling sensation or pins and needles like numbness
* pain and burning
* a dull ache
* shiny, smooth skin on the feet
* hair loss on legs and feet
* loss of feeling in feet or legs
* swollen feet
* feet that don't sweat
* wounds or sores that don’t heal
* cramp in the calves when resting or walking
* changes in the colour and shape of the feet
* cold or hot feet
* blisters and cuts people can’t feel
* foul smell coming from an open wound.
* an ingrown toenail is a common problem where the nail grows into the toe. You usually get an ingrown toenail on your big toe, but you can get them on any toe. The toe may be red, painful and swollen, and the toenail may curve into the toe
* corns and calluses are hard or thick areas of skin that can be tender and painful. Corns are small lumps of hard skin and calluses are larger patches of rough, thick skin
* blisters are a small pocket of fluid that form on an area of the body. These bubbles can vary in size and can occur for different reasons. Blisters commonly develop on the feet. Foot blisters can become infected. Warmth and redness around the blister are signs of infection. Instead of clear fluid, an infected foot blister may become filled with yellow or greenish pus, and/or have a foul smell. In severe cases of Athlete’s foot, we can develop blisters on the foot or between the toes.

Some of the professionals who will provide help with foot care are:

* podiatrists, who will treat ingrown toenails, calluses, fallen arches, heel spurs, deformities of the feet, and some common foot and ankle injuries. They can provide treatment for foot problems related to diabetes and other systemic illnesses
* orthopaedic surgeons, who will perform surgery to correct foot problems
* diabetes specialist nurses, who will check the feet of individuals who have diabetes. If there’s something that needs support, they can refer the individual to a podiatrist
* foot clinics and chiropody clinics, which provide care and services such as nail cutting, dealing with hard skin, corns and cracked heels. Age UK also provides foot care services for older people.

**Let’s review what we’ve learnt so far**

**Quiz**

1. Three benefits of footcare are:

a)

b)

c)

2. True or false?

People who are diabetic are more at risk of foot problems

**Manager’s comments for section 3.6**

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**Progress log – to be completed by the manager**

**3.6 Foot care**

**Supporting the health, well-being and development of individuals with additional support needs**

| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| --- | --- |
| Why foot care is needed for individuals |  |
| Common conditions that can cause problems with feet |  |
| Signs of foot and toenail abnormalities |  |
| The impact of foot conditions or abnormalities on the health and well-being of individuals |  |
| The range of professionals that may help with foot care |  |

## 3.7 Administering medication

Some of the individuals you support may take medication and need support to store and take it correctly. Others may be able to manage their own medication safely, and this should be encouraged to promote their continuing independence. Information about supporting an individual with their medication will be included in their personal plan.

**The law or legislative framework**

The Social Services and Well-being (Wales) Act 2014 gives a ‘steer’ that managing medicines, which means getting medicines and taking them as directed, is an aspect of daily living, so medicines support should be considered part of personal care.

The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017 states care providers must “ensure that staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Staff must receive training and are competent before managing, administering or supporting individuals to manage their own medication.”

The National Institute for Health and Care Excellence (NICE) has guidelines about how to safely support the use of medication. These guidelines are used by local authorities and employers to develop local guidelines, policies and procedures.

There are other laws/legislation about supporting the use of medication, such as:

* The Medicines Act 1968
* The Misuse of Drugs Act 1971
* The Mental Capacity Act 2005.

You’ll learn about these when you have your administration of medication training, if this is part of your role.

**Learning activity**

Ask your manager for a copy of your organisation’s policy for supporting the use of medication. Read this and talk to them about your role and the training you’ll need. Write down your role and responsibilities:

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**The roles and responsibilities of those who prescribe, dispense and support the use of medication**

It’s the doctor’s role to **prescribe** the correct medication with the correct time and the dose to be taken.

It’s the pharmacist’s role to **dispense** the medication, checking the medication given matches the prescription from the doctor. The medication should be labelled with information, such as the name of the person who’s to take the medication, the name of the medication, the date it’s dispensed, the dose to be taken and how and when it’s to be taken. You will be given full training about how medication should be labelled if you’re responsible for supporting the use of medication. Pharmacists are also responsible for making sure the supply of medicines is within the law and that the medicines prescribed are suitable. They also advise individuals about medicines, including how to take them and what reactions may happen, and they can answer any questions.

In the case of ‘over the counter’ medicines, the pharmacist is responsible for making sure the medicine is suitable for the individual and the medical condition they want it for. The risks associated with administering non-prescribed medication happen when there isn’t enough knowledge about potential interactions with other medicines the individual is taking.

Each social care organisation will set out who is responsible for **supporting the use of medication.** You’ll have read this in your workplace policy. If it’s your responsibility, you must not support the use of medication until you’ve been trained and assessed as competent to do so. This relates to prescribed medication and over the counter medication. You must also make sure you’re following individuals’ personal plans, which will give you information about how each person should be supported.

**Links between misadministering medication and safeguarding**

Mistakes are sometimes made when supporting the use of medication, such as an individual being given:

* the wrong medication
* the wrong dose
* medication at the wrong time
* out of date medication
* or missing a dose.

Mistakes like this don’t usually cause significant harm, but can sometimes lead to serious consequences for the individual, which could lead to a safeguarding review. Mistakes must always be reported. Your organisation’s policy and any training you have will make it clear what actions you must take if mistakes happen.

**Let’s review what we’ve learnt so far**

**Quiz**

1. True or false?

You must not support individuals with the use of medication until you’ve been trained and assessed as competent

1. It’s the doctor’s role to …………… the medication
2. It’s the pharmacist’s role to ……………… the medication

**Manager’s comments for section 3.7**

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**Progress log – to be completed by the manager**

**3.7 Administration of medication**

**Roles and responsibilities related to the administration of medication in social care settings**

| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| --- | --- |
| Legislation and national guidance related to the administration of medication |  |
| The roles and responsibilities of those involved in: prescribing, dispensing and supporting the use of medication |  |
| Where responsibility lies for the use of ‘over the counter’ remedies and supplements in social care settings |  |
| Links between misadministration of medication and safeguarding |  |

## 

## 3.8 Nutrition and hydration

**Why is nutrition and hydration important?**

There are concerns that an adult’s typical diet can contribute to health problems such as:

* + being overweight
  + eating too few fruits and vegetables and not enough fibre
  + having too much sugar and too many soft drinks, which can cause damage to teeth and lead to unhealthy weight gain
  + not eating enough food such as fish, especially oily fish
  + eating too much salty and processed food
  + anaemia due to too little iron and low intakes of other important nutrients
  + those on lower incomes may be more at risk of having a poorer quality diet and are more likely to be overweight or obese
  + older people, particularly those living in care settings, are at greater risk of being underweight and malnourished.

Health and social care workers can play an important role in helping people eat well. This can be by providing, encouraging and promoting healthier food and drink choices that meet people’s individual needs and preferences.

**Eating well**

**The Eatwell Guide: Government recommendations for a balanced diet**

The basic principles of healthy eating are set out in the [Eatwell Guide](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/528193/Eatwell_guide_colour.pdf) (the guide). This turs the Government’s nutrient-based dietary recommendations for healthy eating into food-based guidelines.

The guide uses pictures to show the proportion and types of food you need to have a healthy balanced diet.

The guide is suitable for most people including people of all ethnic origins and people who are of a healthy weight or overweight. It’s also suitable for vegetarians.

The guide may not be appropriate for those who are nutritionally at risk, for example, frail older people, people who are ill or those following a specific therapeutic diet because they may have more specific dietary requirements. Older people may be at greater risk of malnutrition.

The guide shows that people don’t have to give up the foods they enjoy and that all foods can be part of a healthy diet. It’s achieving the right balance and variety of foods that’s important for health. It aims to reduce the confusion about what a healthy diet is.

The guide is divided into five food groups:

* fruit and vegetables
* potatoes, bread, rice, pasta and other starchy carbohydrates
* beans, pulses, fish, eggs, meat and other proteins
* dairy and alternatives
* oils and spreads.

Foods from the largest groups should be eaten most often and foods from the smallest group should be eaten less often.

[The Eatwell Guide shows what proportion of food from different groups you should eat and how much water you should drink each day. ](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/528193/Eatwell_guide_colour.pdf)

**Why is balance important?**

No single food contains all the essential nutrients the body needs to be healthy and to work well. The nutritional value of a person’s diet depends on the mixture or balance of foods that’s eaten over a period of time, as well as the needs of the individual. That’s why a balanced diet is likely to include a large variety of foods, so we get enough of all the nutrients.

We need energy to live, but we must have the right balance between carbohydrate, fat and protein to stay healthy. Too little protein can interfere with growth and other body functions, too much fat can lead to obesity and heart disease. Getting enough vitamins and minerals and dietary fibre is important for health.

**Fruit and vegetables**

Most people know we should be eating more fruit and vegetables, but most of us aren’t eating enough. We should be eating at least five portions of fruit and vegetables a day and can choose from fresh, frozen, tinned, dried or juiced. Potatoes don’t count because they’re a starchy food.

Fruit and vegetables should make up more than a third of the food you eat each day. And it’s important to eat a variety. Fruit and vegetables are good sources of many vitamins, minerals and fibre. People who eat lots of fruit and vegetables are less likely to develop chronic diseases, such as heart disease and some cancers. Fruit and vegetables are also low in fat and they can help with weight control when eaten instead of high energy foods.

**Potatoes, bread, rice, pasta and other starchy carbohydrates**

These foods should make up just over a third of the food we eat. These foods give us carbohydrates (starch), fibre, some calcium and iron, and B vitamins. This group includes bread, breakfast cereals, chapattis, oats, rice, pasta, noodles, potatoes, yams, plantains, dishes made from maize, millet, and cornmeal. We should try to eat a variety.

Choose wholegrain, wholemeal, brown or ‘high fibre’ varieties where possible. People often think starchy foods are more likely to make us gain weight than other foods, but it’s too many calories that makes us gain weight. Often it’s the fat we add to starchy foods that adds calories. For example, it’s the margarine or butter we spread on bread, the cream or cheese sauce we add to pasta, or the oil we use for frying.

**Beans, pulses, fish, eggs, meat and other proteins**

For most people, a healthy diet means eating only moderate amounts of meat, fish and alternatives, such as pulses, eggs, nuts, beans and soya products, such as tofu, tempeh and textured soya protein, and choosing lower fat versions where possible. This group of foods gives us iron (for healthy blood), protein, B vitamins, especially vitamin B12, zinc and magnesium.

Processed meat, such as bacon and salami, and meat products, such as sausages, beef burgers and pâté, are all relatively high in fat and aren’t recommended for health, so try to keep them to a minimum. Beans, such as canned baked beans and pulses, are a good low-fat source of protein and are high in fibre.

You should aim to eat at least two portions of fish a week. This can be fresh, frozen or canned and include fish fingers and fish cakes. One of your weekly portions should be made up of oily fish, such as sardines, salmon, mackerel, herring or trout, because they’re rich in omega-3 fatty acids and a good source of vitamins A and D. Fresh or canned tuna doesn’t count as a portion of oily fish but is still a good source of protein and some vitamins.

**Dairy and alternatives**

This group includes milk, cheese, yoghurt, fromage frais and other dairy foods in moderate amounts. Remember to choose lower fat varieties where you can (but check for sugar content). If you use soya or other plant-based alternatives, such as rice or oat milk substitutes, make sure you choose calcium-enriched varieties when possible. These foods supply calcium (for strong bones), protein, vitamin B12, and vitamins A and D.

This group doesn’t include butter, eggs and cream.

**Oils and spreads**

A small amount of fat in the diet is essential for health. This group includes unsaturated fats such as olive oil, rapeseed oil and their spreads. It’s important to get more of our fats from unsaturated oils or spreads because they help reduce cholesterol in the blood.

Fats have twice as many calories weight for weight as protein and carbohydrates so should be used in small amounts.

**Fluid**

You should have at least six to eight glasses of fluid a day. This can be from water, lower fat milk, sugar-free drinks, tea and coffee. Be aware of the calorie content of some drinks, such as fizzy drinks. Limit fruit juice and smoothies to no more than 150ml a day

**Foods high in fat, salt and sugar**

You don’t need the foods in this group so if you do have them, you should only have them occasionally and in small amounts. Some fats are easy to spot, such as cream, fat on meat, butter and margarine. Other fats are hidden in cakes, chocolate, crisps, pastry, mayonnaise, salad dressings, puddings, ice cream and rich sauces and gravies.

Sugar is just made up of calories and has no other nutrients. You can get all the energy you need from other foods, so you don’t need sugar. Too much sugar causes tooth decay and may contribute to obesity. Sugary foods include soft drinks, sweets, jam and sugar, as well as cakes, puddings, biscuits, pastries and ice cream. Read food labels and watch out for sucrose, dextrose, fructose and maltose on the ingredients list of packaged food because they’re all forms of sugar. Honey, syrup, raw sugar, brown sugar, cane sugar, muscovado and concentrated fruit juice are also forms of sugar.

Most of the salt we eat is already in everyday foods, such as bread, breakfast cereal, pasta sauce and soup. Check the label and choose foods that are lower in salt.

**Extra vitamins**

Adults should think about taking a daily vitamin D supplement during the autumn and winter months. Between late March to early April and the end of September most people can get all the vitamin D they need through sunlight on their skin and from a balanced diet.

Some people won’t get enough vitamin D from sunlight because they have very little or no sunshine exposure.

Welsh Government recommends that people should take a daily supplement containing 10 micrograms of vitamin D throughout the year if they:

* + aren’t often outdoors, for example, if they are frail and can’t leave the house
  + are living in a care home
  + wear clothes that cover up most of their skin when outdoors.

People with dark skin from African, African-Caribbean and south Asian backgrounds may also not get enough vitamin D from sunlight and should think about taking a vitamin D supplement all year around.

It’s important that individuals have a balanced diet with a variety of foods from the different food groups. This will help them get all the nutrients they need for their health and well-being.

**Keeping hydrated**

Fluid is essential for health. Individuals who aren’t drinking enough fluids are at risk of repeated infections, confusion or falling over.

Dehydration is the loss of water from the body and this can seriously affect the body if fluids aren’t replaced. The body needs water so that it can go on working normally every day.

The signs of dehydration are:

* + thirst and/or dry lips and tongue
  + sunken eyes and/or skin that looks dry and may sag
  + not passing much urine
  + headaches, confusion, lack of concentration and/or mood swings.

People lose fluid because of:

* + vomiting, diarrhoea and fever
  + heat exhaustion
  + medicines that remove water from the body
  + medical problems and ill health
  + drinking lots of alcohol as it removes water from the body.

People don’t drink enough fluid because:

* + of a loss of appetite
  + they’re not thirsty
  + they forget to drink
  + they can’t access drinks
  + drinks aren’t available
  + they’re trying to manage or avoid going to the toilet.

**How much fluid do we need?**

In the UK, it’s recommended that an adult drinks six to eight full glasses of fluid a day.

**What counts as fluid intake?**

Fluids include water and anything that contains water, such as tea, coffee and fruit drinks or juices. Soft drinks, such as cola and lemonade, are fine in small amounts only, but remember they contain lots of sugar and could lead to tooth decay.

Practical hints **–** you should encourage individuals to:

* + drink fluids often, before they get thirsty
  + drink more fluids on hot and humid days
  + try drinking small amounts of fluid more often throughout the day
  + drink more fluid when they’re more active or exercising
  + drink more if they have fever, diarrhoea or are vomiting.

**The importance of hydration**

Dehydration is common among older people and can lead to headaches, confusion, inability, falls, loss of appetite and constipation.

**Pressure ulcers**

Poorly hydrated individuals are twice as likely to develop pressure ulcers. This is because dehydration reduces the padding over the bony points. Drinking more fluids to improve dehydration increases the levels of oxygen in the tissue and helps ulcers heal.

**Constipation**

Poor fluid intake is one of biggest causes of chronic constipation. It’s more frequent in older people living in care homes and affects 42 per cent of patients admitted to geriatric wards. In individuals who are poorly hydrated, drinking more water can increase stool frequency. It can also help the beneficial effect of daily dietary fibre intake.

**Urinary infections and continence**

Water helps keep the urinary tract and kidneys healthy. Staying hydrated, rather than drinking lots of fluid, will help prevent a urinary tract infection (UTI). Many older people don’t like to drink in the evening because they want to avoid having to go to the toilet in the night. But, it’s been shown that drinking less fluid doesn’t reduce urinary incontinence.

**Kidney stones and gallstones**

Good hydration can reduce the risk of kidney stones forming by 39 per cent. This is because dilute urine helps stop stone-forming salts from crystallising. Drinking water regularly can also help dilute bile and encourage the gall-bladder to empty. This, in turn, helps prevent gall stones from forming.

**Heart disease**

Adequate hydration reduces the risk of heart disease by 46 per cent in men and by 59 per cent in women. It also helps prevent blood clots forming by lessening the blood’s viscosity (how ‘thick’ the blood is).

**Low blood pressure**

Many older people have a drop in blood pressure when they stand. This sometimes causes them to pass out. Drinking a glass of water five minutes before standing helps stabilise blood pressure and prevents fainting.

**Diabetes**

Water is essential for managing diabetes. This is because dehydration can worsen diabetic control. In individuals with poorly controlled diabetes, passing lots of urine can increase the risk of dehydration.

**Cognitive impairment**

Dehydration worsens mental performance. Symptoms of mild dehydration include light headedness, dizziness, headaches and tiredness. It reduces alertness and the ability to concentrate. Once you feel thirsty, mental function may be affected by up to 10 per cent. Mental performance gets worse as the individual becomes more dehydrated. In older people, this affects cognitive function, leading to increasing frailty, reducing their ability to do things for themselves and reducing their quality of life.

**Falls**

The risk of falls increases with age. In older people, falls can cause injury and fractures. For example, a broken hip can cause a person’s quality of life to get worse, over and above the trauma and hurt. These people rarely go back to having the same level of independence they enjoyed before the fall.

Dehydration has been identified as one of the risk factors for falls in older people. This is because it can lead to a deteriorating mental state and increase the risk of dizziness and fainting. Staying adequately hydration when you’re older helps prevent falls.

**Skin**

Being well hydrated is a good way to keep the skin healthy and young-looking. The skin acts like a water reservoir and helps regulate fluid for the whole body. Mild dehydration causes skin to look flushed, dry and loose, with a loss of elasticity, which makes it look older than it is.

**The role of health and social care workers**

Health and social care workers have a vital role in supporting individuals to stay hydrated. You can do this by making sure fluids are freely available during the day and night, and with meals, and that individuals can physically access them. You should be aware of the individual’s need for fluid and encourage them to drink. Many types of food contain lots of water. If an individual finds it difficult to drink more fluid, you can help them stay adequately hydrated by increasing the amount of water they get from foods, such as fruit and vegetables, which are about 80 to 90 per cent water.

There are simple things individuals can do to improve their diet if they have a poor appetite or need to gain some weight such as:

* eating little and often
* aiming for three small meals a day with snacks and nutritious drinks in between, such as cheese and crackers.

A healthy balanced diet is essential for individuals’ health and well-being. In Wales, we don’t eat the best diet for our health and don’t get the recommended levels of physical activity. Because of this, health in Wales compares poorly with that in England and in many other European countries. It’s important that people working in health and social care are aware of the impact of a poor diet and understand the contribution they can make to promoting good nutrition.

**Factors that can affect nutrition and hydration**

Lots of factors can affect individuals’ nutritional intake. These can include health, environmental, financial, cultural and social factors:

* **culture and religion:** Culture will affect the foods people choose and the way they’re cooked and eaten. Some religious groups may avoid certain foods or need food that’s prepared in a specific way, for example, halal meat for Muslims
* **individual preferences and habits:** Creating the right environment in which to eat and drink is important, particularly for older adults in care settings. Find out about a person’s food preferences or dietary requirements and encourage them to have a variety of food and drink so they get as many nutrients as possible
* **physical factors:** Health conditions that cause pain or difficulty when eating, for example, a sore mouth and dysphagia (difficulty swallowing), will affect nutritional intake. If you have any concerns about a person’s ability to swallow, report these to your manager
* **constipation and anaemia** (low iron) have been linked to poor appetite, with constipation specifically linked to poor hydration
* **psychological factors:** Being upset or depressed can discourage people from eating and drinking
* **stress and anxiety** can affect appetite and food choices
* **income, lifestyle and social convention:** Many low-income households struggle to afford a balanced diet. In Wales, about one in four people are living in poverty. Poor housing, lack of transport and a lack of cooking facilities may limit food and drink choices
* **advertising and fads:** Advertising has a significant impact on the foods and drinks we choose to buy. Many unhealthy foods and drinks that are high in fat, sugar and salt are marketed widely. Many fad diets are publicised in the media, which give misleading and false claims and can cause confusion
* **family and peer influences:** Families and carers and health and social care workers can positively affect nutritional intake by acting as role models. Individuals with a poor appetite are more likely to eat and enjoy their food if they can eat with friends, family or health and social care workers
* **ethics, morals and political beliefs:** Some people may avoid certain foods or whole food groups because of ethical beliefs or values, for example, vegans and vegetarians. It’s important they replace the nutrients from the foods they avoid to make sure they have get all the nutrients they need
* **neglect:** It’s important for health and social care workers to look out for those who may not be getting enough food and drink and who aren’t being properly cared for.

**Learning activity**

Read this case study and answer the questions.

**Case study – Aadesh**

Aadesh has just moved into supported accommodation as his father has died and his mother has moved into a residential care home. Aadesh doesn’t have any verbal communication. The team is having a lot of contact with his sister Rani to find out about his likes and dislikes and the best way to support him.

Aadesh’s family are from Gujarat. They’re strict vegetarians and their diet is mostly made up of plant-based foods – fruit, vegetables and grains. Aadesh’s key worker, Kevin, meets with Rani to ask her to plan a menu for Aadesh to include food he likes. Rani agrees to help with the menu planning and offers to come to the house to run cookery classes for the staff about preparing Gujarati food.

The staff are asked to record Aadesh’s reaction to each meal so they can work out which he seems to like best. Kevin also contacts the community dietician to check the menu plan so they can make sure Aadesh is getting all the nutrition he needs.

Answer these questions:

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| 1. How have the staff shown respect to Aadesh and his family? 2. Why do you think this is important? 3. How could the staff increase Aadesh’s choice of what he’s eating? 4. Why was it important to contact the dietician? |

**Let’s review what we’ve learnt so far**

**Quiz**

1. How many portions of fruit and vegetables should we eat each day?
2. five
3. three
4. seven
5. How many glasses of fluid should we be drinking each day?
6. four to six
7. six to eight
8. eight to 10
9. True or false?

Dehydration is the biggest cause of chronic constipation

**Manager’s comments for section 3.8**

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**Progress log – to be completed by the manager**

**3.8 Nutrition and hydration**

**The importance of nutrition and hydration for the health and well-being of individuals**

| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| --- | --- |
| What is meant by the terms ‘nutrition’ and ‘hydration’ |  |
| The principles of a balanced diet and good hydration and government recommendations for a balanced diet and hydration |  |
| National and local initiatives that support nutrition and hydration |  |
| The importance of a balanced diet for the optimum health and well-being of individuals |  |
| **Factors that can affect nutrition and hydration** |  |

## 3.9 Preventing falls

Everyone is at risk of falls as they get older. They’re a big cause of hospital admissions and can cause serious injuries. Falling can also lead to a loss of confidence and independence.

There are several factors that can lead to falls, but we can take action to reduce the risks:

* we rely on our balance to stay upright. As we age our balance, reaction times and reflexes slow down. This makes it harder for us to regain our balance if we over-reach or trip up. Some individuals with physical impairment, learning disabilities or dementia may also have additional challenges with their balance
* between the ages of 50 and 70, we lose about 30 per cent of our muscle strength. Regular physical activity helps to strengthen our muscles whatever our age
* bones become more brittle as we age, which means we’re more likely to get a fracture if we fall. Weight bearing activities are important for keeping bones strong, a healthy balanced diet will help make sure individuals get enough calcium and individuals should take vitamin D supplements over the winter months
* dizziness and drowsiness are common side effects of many medications. If individuals experience either, they should be referred to their GP
* as we age, our vision changes, including depth perception and the ability to see edges such as steps and kerbs. Having regular eye tests is really important for checking changes in our eyesight and our eye health. Individuals with a learning disability are more likely to have sight loss
* as we get older, drinking the same amount of alcohol results in a higher blood alcohol concentration. This is because as we age fat replaces muscle and alcohol isn’t drawn into body fat as well as it is into muscle. Older people are more likely to experience unsteadiness after drinking alcohol and are more at risk of falls. Medication may also affect how our body deals with alcohol
* poor lighting and clutter are particularly dangerous for falls. Good lighting and removing clutter, especially around the stairs, is important as is making sure that loose rugs, frayed carpets or trailing wires aren’t causing a tripping hazard
* foot care and wearing shoes or slippers that fit properly also reduce the risk of tripping and falling. Wet and slippery floors should be avoided, as well as walking around the house in socks
* how you organise the environment can cut the risk of falling, too. For example, having things within easy reach to avoid climbing or stretching too much to get them and having grab bars in bathrooms and rails by steps.

For more information about falls prevention, look at the Age Cymru’s [falls prevention information[[3]](#footnote-4)](https://www.ageuk.org.uk/cymru/information-advice/health-wellbeing/fitness/falls-prevention/) and the Health and Safety Executive’s webpage about [slips and trips in health and social care](http://www.hse.gov.uk/healthservices/slips/index.htm).[[4]](#footnote-5)

**Learning activity – foot care**

Read the case study and answer the questions.

**Case study – Mr Jones**

You support Mr Jones in his home. Mr Jones has some mobility problems but usually manages to get around the home using chairs and walls as props. You notice that Mr Jones seems to be having trouble reading his letters lately and the house is becoming more cluttered with newspapers stacked by the chair and dirty dishes left out in the kitchen. Mr Jones also insists on wearing his favourite slippers that are worn and no longer fit properly because they’ve stretched so much.

Answer these questions:

|  |
| --- |
| 1. What would your concerns be? 2. What actions should you take? 3. Where could you get more information and support to help Mr Jones? |

**Manager’s comments for section 3.9**

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**Progress log – to be completed by the manager**

**3.9 Falls prevention**

**How to support falls prevention**

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| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| **Factors that can contribute to falls** |  |
| How falls can be prevented |  |

## 3.10 End of life care

Social care settings may provide end of life care. We will all react differently when we approach the end of our lives and this is the same for the people you care for. Some will understand what’s happening, some won’t, some will be scared, others will find a sense of peace.

If you need to provide care for an individual at the end of their life, talk to the person you’re caring for or the people who know them well to find out what matters most to them. You can use this information to give comfort in a person’s final moments, acknowledging the life they’ve had and the person they are. What you’re doing is one of the most important things you can do for another human being.

**The five stages of grief**

The five stages of grief model was developed by Elisabeth Kübler-Ross, and became famous after she published her book *On Death and Dying* in 1969. Kübler-Ross developed her model to describe people with terminal illness facing their own death. But it was soon adapted as a way of thinking about grief in general.

The five stages – denial, anger, bargaining, depression and acceptance – are often talked about as if they happen in order, moving from one stage to the other, but this isn’t usually the case. People can experience aspects of grief at different times, and they don’t happen in one order. You may not experience all the stages and you may find feelings are quite different with different bereavements.

* **Denial –** feeling numb is common in the early days after a bereavement. Some people at first carry on as if nothing has happened. Even if we know in our heads that someone important has died, it can be hard to believe they aren’t coming back. It’s also very common to feel the presence of someone who has died, hear their voice or even see them
* **Anger –** this is a completely natural emotion after someone dies. Death can seem cruel and unfair, especially when you feel someone has died before their time or you had plans for the future together. It’s also common to feel angry towards the person who has died or angry at ourselves for things we did or didn’t do before their death
* **Bargaining –** when we’re in pain it’s sometimes hard to accept there’s nothing we can do to change things. Bargaining is when we start to make deals with ourselves, or perhaps with God if you’re religious. We want to believe that if we act in a certain way we’ll feel better. It’s also common to find ourselves going over and over things that happened in the past and asking lots of “what if” questions, wishing we could go back and change things in the hope things could have turned out differently
* **Depression –** sadness and longing are what we most often think of when we think about grief. This pain can be very intense and come in waves over many months or years. Life can feel like it no longer holds any meaning, which can be very scary
* **Acceptance –** grief comes in waves and it can feel like nothing will ever be right again. But gradually most people find that the pain eases and it’s possible to accept what’s happened. We may never ‘get over’ the death of someone precious, but we can learn to live again, while keeping the memories of those we have lost close to us.

Having families and loved ones close by at the end of life is important for many people, but for some this may not be wanted or possible. Either way, it’s important to find out what makes the individual feel safe and cared for such as:

* are they physically comfortable? Are they clean? Is their hair brushed? Is their dignity being protected?
* are there things they normally enjoy doing, such as listening to music, watching TV or gardening – how can you creatively support these activities in the current situation? Can you bring flowers from the garden into their room? Sit and listen to their favourite music with them? Read from a favourite book?
* are there ways to help their physical comfort by holding their hand, providing a favourite blanket, cushion or item of clothing?
* are there any religious or spiritual things that bring the person comfort, for example, a favourite reading or prayer, a hymn or a video call from their faith/spiritual leader?
* how can you keep the environment calm by avoiding loud noise and bright light?

**Communication**

If you’re in this situation you’ll need to consider what helps the individual and their loved ones understand the things that are happening and the choices they may have to make. Think about:

* what the person knows or understands already
* how to be with the person where they are. Perhaps they know what they want, so honour their decision making, or maybe they’re confused or have memory difficulties. They may still be fearful even if they can’t express their fears or wishes
* reflecting the words and language they use to talk about their health. This means using the same sort of words they use
* using clear words to avoid confusion even if those words don’t feel comfortable, for example, ‘dying’
* allowing silence and tears if they’ve just had bad news or if they sense their life is ending – sometimes just being there with them is all that’s needed
* who you can go to if the individual has questions you don’t feel you can answer. As a team, create a list of healthcare professionals involved in their care who can be contacted if you need advice
* your position – sit at the same level as the person where possible
* the tone of voice you use – try to reassure them and stay calm
* the reactions or emotions you might show in your face and try to put them into words, such as “I’m pleased you said that” or “I’m sad that this has happened to you”
* how to show you’re listening to the individual. Be patient, summarise what you’re hearing and check you’ve understood.

Remember: hearing is the last sense to go, so be careful about what you say and keep talking to the person.

**Leaving well**

If possible, it’s important to give people a chance to prepare for dying in their own way. This can also give the people left behind reassurance and memories. They may like to think about:

* how they want to say goodbye to their loved ones
* the affairs they need to leave in order, including writing wills, planning for social media profiles after death or buying presents
* the final goals they want to achieve
* the ways they want to help people remember them, such as through art, recorded messages, music and funeral planning. Think about their abilities when you’re helping them do it. If they have additional learning or physical needs, think creatively about how you can support them.

**Offering spiritual care**

According to Marie Curie: “Spirituality means different things to different people. Religion and faith might be part of someone’s spirituality, but spirituality isn’t always religious. Everyone has spiritual needs throughout their lives whether they follow a religion or not.” Spiritual needs can include the need:

* for meaning and purpose in our lives
* to love and feel loved
* to feel a sense of belonging
* to feel hope, peace and gratitude.

An individual’s approach to death and dying will be affected by their culture, religion, spirituality and personal belief. Each culture has rituals around expressing grief. These give a sense of stability and security, and bring comfort.

**End of life wishes, advance care planning and advance care plans**

We can think about what we’d like to happen if we became critically unwell and died. As a health and social care worker, you may come across times when the people you provide care for want to talk to you about their wishes if they need end of life care. These discussions are often called 'advance care planning'.

This means discussions where the individual concerned can talk about their preferences for the care they receive, who or what is important to them and decisions about their personal affairs. An advance care plan is a written record of those wishes.

**Advance Decisions to Refuse Treatments (ADRT)**

Some individuals have very clear wishes about the treatment they don’t want if they become critically unwell. These decisions can be recorded in a legal document called an ‘Advance Decision to Refuse Treatment’. These documents need to be signed by their GP or named doctor.

There’s a range of support for end of life care such as:

* hospices – these care for people from the point at which an illness is terminal until their death. They aim to improve the lives of people with a terminal illness, treating them with dignity and respect. Hospices provide holistic care for medical, emotional, social, practical, psychological and spiritual needs, as well as those of the family. Care in a hospice will be provided by doctors, nurses, social workers, therapists, counsellors and trained volunteers
* hospitals – with care from doctors, nurses and healthcare professionals, supporting medical care and pain relief
* palliative care teams – these provide pain and symptom control aiming to relieve pain and discomfort and improve quality of life. They can help with discharge plans from hospital or transfer to a hospice
* general practitioners – will prescribe medication, liaise with community nurses about care at home and care homes or hospices to make sure there’s 24-hour care
* community nurses – can give practical care in the home, advise on pain control and support family carers. They may include Macmillan nurses and Marie Curie nurses who provide palliative care and support families.

**Self-care**

If you’re supporting individuals with end-of-life care, it’s important to take time to acknowledge your own needs and provide self-care, recognising that you’re human and any loss of life is incredibly sad. You may well be going through the five stages of grief yourself.

[My Home Life](http://myhomelife.org.uk/wp-content/uploads/2014/11/MHL-issue-17.pdf) has resources about self-care and ways of coping with the death of someone you care for as a health and social care worker.

**Learning activity – end of life care**

Imagine you’re working with an individual and your manager asks you to find out what they’d like to happen should they become critically ill. How would you go about this? Who would you involve?

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**Manager’s comments for section 3.10**

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**Progress log – to be completed by the manager**

**3.10 End of life care**

**Factors that affect end of life care**

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| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| How death and dying, grief and mourning may impact on individuals and key people in their lives |  |
| How culture, religion and personal beliefs will impact upon approach to death and dying |  |
| What is meant by the terms ‘advance care planning’ and ‘advance directives’ and why these are important |  |
| The range of support that is available to support individuals with end of life care |  |
| The range of assistance that is available for workers when supporting individuals with end of life care |  |

## 

## 3.11 Assistive technology

Technology can and does make a real difference to people’s lives every day. Where would we be without all those gadgets and apps that help make our lives easier or more fun? Think about the technology you’ve already used today. Maybe your day started with a bedside alarm clock going off or an app on your smartphone and then perhaps you switched the light on in your bedroom and appreciated how warm it felt thanks to the central heating. Perhaps you then used the toilet – where would we be without that piece of technology! – and had a shower before taking the towel off your towel heater to get warm and dry.

Maybe you used a hairdryer to dry your hair while checking the news and weather for the day on your smartphone, then flicked through some of your messages or emails and your calendar to see what events you have on. You may then head downstairs to make a cup of coffee with your espresso machine, which you drink with a warm piece of toast that popped out of your toaster.

We all use technology to make our lives easier. We just take so much of it for granted that sometimes we don’t even think about it being ‘technology’ anymore.

There are a range of technologies to support people’s independence. These are often referred to as ‘assistive technology’. Assistive technology covers assistive products and services that can be used to help people live healthy, productive, independent and dignified lives, and to take part in daily life activities. They can maintain and improve an individual’s independence, promoting their well-being. Hearing aids, wheelchairs, spectacles, pill organisers and memory aids are all examples of assistive products.

In your role, it’s important to understand how assistive technology can help support individuals’ health, well-being and independence. There are many different terms used when talking about assistive technology, but it’s important to understand the technology we all use can also support and aid individuals to do things.

Technology can be used in two main ways:

1. support and assistance – helping individuals get on with their lives by making things easier

2. safety and well-being – helping keep individuals safe and which will contact responders automatically if there’s a problem.

Technology is all around us and is used to make life safer and easier for everyone. Sometimes the technology individuals use will be specifically designed to support their independence and keep them safe. Or it may be more everyday technology that everyone uses, such as smartphones.

Sometimes the assistive technology will be ‘low tech’, such as grab rails or walking aids, other times it will be ‘high-tech’ electronic assistive technology, which uses phone lines or computer systems. Examples include alternative keyboards, touch screens, voice and speech recognition and eye-gaze systems that allow individuals who are physically impaired to access a computer. These high-tech systems have an inbuilt camera which tracks where the person’s eyes are looking, allowing them to move the mouse pointer around. The individual can 'click' by blinking, staring at the screen for a certain length of time or using a switch.

The most commonly used high-tech electronic assistive technology you need to be aware of are telecare and telehealth.

**Telecare**

Telecare provides support and assistance from a distance using information and communication technology. It uses sensors to monitor individuals continuously, automatically and remotely so they can continue living in their own home, It can help minimise risks, such as falls, and detect gas leaks, fires or floods.

For example, Tudor lives on his own. He’s 87 years old and has dementia. He’s had some falls at home and recently left the grill on, causing smoke damage to his cooker. After an assessment, Tudor is given a ‘falls alarm pendant’, which he can press if he falls to alert the telecare centre. They also fitted a smoke alarm and carbon monoxide monitors, which are linked to the telecare centre.

**Telehealth**

Telehealth exchanges data remotely between an individual at home and their health professionals using phone lines or wireless technology. It can be used to help with diagnosis and monitoring, and can include devices to measure and monitor temperatures, blood pressure and other vital signs for review. Because of the Covid-19 pandemic, many health professionals have moved to online medical appointments and consultations.

Technology isn’t the answer for everything. It must be used responsibly and ethically and we must be realistic about the benefits. There are some things that technology does very well, but there are many examples where real-life health and social care workers are, and always will be, the best option.

Local health boards have teams of people that are trained to carry out assessments for assistive technology. These are often multi-agency teams that include rehabilitation officers, occupational therapists, assistive technology specialists and social workers. The use of assistive technology should be recorded in the individual’s personal plan.

**Learning activity – assistive technology**

Read the case study and answer the questions

**Case study – John**

John lives in a residential care home. He’s paralysed from the neck down. His wheelchair is set up with an environmental control system, which he can use to change the channel on the TV and make phone calls in private – something which is important to him. He has a set of door openers, which are linked to the system, meaning he can leave and enter his room without having to wait for staff support. He uses virtual assistant technology to open his curtains and turn his lights on and off.

Answer these questions:

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| * 1. How does assistive technology help John?   2. What impact do you think this has on his well-being? |

**Learning activity – assistive technology**

Think about the individuals you support and make a list of the assistive technology they use. Write down how this supports their well-being and helps them take part in activities

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**Manager’s comments for section 3.11**

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**Progress log – to be completed by the manager**

**3.11 Assistive technology**

**How assistive technology can be used to support the health and well-being of individuals**

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| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| What is meant by the terms ‘assistive technology’ and ‘electronic assistive technology’ |  |
| The types and range of technological aids that can be used to support an individual’s independence and how these can be accessed |  |
| How technological aids can be used to support **active participation** |  |
| The range of support that is available for the use of assistive technology |  |

## 3.12 Sensory loss

People who are older, have a learning disability or physical impairment are more likely to experience sensory loss. The individual may have had sensory loss from birth or it may have happened at a later age. It’s likely your work as a health and social care worker will bring you into contact with individuals who have sensory loss.

Sensory loss is when one of your senses; sight, hearing, smell, touch, taste and spatial awareness, doesn’t work as it should. For example, if you wear glasses you have sight loss, or if you find it hard to hear or have a hearing aid, then you have a hearing loss. An individual doesn’t have to have full loss of a sense for the impairment to be described as ‘blind’, ‘deaf’ or ‘deafblind’, as it can be partial.

Dual sensory loss or deafblind is the combination of hearing and sight impairment. It isn’t necessarily a total loss of both senses. In fact, most dual sensory impaired individuals have some sight and/or hearing.

The combination of the two sensory impairments intensifies the impact of each other, which usually means an individual who is deafblind will have difficulty using services for deaf people or services for blind people. Meeting the needs of deafblind people needs a separate approach.

Deafblindness is a unique and extremely complex disability that often needs specialist communication methods and systems to be introduced to the person and those around them so communication can take place

There are many causes of deafness, blindness and deafblindness. The two broad types are:

* congenital – this is the term used if an individual is born with a sight and/or hearing impairment. This may be due to infections during pregnancy, premature birth, birth trauma and rare genetic conditions
* acquired – this is the term used if a person experiences sight and/or hearing loss later in life. Anyone can experience sensory loss at any time through illness, accident or because of ageing.

Causes can include:

* medical complications during pregnancy and birth, including cerebral palsy
* a range of syndromes, such as Usher syndrome, CHARGE syndrome, congenital rubella syndrome and Down’s syndrome
* premature birth
* illness and accidents
* ageing
* glaucoma – damage to the optic nerve by pressure of fluid in the eye
* cataracts – clouding of the lens in the eye leading to a loss of vision
* macular degeneration – this is usually age related. It affects the middle part of vision and can be linked to smoking, high blood pressure, being overweight and family history
* diabetic retinopathy – a complication of diabetes caused by high blood sugars damaging the retina. It can cause blindness if left undiagnosed and untreated
* viral infections, such as meningitis
* hereditary conditions
* industrial and noise-induced deafness
* Meniere’s disease – a disorder of the inner ear, which causes vertigo and hearing loss.

Sensory loss can potentially impact:

* emotional and physical well-being
* voice and control
* choice
* confidence, self-esteem and sense of self
* independent living
* employment and training
* relationships
* social interactions
* community participation
* the ability to interact physically with an environment – both familiar and unfamiliar.

Making sure individuals can access information, are communicated with appropriately and have suitable environments are all important in reducing negative impacts. For example:

A GP surgery in Cardigan has identified everyone with sight loss who’s registered with them. They find out the preferred communication method for each person – phone calls, emails, texts or large print letters. Just sending printed letters, which they do for everyone else who’s registered with them, could mean people with sensory loss can’t access the services they need.

**Physical and environmental access**

Physical and environmental access needs to consider things such as:

* the layout – no clutter, the use of contrasting colours or textures and clear signage
* intercom or entry systems for individuals who have hearing loss
* lighting.

**Supporting effective communication**

People who are hard of hearing, deaf or deafblind communicate in many different ways. The way someone communicates is likely to depend on their preference and if they’ve acquired their sensory loss or were born with it.

Here are the top 10 tips from Sense for communicating with someone who has hearing loss:

1. avoid covering your mouth and try not to exaggerate your mouth patterns, as people may need to lip read
2. body language is important. Smiles translate in every language!
3. don’t shout, it can be uncomfortable for hearing aid users and might come across as aggressive
4. if there’s strong light, stand with it in front of you rather than behind you as it’s harder to see someone in silhouette
5. try to wear a plain, single coloured top. Bright, multi colours can be off putting to someone who relies on visual communication
6. if someone can't understand you, find another way to communicate. Could you re-phrase it, use gestures or write it down?
7. gently tap someone’s arm to politely get their attention
8. try to reduce background noise
9. if you have a T-Loop, turn it on!
10. be patient. If someone can’t hear you, try not to say “Oh never mind” or “I’ll tell you later”.

Everybody with a combined sight and hearing impairment connects, communicates and experiences the world differently. The approach to support will vary, but with the right support, individuals can lead a connected and fulfilled life.

There are thousands of ways to communicate and connect – be it through speech, sign language, touch, movement, gesture, sound, pictures, objects and manual or electronic aids.

Common ways of communicating include:

* sign language
* Makaton, a simpler version of sign language that uses signs and symbols
* braille, using raised dots to touch
* deafblind manual, spelling words on your hand
* lip reading.

Communication is also about creating a positive environment that helps interaction. For example, this may mean:

* changing the lighting in the room
* reducing the amount of background noise
* moving position so that you can see or hear better
* reducing clutter or removing things that are distracting.

**Indicators of sensory loss**

There are many indicators or signs of sensory loss that you can look out for. For sight loss, they include:

* holding reading materials further away or nearer than usual
* not reacting to visual clues or signs
* sitting too close to the television
* bumping into or tripping over objects
* moving around slowly and using walls as a guide
* not seeing nearby objects
* difficulty in seeing floor level changes
* discomfort with changes between light and dark
* difficulty in seeing objects off to the side
* white areas on the pupil
* irises changing colour
* complaining of seeing bright flashes of light.

Indicators and signs of hearing loss include:

* failing to react to voices coming from behind
* difficulty following and joining a group conversation
* inattention
* using a loud voice
* asking people to repeat what they’ve said
* turning the television volume up
* not responding to the doorbell or the telephone
* giving inappropriate responses to questions and conversation
* complaining of not being able to hear when there’s a lot of background noise
* feeling tired or stressed from having to concentrate while listening.

If you have any concerns about individuals you’re supporting, you should report them to your manager as soon as possible.

**Loss of taste and smell**

As we age, our sensory systems gradually lose their sharpness. This includes our ability to taste and smell.

The loss of taste experienced by individuals is made worse by smoking, chewing tobacco and poor oral care. This can make food taste unpleasant and can lead to the individual losing their appetite and not eating enough, increasing the risk of dehydration and malnutrition. Loss of taste and smell is experienced by many individuals who have diabetes, are living with dementia or those who’ve had a stroke

Loss of sense of taste and smell can also result in not being able to sense danger, such as gas leaks or smoke.

**Emotional impact**

We may not think about taste and smell very much, but they play a part in our feelings and memories.

Smell can trigger powerful emotions, such as disgust caused by the bad smell of a dirty bin, or joy from a scented flower. Smell can be part of attraction, such as your partner’s perfume. Smells can give you information, such as the smell of coffee telling you that you’re near a café. They can bring back memories, such as the smell of seaweed making you think of a holiday by the sea.

Losing the ability to smell can make you feel cut off from some experiences or give you a feeling of missing out. It can also be upsetting if your sense of taste and smell are altered, and you experience bad smells or tastes.

Taste also has an emotional and social impact. The pleasure you get from eating adds to your enjoyment of life. If you stop liking your favourite food and drink, this can make you feel sad or upset. On top of that, eating with other people can be an important social activity. Some people say they feel isolated if they can’t enjoy their food with everyone else.

Some ideas to improve appetite are:

* making food look bright and fresh
* vary the texture to make things more interesting to eat. Add crunch with raw vegetables, such as red pepper and cucumber, and have different textures, such as a handful of tortilla chips alongside a bowl of veggie chilli and rice
* arrange the food on the plate so it looks appealing
* try offering the food cold or at room temperature, rather than hot. Cooling can reduce strong or sweet flavours
* if the individual has a bad taste in their mouth, encourage plenty of fluids
* dilute sweet drinks, such as squash or juice, with water or soda
* use aromatic herbs and spices to add more flavour. Try herbs, such as tarragon, rosemary and mint, or spices, such as cumin, curry powder and chilli
* try adding toasted nuts, seeds or a squeeze of lemon to vegetables
* use pickles, chutneys or relishes
* use flavour boosters, such as low-salt stock cubes, mustard, a dash of Thai fish sauce or Worcestershire sauce, to add a savoury taste without too much salt.

If food tastes too sweet:

* choose sharp-tasting fruits such as gooseberries, blackcurrants, grapefruit or stewed rhubarb
* add spices to puddings, for example, nutmeg to rice pudding or custard, or ginger to stewed fruit or fresh melon.

If food tastes bitter:

* add some sweetness, such as small amounts of honey, or sweet spices, such as cinnamon, to hide bitter tastes.
* try alternatives to tea and coffee, such as lemon or herbal tea, hot chocolate or fruit juices.

If you support individuals who have sensory loss, you’ll find lots of organisations that provide support and information, including:

* RNIB: [www.rnib.org.uk/wales-cymru-1](https://www.rnib.org.uk/wales-cymru-1)
* RNID: [rnid.org.uk/about-us/rnid-in-wales/](https://rnid.org.uk/about-us/rnid-in-wales/)
* Sense: [www.sense.org.uk/](http://www.sense.org.uk/)

**Learning activity**

Read the case study and answer the questions.

**Case study – Peter**

Peter is 65 years old. He’s lived in an adult placement / shared lives arrangement in Ammanford for 10 years. Peter has hearing loss and uses Makaton to help with his communication.

Peter’s adult placement / shared lives carers have noticed he doesn’t always respond appropriately when they’re communicating with him – as if he doesn’t understand the Makaton they’re using. He’s also started ignoring them. Last week he hit out at them.

This week, Peter trips on the kerb and the steps on the bus.

Answer these questions:

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| 1. What do you think are the issues here? 2. What are the signs of further sensory loss for Peter? 3. What actions would you take? |

**Manager’s comments for section 3.12**

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**Progress log – to be completed by the manager**

**3.12 Sensory loss**

**How sensory loss can impact upon the health and well-being of individuals**

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| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| What is meant by the term ‘sensory loss’ |  |
| The causes and conditions of sensory loss |  |
| Indicators and signs of sensory loss |  |
| Factors that impact upon an individual with sensory loss |  |
| What needs to be considered when communicating with an individual with: sight loss; hearing loss; Deafblindness |  |
| The importance of supporting individuals to use aids such as hearing aids and glasses |  |
| What needs to be considered when supporting an individual with: loss of taste; smell or touch |  |
| The range of support that is available for individuals with sensory loss |  |

## 3.13 Dementia

**What is dementia?**

Dementia is an umbrella term for several conditions, such as Alzheimer’s disease.

There are more than 100 different types of dementia and depending on the type of dementia, you can expect to see changes in a person’s ability to remember, think, reason and solve problems. There may also be changes to a person’s communication skills and their ability to carry out everyday activities. These symptoms may become worse over time and will affect different people in different ways.

As people with dementia won't get better, we need to make sure we’re providing the best care and support to help minimise its impact on their everyday life.

While things will certainly change if a person has dementia, people can and do live well with the condition. Simple adjustments can help compensate for some of the symptoms and changes. These may include changes in and around the home, simplifying favourite hobbies and pastimes, and maintaining relationships with friends and family.

The three main types of dementia are:

**Alzheimer’s disease**

Alzheimer’s disease is the most common type of dementia, affecting six out of 10 people with dementia in the UK.

Proteins build up in the brain to form 'plaques' and 'tangles’, which cause structural changes to the brain. The brain becomes physically smaller and lighter, and chemical changes mean messages aren’t transmitted effectively.

Symptoms develop slowly over several years, gradually becoming worse and having a greater impact on a person’s ability to carry out everyday tasks.

**Vascular dementia**

Vascular dementia is the second most common type of dementia and is caused by reduced blood supply to the brain. This may be because of a stroke or a series of mini strokes or changes to the small vessels in the brain.

**Mixed dementia**

Mixed dementia occurs when Alzheimer’s disease comes with another type of dementia, usually vascular dementia.

**Myths about dementia**

There are many untrue myths about dementia

**Myth 1: Dementia is a natural part of ageing**

While age is a significant risk factor in developing dementia, not all older people will have dementia.

* There are 850,000 people living with dementia in the UK. Of those, 42,325 are under 65. This is called young-onset dementia
* One in six people over 80 are living with dementia. This means that five in six people over 80 don’t have dementia.
* One in 14 people over the age of 65 and one in 688 people under the age of 65 are living with dementia.[[5]](#footnote-6)

**Myth 2: Whether you get dementia or not is a lottery**

The causes of dementia aren’t fully understood, but we’re learning there are things we can do to reduce our risk factors:

* be physically active
* maintain a healthy weight
* be socially active
* avoid drinking too much alcohol
* stop smoking
* commit to review your health.

In doing so, we can reduce our risk factors by up to 60 per cent.

**Myth 3: People with dementia are like babies**

Some people will talk about people with dementia regressing and becoming like babies but this simply isn’t true. People living with dementia will have experienced and achieved many things in life and it’s damaging to think about them as childlike. This incorrect view can affect people’s attitudes by treating the person like a child and using terms such as “good girl” and “naughty boy,” which doesn’t treat individuals with respect and dignity.

The language used in dementia care is often negative, for example, “elderly mentally infirm”, “sufferers”, “wanderers”, people who are “damaged”. The language we use to talk about dementia influences how people with the condition are seen and how they feel about themselves. Every word matters – we must use positive words that focus on people’s strengths not their limitations. For example, say “a person living with dementia” rather than “a person suffering with dementia”.

**Focus on people's strengths**

It‘s important to recognise that while people with dementia may need support with some areas of their lives, particularly as their dementia progresses, they will keep their abilities. It’s better to think about the new behaviours people with dementia may experience as change rather than loss. It’s important to recognise strengths and work in an enabling way.

It’s about working with people, not doing to people. We all need to practise things to keep up our abilities. When friends, family and carers take over, often with a kind intent, people who have dementia will become more dependent on others and start to lose their previous abilities.

**There’s more to a person than dementia**

There’s a danger that when someone develops dementia, this becomes the main thing people see in them, not the person. As a result, some might think that the person with dementia is ‘no longer there’. This is harmful to the person, who may be treated as an object and not as someone with a life history and thoughts, feelings and desires.

**Why healthy living is important for people with dementia**

While diet, physical exercise and activities that stimulate the brain aren’t a miracle cure, they can improve quality of life for people with dementia, and in some cases, slow its progression.

**Health checks**

People living with dementia should continue to access local services and have regular checks with their GP. Problems with vision and hearing can add to the confusion of dementia, so make sure they have regular appointments.

Also, regular visits to the chiropodist can help maintain good foot health. Poor foot care can cause falls and will impact mobility. Dental checks to promptly treat or manage problems with teeth, gums or dentures may prevent pain or discomfort and difficulties with eating or drinking.

**Diet and dementia**

A healthy diet is important for health. Some people with dementia may eat too much and gain weight, which may have a knock-on effect on their mobility. In other cases, people may become undernourished. This can cause fatigue, confusion, irritability, constipation, muscle weakness and increased risk of infection.

Some problems with eating and drinking are caused by changes in a person’s ability to manage the food in their mouth.

They may experience problems with chewing and swallowing. Their tastes may have changed. People often favour sweet foods or may have changes to their appetite.

If you notice any changes, you must refer people for expert advice from speech and language therapists and/or dieticians.

**The importance of exercise**

Staying physically active is also important. Physical activities may include structured classes or just a gentle walk in the garden. Choosing an activity that motivates the person is most important and you should encourage them to do what they’ve always done to keep fit.

**Understanding personal histories**

Everyone has a story to tell, and the more you know about a person the better. Some information will be in the personal plan but this often focuses on care needs rather than the person’s history.

**Finding out about a person**

There are many ways to gather more personal information. These could be the person's preferred name, family, previous work, hobbies, routines and things that are important for you to know. This information can help you meet a person’s needs and will give you conversation starters. For instance, if you notice that someone has holidayed in Greece, you could say “tell me about your holiday in Greece”.

**Using life story work with people living with dementia**

Life story work will give more in-depth information about a person and is usually in the form of a book. It could be a collection of objects or a memory box.

Life story work can be useful in many ways. Among other things, it can be empowering and life affirming for the person living with dementia to record their story. It can help family members, too, and it’s a useful resource for workers to use and look at with the person with dementia.

**Friends and family of people with dementia**

Relationship-centred care acknowledges the value of relationships with family, friends, the wider community and paid workers who influence the experience of living with dementia.

**A dementia diagnosis will affect the whole family:**

* it's challenging. Families and carers will have to manage difficult changes in their loved ones’ behaviour and personality, including aggression in some cases. Caring full-time can leave family members feeling socially isolated and having to meet hidden costs
* it's rewarding. Caring is often a rewarding experience that can strengthen family bonds through the close and intimate relationship shared
* it can change family relationships. Changes in behaviour and personality can cause family carers to treat their loved one in a different, more childlike way. Carers’ relationships with siblings can also become strained as the amount of care increases
* it can affect mental and physical health. The negative health consequences of looking after a family member with dementia are well documented.[[6]](#footnote-7)

**Having a break from routine**

It’s also important to recognise that people living with dementia may also need a break from their everyday routine and environment. Research by the Older People’s Commissioner for Wales found that seeing their loved one stressed or worried impacted their quality of life and that a break either together or apart could make a difference.

(Rethinking Respite, the Older People’s Commissioner for Wales, 2018)

**Supporting families and carers**

Often it’s the little things that matter, such as a listening ear, words of reassurance, acknowledgement of feelings and the opportunity for support to do things that matter to them.

In an Alzheimer’s Society survey, family carers listed what they wanted most from home care support:

* enabling people with dementia to live an active and engaged life
* help to live and stay in their own home for as long as possible
* help to live as near normal a life as possible
* support in socialising with people and staying involved in their community
* regular support groups and respite for carers.[[7]](#footnote-8)

**One size doesn't fit all**

Think about yourself:

* what time do you normally wake?
* what is the first thing you do in the morning?
* are you washed and dressed before going downstairs or do you need a cup of tea before you even think about getting washed?
* when do you brush your teeth?
* do you prefer a bath or shower?
* which order do you do things in the shower? Hair first or body first?
* do you use particular products or are you happy to use anything?
* do you use a sponge, scrunchy or flannel?
* do you get your clothes ready the night before or grab anything in the morning?
* when do you have breakfast?
* what do you usually have? Or do you skip breakfast?

How do you feel if you can’t follow your normal routine?

We need to know as much detail as possible about a person with dementia’s routine, so that we can follow their way of doing things, instead of expecting them to follow our own routine.

**Non-verbal communication in dementia care**

We do many things each day on automatic pilot. We don’t think about it, we just do it. We do this using our procedural memory, that is our memory of how to do things. People with dementia can use their procedural memory to do everyday things, maybe with a little help to get them started.

**Why are hobbies so important?**

People are often identified by their hobbies, for example, as a 'footballer', an 'avid knitter' or 'crossword fanatic'. It's an important part of their makeup and as human beings, we need to be active and engaged to live well.

Doing our favourite things has many benefits for our health and well-being and can help us be more mentally alert. Hobbies involving other people also help keep us socially engaged and connected with those around us, chatting, laughing and preventing loneliness.

**Communication**

To communicate, we have to do certain things in a certain order. We must decide what we want to say and what method of communication would be most effective. We then send the message to someone else. They have to interpret the message and decide their response and reply or react.

**Why communication breaks down**

The process of communication can break down at any point. Perhaps there’s a lot of background noise and it’s difficult to hear or maybe we’re tired or we’re using the wrong way to communicate.

A breakdown in communication can cause feelings of frustration in a person living with dementia, which may then impact the way they behave.

**Recognising change in communication**

Communication skills will change over time. Changes may be subtle to begin with:

* taking a little longer to find the right word or describing items instead
* losing their train of thought mid-sentence
* difficulties understanding what’s being said or following complex sentences.

As dementia progresses, people will rely more and more on the other person’s non-verbal communication, how things are said and the tone of voice.

**Effective communication**

It’s important we recognise these changes and adapt what we do to make communication as effective as possible:

* minimise distraction: turn the television off or move to a quieter area or get the person’s attention. Try using their name at the beginning of the sentence
* think about your body position: can they see you? Get down to the person’s level and make eye contact. The visual field will shrink as the dementia progresses, so always approach from the person’s dominant side. You may need to get quite close before a connection is made
* speak clearly and calmly
* simplify your sentences without speaking in childlike terms
* use words the person uses. If they call the toilet the “powder room”, so should you
* avoid joining two sentences together by using “and”, “or”, “but”. Start a new sentence
* think about your tone of voice. Don’t speak to the person as you would to a child. Your tone of voice will be affected if you are in a rush, cross or fed up so remember it’s not always what you say, it’s how you say it
* avoid asking too many questions and consider yes or no questions instead
* while it’s important to give people choices, sometimes too many choices will cause confusion. If you read out a list of choices at mealtimes, people often ‘choose’ the last on the list, as it’s the one they remember. It may be better to simply ask “would you like fish?”, which needs a “yes” or “no” response, or even better show them the options
* communicate without words and use exaggerated gestures. For example, show a person how to brush their teeth by doing the actions instead of explaining how to do it. Use pictures to help with decision making and consider writing it down. Some people will be able to read but others may not. Use touch to reinforce spoken word.

**Being language sensitive**

Being language sensitive is very important in dementia care and equally affects people who speak a language other than English or Welsh. It also affects people who use British Sign Language.

One of the features of dementia is a progressive reduction in the ability to express ideas as words, and to recognise the meaning of spoken and written words. Where English was learned as a second language, the person may initially mix up English and their first language and then lose the ability to speak English completely, making it difficult to communicate with support workers and younger family members who don’t speak their language.

**Changes in people's behaviour – physical health**

If there’s a sudden change in a person living with dementia’s behaviour, there may be a physical reason for this.

**Delirium and dementia**

Has the person got an infection? Have they got a temperature? Are they constipated? Has there been a change in their medication? Have they had an anaesthetic? Any one of these could cause a delirium.

Delirium is more common in people with dementia than in those without. Delirium is a state of mental confusion that can occur when the person is medically unwell.

The person may become more agitated, more forgetful, more disorientated and experience hallucinations, especially by night. Some people will become more withdrawn and lethargic. Delirium is a medical emergency. We need to recognise it and treat the underlying cause**.**

**Is the person in pain?**

The experience of pain is different and personal to us. Try to remember a time you were in pain and think about how it made you feel and how it changed your behaviour. Research tells us pain is often under-recognised and under-treated in people with dementia.

The assessment of pain is usually self-reported, that is, we would describe our pain and may rate it using a scale of one to 10.

Where self-reporting isn’t possible or is unreliable because of a person’s dementia or communication difficulty, we can look at indicators to see if a person is in pain:

* **physical changes** – pallor, sweating, altered breathing or hypertension
* **facial expression** – grimacing, wincing, frowning, rapid blinking, brow raising or lowering, cheek raising, eyelid tightening, nose wrinkling, lip corner pulling, chin raising, lip puckering
* **body movements** – altered gait, pacing, rocking, hand wringing, repetitive movements, increased tone, guarding, bracing
* **verbalisations and vocalisations** – sighing, grunting, groaning, moaning, screaming, calling out, aggressive or offensive speech
* **changes in behaviour** – aggression, withdrawal, resistance
* **changes in activity patterns** – unsettled, altered sleep or rest patterns, changes in eating or a change in the level of interaction
* **mental state changes** – confusion, crying, distress, irritability, mood changes.

Understanding dementia is important for us all, not just those who are supporting individuals living with it. There’s a strong movement called ‘dementia friendly communities’, which has a programme encouraging everyone to share responsibility for making sure people with dementia feel understood, valued and able to contribute to their communities

**Learning activity – dementia**

Read this case study.

**Case study – Ceri**

Ceri has Alzheimer’s disease and has been admitted to a care home on an emergency basis as his wife has been taken into hospital following a stroke. The staff team report that while Ceri has settled well given the circumstances, he became upset and agitated when they helped him to bath.

Answer these questions:

|  |
| --- |
| 1. What do you think might be happening? 2. What action could you take? |

A member of staff speaks to Mari, Ceri’s daughter, on the phone. Mari explains that her dad has always preferred to shower since an incident when he got stuck in the bath a few years ago.

The staff have now changed the way they support Ceri with his personal care and it has made a difference. Once or twice Ceri has even burst into song when showering!

There’s lots of support for people living with dementia. Some key organisations are the Alzheimer’s Society [(www.alzheimers.org.uk)](http://(www.alzheimers.org.uk)) and Age Cymru ([www.ageuk.org.uk/cymru)](http://www.ageuk.org.uk/cymru)).

Individuals living with dementia can access support from services such as:

* GP
* community mental health teams (CMHTs)
* social (or community) care
* residential care
* crisis intervention
* hospital treatment.

**Let’s review what we’ve learnt so far**

**Quiz**

1. We can reduce our risk factors of getting dementia by:
2. being physically active
3. drinking alcohol
4. being socially active
5. stopping smoking
6. Which of these terms should we not use?
7. people living with dementia
8. people suffering dementia
9. people affected by dementia
10. Alzheimer’s disease affects how many people living with dementia in the UK?
    1. six out of 10
    2. four out of 10
    3. eight out of 10
    4. two out of 10

**Manager’s comments for section 3.13**

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**Progress log – to be completed by the manager**

**3.13 Dementia**

**How living with dementia can impact on the health and well-being of individuals**

|  |  |
| --- | --- |
| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| What is meant by the term ‘dementia’ |  |
| Indicators and signs of dementia |  |
| The ways dementia can affect individuals and how they experience the world |  |
| What is meant by ‘living well with dementia’ |  |
| How person centred approaches can be used to support individuals living with dementia |  |
| What needs to be considered when communicating with an individual living with dementia |  |
| The impact supporting and caring for an individual living with dementia, can have on family / carers |  |
| Ways that carers can be supported to continue in their role |  |
| What is meant by a ‘dementia friendly community’ and how this can contribute to the well-being of individuals living with dementia |  |
| The range of support that is available for individuals living with dementia |  |

## 3.14 Mental health

In many ways, mental health is just like physical health: everybody has it and we need to take care of it.

Good mental health means being able to think, feel and react in the way you need and want to live your life. But if you go through a period of poor mental health, you may find the way you think, feel or react becomes difficult, or even impossible, to cope with. This can feel just as bad as a physical illness, or worse.

Mental health problems affect around one in four people in any given year. They range from common problems, such as depression and anxiety, to rarer problems, such as schizophrenia and bipolar disorder.

Experiencing a mental health problem is often upsetting, confusing and frightening – particularly at first. If you become unwell, you may feel it's a sign of weakness or that you’re 'losing your mind'. But mental health problems are a common human experience.

Most people know someone who’s experienced a mental health problem. They can happen to all kinds of people from all walks of life. And it's likely that when the person finds a combination of self-care, treatment and support that works for them, they’ll get better.

There are many different mental health problems. Some have similar symptoms, but everyone's experience is different and can change at different times.

**Depression**

Depression is a feeling of low mood that lasts for a long time and affects everyday life. It can make people feel hopeless, despairing, guilty, worthless, unmotivated and exhausted. It can affect self-esteem, sleep, appetite, sex drive and physical health.

In its mildest form, depression doesn't stop people leading a normal life, but it makes everything harder to do and seem less worthwhile. At its most severe, depression can make people feel suicidal and be life-threatening.

Some types occur during or after pregnancy, known as antenatal and postnatal depression. Or, it may come back around the same time every year (seasonal affective disorder).

**Anxiety problems**

Anxiety is what we feel when we’re worried, tense or afraid, particularly about things that are about to happen or that we think could happen in the future.

Occasional anxiety is a normal human experience. But if a person’s feelings of anxiety are very strong, or last for a long time, they can be overwhelming. They may also experience physical symptoms, such as sleep problems and panic attacks.

**Phobias**

A phobia is an extreme form of fear or anxiety triggered by a particular situation, such as going outside, or by an object, such as a spider, even when it's very unlikely to be dangerous.

A fear becomes a phobia if the fear is out of proportion to the danger, it lasts for more than six months, and has a significant impact on how a person lives their day-to-day life.

**Eating problems**

Eating problems aren’t just about food. They can be about difficult things and painful feelings that a person may be finding hard to face or resolve. Lots of people think that if you have an eating problem you will be over or underweight, and that being a certain weight is always associated with a specific eating problem, but this is a myth. Anyone, regardless of age, gender or weight, can be affected by eating problems.

The most common eating disorder diagnoses are anorexia, bulimia and binge eating disorder. But it's also possible to have a very difficult relationship with food and not fit the criteria for any specific diagnosis.

**Schizophrenia**

Views on schizophrenia have changed over the years. Lots of people question whether it's a distinct condition or a few different conditions that overlap. But an individual may still be given this diagnosis if they experience symptoms such as:

* psychosis, for example, hallucinations or delusions
* disorganised thinking and speech
* feeling disconnected from their own feelings
* difficulty concentrating
* wanting to avoid people
* a lack of interest in things
* not wanting to look after oneself.

**Obsessive-compulsive disorder (OCD)**

Obsessive-compulsive disorder is a type of anxiety disorder. The term is often misused in daily conversation – for example, you may hear people talk about being “a bit OCD”, if they like things to be neat and tidy. But this disorder is a lot more complex and serious.

OCD has two main parts:

* obsessions – unwelcome thoughts, images, urges, worries or doubts that repeatedly appear in an individual’s mind
* compulsions – repetitive activities the individual feels they have to do to reduce the anxiety caused by the obsession.

**Personality disorders**

Personality disorder is a type of mental health problem where a person’s attitudes, beliefs and behaviours cause them longstanding problems in their life. If a person has this diagnosis, it doesn't mean they’re fundamentally different from other people – but they may regularly experience difficulties with how they think about themselves and others and find it very difficult to change these unwanted patterns.

There are several different categories and types of personality disorder, but most people who are diagnosed with a particular personality disorder don't fit any single category very clearly or consistently. Also, the term 'personality disorder' can sound very judgemental.

**Bipolar disorder**

Bipolar disorder, which was once called manic depression, mainly affects your mood. With this diagnosis an individual is likely to have times when they experience manic or hypomanic episodes, which means they feel high, depressive episodes when they feel low and potentially some psychotic symptoms.

Everyone has variations in their mood, but in bipolar disorder these swings can feel extreme and have a big impact on someone’s life. In between, the individual may have stable times where they experience fewer symptoms.

**Factors that may cause a period of mental ill-health:**

There are three main categories – biological, psychological and environmental or social. They can include:

* + childhood abuse, trauma or neglect
  + domestic violence, bullying or other abuse experienced as an adult
  + social isolation or loneliness
  + discrimination and stigma
  + social disadvantage, poverty or debt
  + bereavement
  + severe or long-term stress
  + having a long-term physical health condition
  + unemployment or losing a job
  + homelessness or poor housing
  + being a long-term carer for someone
  + drug and alcohol misuse
  + significant trauma as an adult, such as military combat, being involved in a serious incident, or being the victim of a violent crime
  + physical causes – for example, a head injury or a neurological condition such as epilepsy can have an impact on behaviour and mood
  + pregnancy
* postnatal period
  + gender identity.

Although lifestyle factors including work, diet, drugs and lack of sleep can all affect mental health, if individuals experience a mental health problem there are usually other factors as well.

People who are experiencing mental ill health may also have:

**Panic attacks**

Panic attacks are a type of fear response. They're an exaggeration of your body's normal response to danger, stress or excitement.

During a panic attack physical symptoms can build up very quickly, including:

* a pounding heartbeat or chest pains
* sweating and nausea (feeling sick)
* feeling faint and unable to breathe
* shaky limbs, or feeling like your legs are turning to jelly
* feeling as if you aren't connected to your body.

**Self-harming behaviours**

Self-harm is when a person hurts themselves as a way of dealing with very difficult feelings, painful memories or overwhelming situations and experiences. They may not know why they self-harm, but it can be a means of expressing feelings they can't put into words or think clearly about.

**Suicidal feelings**

Many people experience suicidal thoughts and feelings at some point in their life. They can be very unpleasant, intrusive and frightening, but having thoughts about suicide doesn't necessarily mean they intend to act on them. Most people don't go on to attempt to take their own lives.

**Psychosis**

Psychosis, also called a psychotic experience or psychotic episode, is when the person perceives or interprets reality in a very different way from people around them. The most common types of psychosis are:

* hallucinations, such as hearing voices or having visions
* delusions, such as paranoia or delusions of grandeur.

Psychosis affects people in different ways. They might experience it once, have short episodes throughout their life, or live with it most of the time. It's also possible to have a psychotic experience without ever being diagnosed with a particular mental health problem.

Some people have a positive experience of psychosis. They may find it comforting or feel that it helps them understand the world or makes them more creative.

**Living well with mental ill health**

Self-care techniques and general lifestyle changes can help manage the symptoms of many mental health problems. They may also help prevent some problems from developing or getting worse. These can include:

**Being aware of mental health**

* knowing what helps, telling people and being aware of triggers
* spotting the early warning signs. Being aware of feelings and watching out for any signs of becoming unwell
* keeping a mood diary, as tracking moods can help someone work out what makes them feel better or worse. They can then take steps to avoid, change or prepare for difficult situations
* building self-esteem. Taking steps to increase self-esteem can help the person feel more confident and able to cope.

**Having a good social life**

Feeling connected to other people is important. It can help us feel valued and confident about ourselves and can give a different perspective on things. It’s important to try to spend some time connecting with friends and family. Even a text or phone call can make a difference.

**Using peer support**

When a person experiences a mental health problem it can feel like no one understands. Peer support brings together people who've had similar experiences to support each other. This can offer many benefits, such as:

* feeling accepted for who you are
* increased self-confidence
* meeting new people and using your own experiences to help others
* finding out new information and places for support
* challenging stigma and discrimination.

**Therapeutic activities**

There are techniques and therapies people can safely practise on their own. For example:

* relaxation, such as having a bath, listening to music or taking the dog for a walk
* mindfulness, which is a therapeutic technique that involves being more aware of the present moment. This can mean both outside, in the world around us, and inside, in our feelings and thoughts. Practising mindfulness can help the individual become more aware of their own moods and reactions, but not everyone finds mindfulness helpful
* getting into nature. Getting out into a green environment, such as a park or the countryside, is especially good for us. Even if individuals don’t have a garden or aren't very mobile, caring for plants or animals indoors can still help them get some benefits from nature.

**Looking after physical health**

**Avoid drugs and alcohol**

While the individual might want to use drugs or alcohol to cope with difficult feelings, in the long run they can make them feel a lot worse.

**Make time for personal care**

When an individual is experiencing a mental health problem, it's easy for personal care to not feel like a priority. But small everyday things, such as taking a shower and getting fully dressed, can make a big difference to how we feel.

**Eat healthily**

What we eat and when we eat can make a big difference to how well we feel.

Individuals experiencing mental ill health can get support from a range of services such as:

* GPs
* community mental health teams (CMHTs)
* social or community care
* residential care
* crisis intervention
* hospital treatment.

MIND has lots of information about mental health if you would like to find out more: [www.mind.org.uk/](https://www.mind.org.uk/)

**Let’s review what we’ve learnt in this section**

**Quiz**

1. Mental health problems affect how many people each year?
2. one in two
3. one in four
4. one in six
5. one in eight
6. Tick the four factors from this list that may result in a period of mental ill health
7. abuse
8. loneliness
9. bereavement
10. ageing
11. alcohol misuse
12. Write down three self-care techniques that can help manage the symptoms of mental health problems

a)

b)

c)

**Manager’s comments for section 3.14**

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**Progress log – to be completed by the manager**

**3.14 Mental health**

**How mental ill-health can impact upon the health and well-being of individuals**

|  |  |
| --- | --- |
| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| What is meant by the term ‘mental ill-health’ |  |
| Factors that can contribute or lead to mental ill-health |  |
| Indicators and signs of mental illness |  |
| The potential impact of mental ill-health on health and well-being |  |
| Ways in which individuals can be supported to live well with mental ill-health |  |
| Positive outcomes associated with improved mental health and well-being |  |
| The range of support that is available to help individuals with mental ill-health |  |

## 3.15 Substance misuse

Substance misuse refers to the harmful use of substances, such as drugs and alcohol, for non-medical purposes. It includes substances such as glue, petrol, caffeine and prescribed medication. People who misuse substances do it no matter what the consequences because they might enjoy the feelings they get. Or they use substances as a way of escaping painful and distressing thoughts. Some substances, such as alcohol and heroin, can be physically addictive, so for people who misuse them regularly it can be hard to stop. They need to do this safely to minimise harmful effects on their bodies.

Many people use substances from time to time. This is known as recreational use and for most there are no harmful effects. Longer term, regular misuse is known to cause a range of problems and can lead to the person:

* being isolated from family and friends
* being physically unwell
* experiencing mental health problems
* being unable to maintain education or employment
* becoming involved with the police if crimes are committed.

Substance misuse is something that can affect people from all backgrounds. Substance misuse and addiction don’t discriminate and anyone can be affected, regardless of gender, age, race, education, wealth or religion. While taking drugs or alcohol for the first time is generally down to choice, nobody plans to become addicted.

**Drugs**

Some people can experiment out of curiosity and then never touch drugs again, but others like the feelings they get and become hooked after their first try. Unlike other types of addiction, such as gambling or sex, there are some obvious signs of substance misuse.

Because drug misuse tends to lead to addiction, which is classed as an illness of the brain, there are usually behavioural symptoms that lead others to believe something isn’t quite right with the affected individual. After a while, certain physical symptoms may become more noticeable.

Although the signs of drug misuse vary depending on the drug being used, there are common symptoms that show there’s a problem. These can include:

* severe mood swings where the person is depressed one minute and then suddenly becomes happy and carefree
* becoming increasingly isolated and withdrawn, and spending more and more time alone
* neglecting personal hygiene and grooming
* losing interest in activities and hobbies that he or she previously enjoyed
* trouble sleeping or sleeping more than usual
* glassy or watery eyes
* dilated pupils
* runny nose.

**Alcohol**

Since alcohol is so widely accepted in modern culture, it can be difficult to know when a person’s drinking has crossed the line from casual to problematic. Identifying alcohol misuse is challenging. This is why we say it’s important for anyone who thinks someone has a drinking problem to understand and be able to identify the signs.

The NHS defines alcohol misuse as drinking more than what’s considered lower-risk by government standards[[8]](#footnote-9). For alcohol use to be seen as abuse, a drinker needs to be routinely at the upper end of misuse. That would mean consuming between 15 and 35 units of alcohol every week. A 750ml bottle of wine is around 10 units[[9]](#footnote-10).

Unfortunately, the NHS guidelines don’t tell the whole story. That’s because units of alcohol are based on what the average adult body can process in one hour of drinking. But people are different. The amount of alcohol your body can process in one hour might be different to your spouse, partner or friends. To understand what alcohol misuse looks like, we must look at other factors.

You may have a drinking problem if you:

* tend to drink to make yourself feel better
* think you need to drink to relax
* lie to other people about your drinking habits
* experience guilty feelings after a drinking episode
* routinely experience blackouts after drinking
* regularly find yourself drinking more than you had planned
* notice friends and family members showing concern about your drinking habits.

These are all warning signs that suggest something is going on. They don’t necessarily mean that a doctor would clinically diagnose you as an alcohol abuser or alcoholic, but they are cause for concern to the degree that you should seek professional help.

Other signs are:

* poor work performance
* neglecting home responsibilities
* reckless behaviour
* damaged relationships
* financial problems.

**Learning activity – substance misuse**

Read this case study and answer the questions:

**Case study – Jackie**

Jackie is 78 years old. She has mobility problems and receives care and support in her own home three times each day. Her daughter Karen orders her food shopping online each week. Jackie likes to drink wine in the evening so her food order always includes three bottles of wine. Jackie has been asking her workers to go to the shop to buy her more wine within three days of her food shop being delivered. She asks them not to tell Karen as she will make a fuss and it’s none of her business how she spends her money or what she drinks. Jackie’s mobility seems to be getting worse and she has had several falls recently in the evenings.

Answer these questions:

|  |
| --- |
| 1. What would your concerns be? 2. How many units of alcohol is Jackie consuming if she drinks five bottles of wine? 3. What is the maximum number of units recommended by the NHS over a week? 4. What may the impact be on Jackie’s health and well-being? 5. What actions would you take? 6. What would the dilemmas be in this situation? 7. What section of the [Code](https://socialcare.wales/cms_assets/file-uploads/Code-of-Professional-Practice-for-Social-Care-web-version.pdf) would help guide you? |

**Manager’s comments for section 3.15**

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**Progress log – to be completed by the manager**

**3.15 Substance misuse**

**How substance misuse can impact upon the health and well-being of individuals**

|  |  |
| --- | --- |
| **By completing the workbook activities in this section the worker has shown they know** | **Sign and date** |
| What is meant by the term ‘substance misuse’ |  |
| Indicators and signs of substance misuse |  |
| The potential impact of substance misuse on the health and well-being of individuals |  |
| The range of support that is available to individuals who misuse substances |  |

## 3.16 Workbook reflection

**Learning activity**

Reflection is an essential part of health and social care practice. In the space below, write down three things you’ve learnt from completing this workbook and how you will put them into practice:

|  |
| --- |
|  |

|  |
| --- |
| **New worker declaration**  I confirm the evidence listed for the workbook is authentic and a true representation of my own work.  Learner’s signature:  Date:  **Manager’s declaration**  I confirm the new worker has achieved all the requirements of the workbook with the evidence submitted.  Manager’s signature:  Date: |

## Practice learning outcomes

These are the practice learning outcomes of the All Wales induction framework (AWIF). It may be helpful to ask your manager to complete these here rather than have a separate document to record evidence of how you apply your knowledge in your day-to-day work.

**3.1 Well-being**

**What well-being means in the context of health and social care**

|  |  |  |
| --- | --- | --- |
| **3.1b AWIF practice learning outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| Recognise the importance of families, friends and community networks and work in a way that supports and develops these relationships |  |  |
| Recognise what matters to individuals |  |  |

* 1. **Factors that impact upon the health and well-being of individuals**

**Factors that impact upon the health and well-being of individuals**

|  |  |  |
| --- | --- | --- |
| **3.2b AWIF practice learning outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| You know where to access further information or support related to the health and well-being of the individuals that you support |  |  |
| Take account of any specific factors that impact upon the health and well-being of the individuals that you work with |  |  |
| Support health promotion |  |  |

**3.3 Support for personal care and continence**

**How to support individuals with their personal care and continence management**

|  |  |  |
| --- | --- | --- |
| **3.3b AWIF practice learning outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| Follow individuals’ **personal plans** when assisting them with their personal care and / or continence management |  |  |
| Follow **workplace** policies and procedures for the recording of information when supporting a person with management of their continence |  |  |
| Follow workplace policies and procedures for infection prevention and control when supporting an individual with their personal care and continence management |  |  |

**3.4 Pressure area care**

**Good practice in relation to pressure area care**

|  |  |  |
| --- | --- | --- |
| **3.4b AWIF practice learning outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| Follow individuals’ personal plans and risk assessment when assisting them with pressure area care |  |  |
| Follow workplace policies and procedures for infection prevention and control when supporting an individual with pressure area care |  |  |
| Follow workplace policies and procedures for reporting and recording any changes in skin condition including improvement or deterioration |  |  |

**3.5 Oral health care**

**How to support good oral health care and mouth care for individuals**

|  |  |  |
| --- | --- | --- |
| **3.5b AWIF practice learning outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| Follow individuals’ personal plans when assisting them with mouth care |  |  |
| Follow workplace policies for infection prevention and control when supporting individuals with mouth care |  |  |
| Follow workplace policies and procedures for recording and reporting any changes in the condition of the mouths of individuals |  |  |

**3.6 Foot care**

**Supporting the health, well-being and development of individuals with additional support needs**

|  |  |  |
| --- | --- | --- |
| **3.6b AWIF practice learning outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| Follow individuals’ personal plans when assisting them with their foot care |  |  |
| Follow workplace policies and procedures in the monitoring, recording and reporting of the feet condition of individuals |  |  |

**3.7 Administration of medication**

**Roles and responsibilities related to the administration of medication in social care settings**

|  |  |  |
| --- | --- | --- |
| **3.7b AWIF practice learning outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| You are aware of what you can and cannot do in relation to the administration and use of medication at this stage of your training in the context of your role |  |  |
| Follow your workplace policies and procedures in support of the administration and use of medication |  |  |

**3.8 Nutrition and hydration**

**The importance of nutrition and hydration for the health and well-being of individuals**

|  |  |  |
| --- | --- | --- |
| **3.8b AWIF practice learning outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| Take account of any specific nutrition and hydration requirements for the individuals that you support |  |  |
| Follow workplace policies and procedures for monitoring and recording when supporting individuals with the management of their nutrition and hydration |  |  |

**3.9 Falls prevention**

**How to support falls prevention**

|  |  |  |
| --- | --- | --- |
| **3.9b AWIF practice learning outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| Minimise the factors that can contribute to falls |  |  |
| Follow workplace policies and procedures for the recording and reporting of any concerns about factors that may lead to falls |  |  |

**3.10 End of life care**

**Factors that affect end of life care**

|  |  |  |
| --- | --- | --- |
| **3.10b AWIF practice learning outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| Follow workplace policies and procedures when supporting individuals with end of life care |  |  |

**3.11 Assistive technology**

**How assistive technology can be used to support the health and well-being of individuals**

|  |  |  |
| --- | --- | --- |
| **3.11b AWIF practice learning outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| Follow workplace policies and procedures for the use of assistive technology |  |  |

**3.12 Sensory loss**

**How sensory loss can impact upon the health and well-being of individuals**

|  |  |  |
| --- | --- | --- |
| **3.12b AWIF practice learning outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| Take account of sensory loss support requirements |  |  |

**3.13 Dementia**

**How living with dementia can impact on the health and well-being of individuals**

|  |  |  |
| --- | --- | --- |
| **3.13b AWIF Practice Learning Outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| Support individuals that you work with to live well with dementia |  |  |

**3.14 Mental health**

**How mental ill-health can impact upon the health and well-being of individuals**

|  |  |  |
| --- | --- | --- |
| **3.14b AWIF Practice Learning Outcomes: You are able to work in ways that:** | **Evidence used** | **Signature and date** |
| Support individuals to live well with mental ill-health |  |  |

**3.15 Substance misuse**

**How substance misuse can impact upon the health and well-being of individuals**

There are no general practice learning outcomes. These will be covered by your employer if there are any specific to your role.

**Checklist for related workplace policies and procedures**

Administering medication

Infection prevention and control

Personal care including:

pressure area care

oral care

foot care

End of life care

## Glossary:

**Active participation** is a way of working that looks at individuals or children and young people as active partners in their own care or support, rather than people who passively receive it. Active participation recognises each individual or young person’s right to take part in everyday activities and relationships, as independently as possible. For children and young people, this will depend on their age and stage of development.

**Carers** includes any person over 18 who provides or plans to provide care or support to another adult who needs care. This includes emotional, as well as physical, care and support. A person who’s paid to provide care or does so as a voluntary worker is not considered a carer.

**Factors that can contribute to falls** include:

* balance problems
* muscle weakness
* poor vision
* long-term health conditions, such as heart disease, dementia or low blood pressure, that can lead to dizziness and brief loss of consciousness
* environmental factors.

**Environmental factors** include:

* wet floors
* dim lighting
* rugs or unsecured carpets
* clutter
* reaching for storage areas
* going up or down stairs
* rushing to get to the toilet or answer the door.

**Factors that affect individuals’ health, well-being and development may include:**

* adverse circumstances or trauma before or during birth
* attachment
* autistic spectrum conditions
* dementia
* family circumstances
* frailty
* harm or abuse
* injury
* learning disability
* medical conditions (chronic or acute)
* mental health
* physical disability
* physical ill health
* placement disruption
* poverty
* profound or complex needs
* sensory needs
* stability
* social deprivation
* substance misuse.

**Factors that can affect nutrition and hydration** can include:

* culture and religion
* individual preferences and habits
* physical factors, such as positioning and oral hygiene
* psychological factors, such as depression and eating disorders
* income, lifestyle and social convention
* advertising and fads
* family and peer group influences
* ethics, morals and political beliefs
* neglect.

The **individual** is the person you support or care for in your work. This could be a child or an adult.

1. *Social services: The national outcomes framework for people who need care and support and carers who need support.* Date issued: February 2019 [↑](#footnote-ref-2)
2. [www.sheffield.ac.uk/polopoly\_fs/1.811379!/file/Senses\_Framework\_Posters.pdf](https://www.sheffield.ac.uk/polopoly_fs/1.811379!/file/Senses_Framework_Posters.pdf) [↑](#footnote-ref-3)
3. Web address: <https://www.ageuk.org.uk/cymru/information-advice/health-wellbeing/fitness/falls-prevention/> [↑](#footnote-ref-4)
4. Web address: www.hse.gov.uk/healthservices/slips/index.htm [↑](#footnote-ref-5)
5. Source: Dementia UK, 2014 [↑](#footnote-ref-6)
6. Dementia in the Family, Alzheimer's Research UK, 2017 [↑](#footnote-ref-7)
7. Support. Stay. Save, Alzheimer's Society, 2012 [↑](#footnote-ref-8)
8. [Alcohol misuse - Risks - NHS (www.nhs.uk)](https://www.nhs.uk/conditions/alcohol-misuse/risks/) [↑](#footnote-ref-9)
9. [Alcohol units - NHS (www.nhs.uk)](https://www.nhs.uk/live-well/alcohol-advice/calculating-alcohol-units/) [↑](#footnote-ref-10)