Case Study

say design UK

GRAPHIC & DIGITAL DESIGN

saydesignUK

Get creative
with your business

GRAPHIC & DIGITAL DESIGN

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INFOGRAPHICS
DIGITAL DOCS
PROSPECTUSES
WORKBOOKS
WEB DESIGN
BRANDING

Welcome.

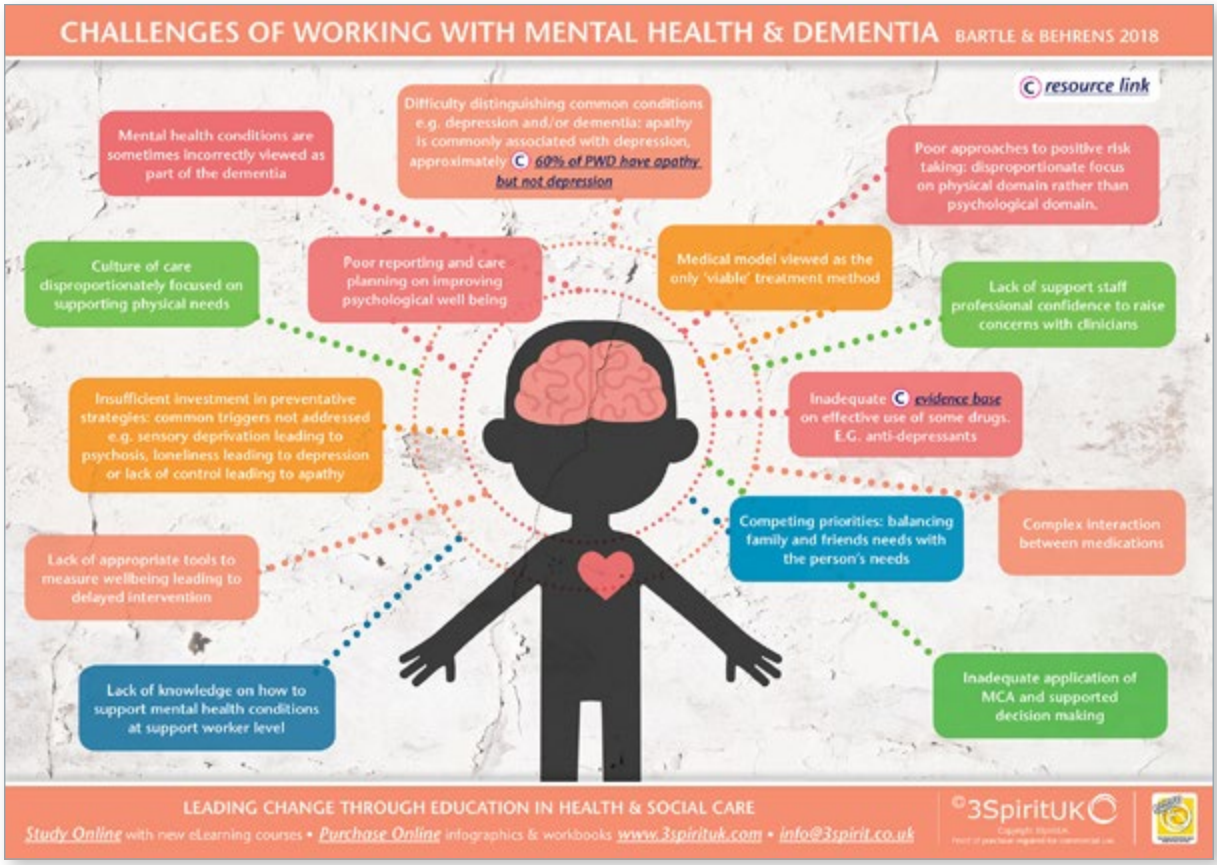
I have worked for 10 years with 3SpiritUK on educational and dementia care materials.

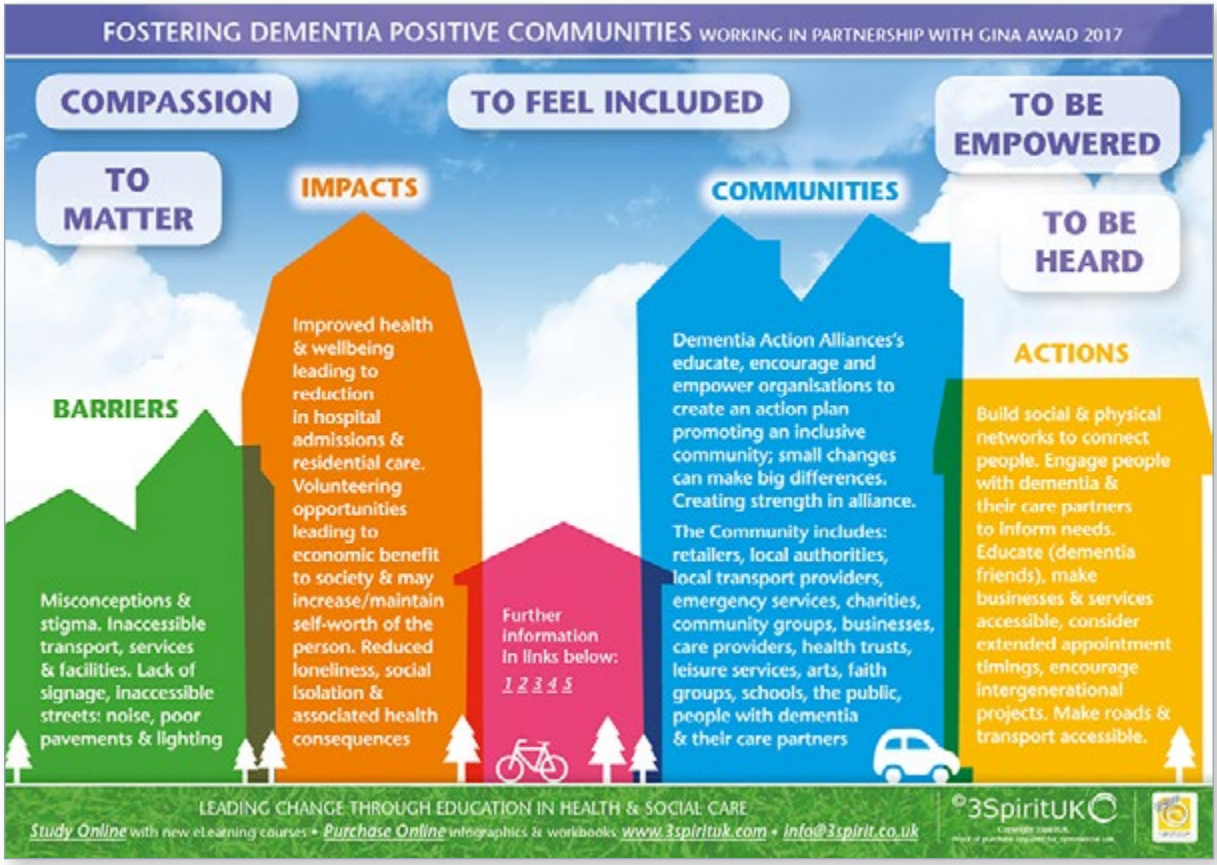
Here you'll find some highlighted projects.

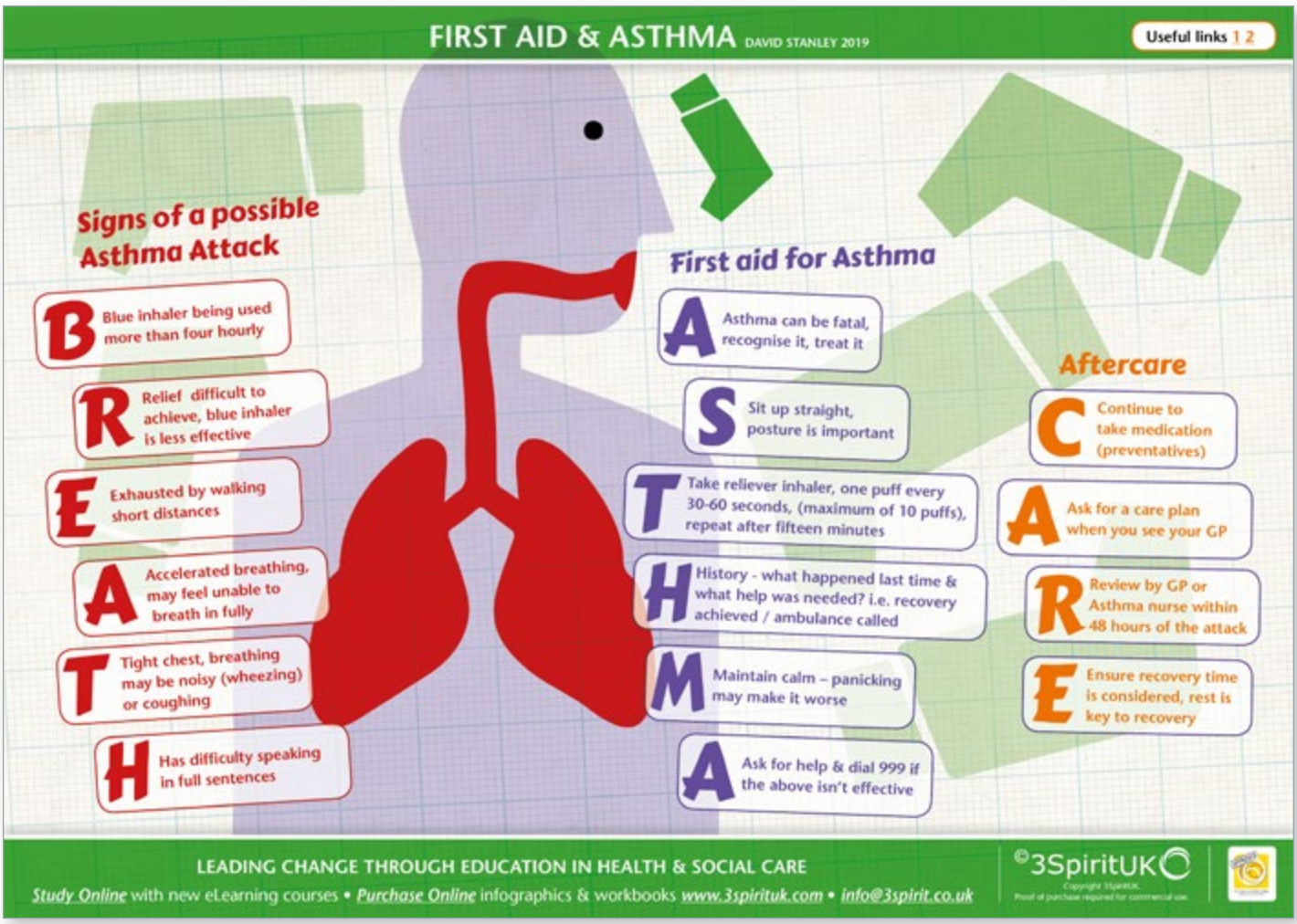
> *Utterly brilliant - exceptionally creative. Stephanie has a really broad range of skills from design to branding to website design. She has done wonders for my business to grow our audience both nationally and internationally. Highly recommended.*
>
> *Caroline Bartle, Founder Chair, CEO 3Spirit*
> *Dip SW, BA Hons, M.B.A, Pg Dip Dementia Studies*

"Developing highly creative and impactful infographics put us in front of a much larger audience, and directly led to new commissions."

Caroline Bartle






FIRST AID & ASTHMA DAVID STANLEY 2019
Useful links 1 2
Signs of a possible Asthma Attack
B Blue inhaler being used more than four hourly
R Relief difficult to achieve, blue inhaler is less effective
E Exhausted by walking short distances
A Accelerated breathing, may feel unable to breath in fully
T Tight chest, breathing may be noisy (wheezing) or coughing
H Has difficulty speaking in full sentences
First aid for Asthma
A Asthma can be fatal, recognise it, treat it
S Sit up straight, posture is important
T Take reliever inhaler, one puff every 30-60 seconds, (maximum of 10 puffs), repeat after fifteen minutes
H History - what happened last time & what help was needed? i.e. recovery achieved / ambulance called
M Maintain calm – panicking may make it worse
A Ask for help & dial 999 if the above isn't effective
Aftercare
C Continue to take medication (preventatives)
A Ask for a care plan when you see your GP
R Review by GP or Asthma nurse within 48 hours of the attack
E Ensure recovery time is considered, rest is key to recovery
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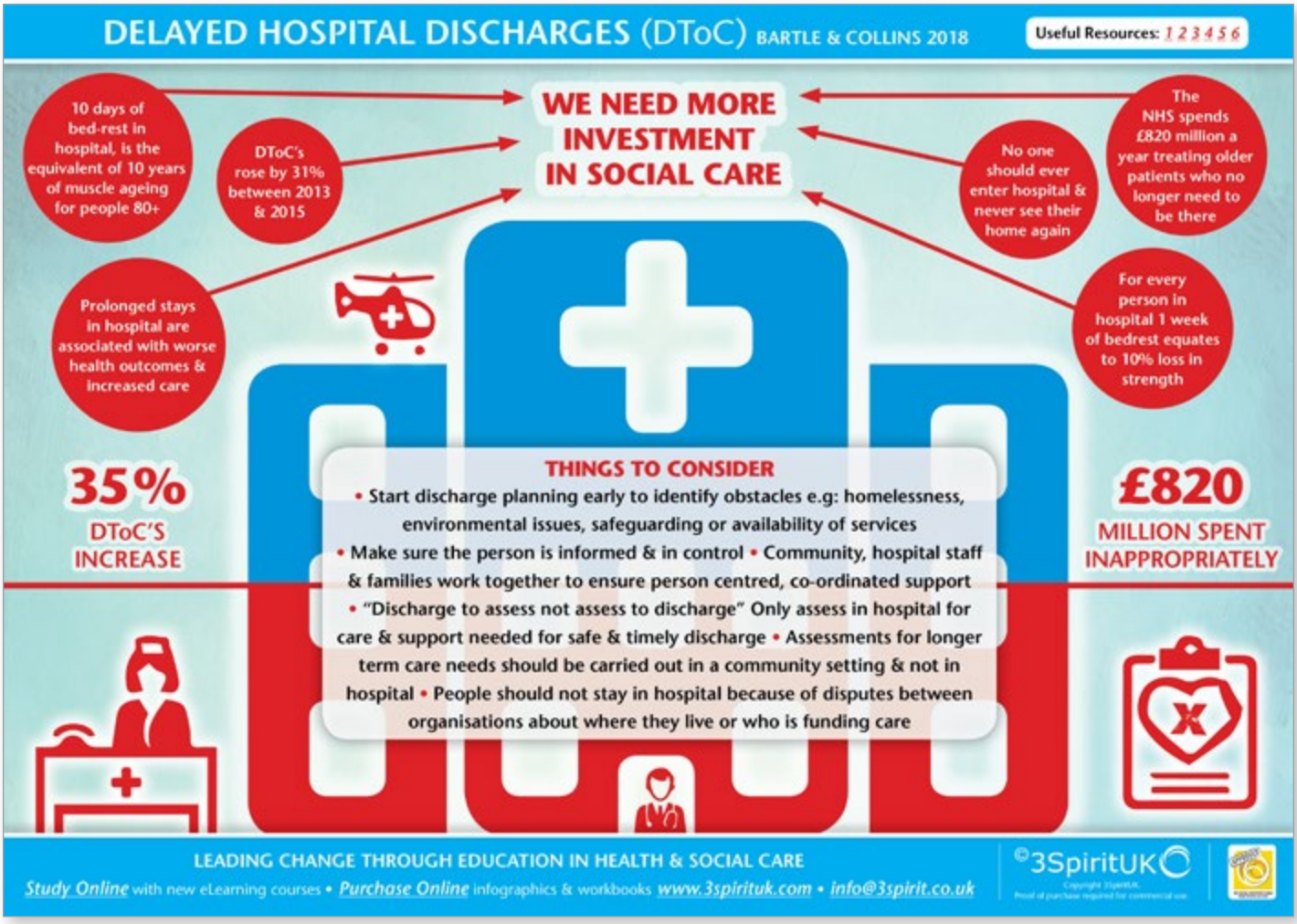
DELAYED HOSPITAL DISCHARGES (DToC) BARTLE & COLLINS 2018
Useful Resources: 1 2 3 4 5 6
WE NEED MORE INVESTMENT IN SOCIAL CARE
10 days of bed-rest in hospital, is the equivalent of 10 years of muscle ageing for people 80+
DToC's rose by 31% between 2013 & 2015
Prolonged stays in hospital are associated with worse health outcomes & increased care
The NHS spends £820 million a year treating older patients who no longer need to be there
No one should ever enter hospital & never see their home again
For every person in hospital 1 week of bedrest equates to 10% loss in strength
35% DToC'S INCREASE
£820 MILLION SPENT INAPPROPRIATELY
THINGS TO CONSIDER
• Start discharge planning early to identify obstacles e.g: homelessness, environmental issues, safeguarding or availability of services • Make sure the person is informed & in control • Community, hospital staff & families work together to ensure person centred, co-ordinated support • "Discharge to assess not assess to discharge" Only assess in hospital for care & support needed for safe & timely discharge • Assessments for longer term care needs should be carried out in a community setting & not in hospital • People should not stay in hospital because of disputes between organisations about where they live or who is funding care
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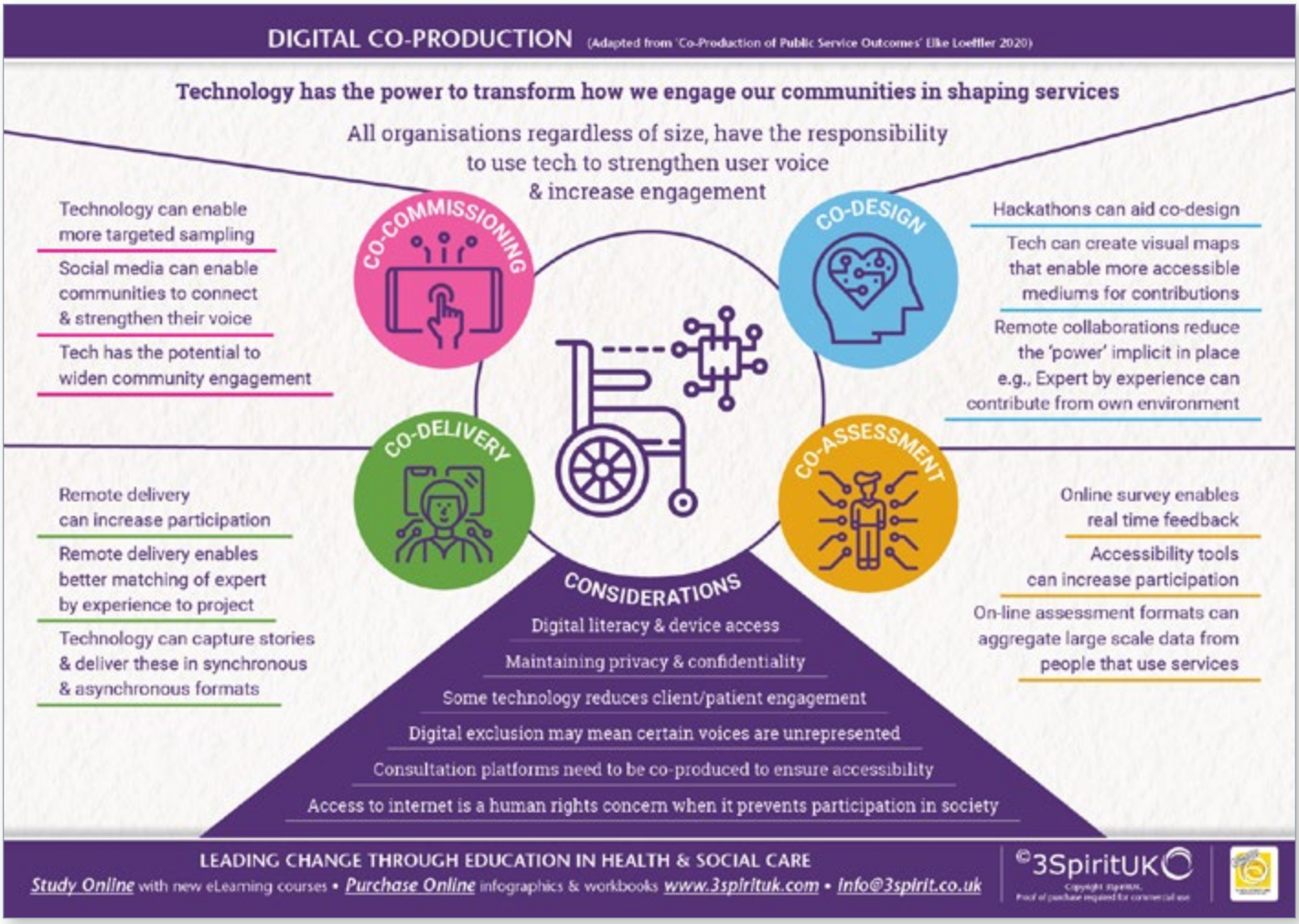
DIGITAL CO-PRODUCTION (Adapted from 'Co-Production of Public Service Outcomes' Elke Loeffler 2020)
Technology has the power to transform how we engage our communities in shaping services
All organisations regardless of size, have the responsibility to use tech to strengthen user voice & increase engagement
CO-COMMISSIONING
Technology can enable more targeted sampling
Social media can enable communities to connect & strengthen their voice
Tech has the potential to widen community engagement
CO-DESIGN
Hackathons can aid co-design
Tech can create visual maps that enable more accessible mediums for contributions
Remote collaborations reduce the 'power' implicit in place e.g., Expert by experience can contribute from own environment
CO-DELIVERY
Remote delivery can increase participation
Remote delivery enables better matching of expert by experience to project
Technology can capture stories & deliver these in synchronous & asynchronous formats
CO-ASSESSMENT
Online survey enables real time feedback
Accessibility tools can increase participation
On-line assessment formats can aggregate large scale data from people that use services
CONSIDERATIONS
Digital literacy & device access
Maintaining privacy & confidentiality
Some technology reduces client/patient engagement
Digital exclusion may mean certain voices are unrepresented
Consultation platforms need to be co-produced to ensure accessibility
Access to internet is a human rights concern when it prevents participation in society
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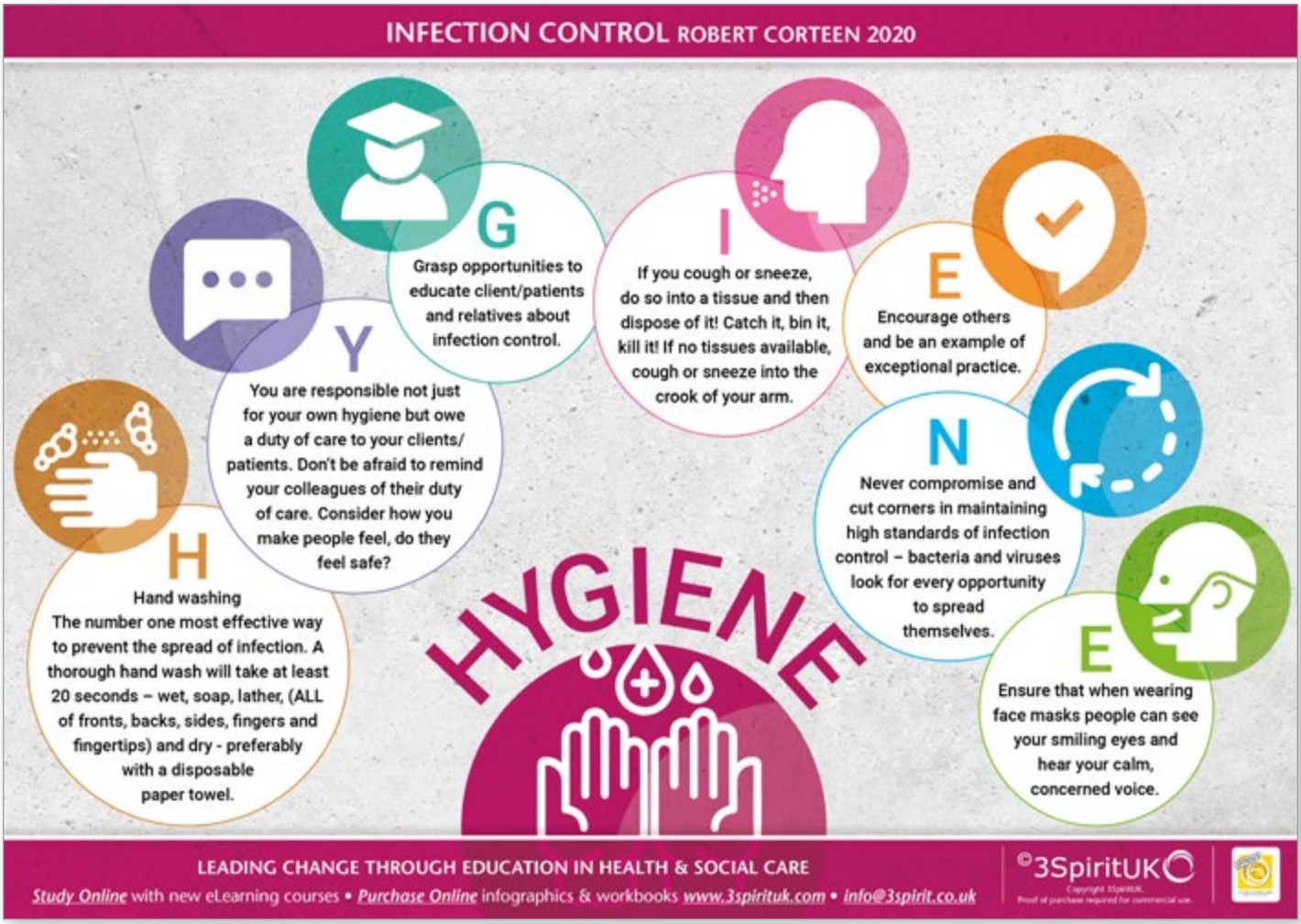
INFECTION CONTROL ROBERT CORTEEN 2020
G
Grasp opportunities to educate client/patients and relatives about infection control.
I
If you cough or sneeze, do so into a tissue and then dispose of it! Catch it, bin it, kill it! If no tissues available, cough or sneeze into the crook of your arm.
E
Encourage others and be an example of exceptional practice.
Y
You are responsible not just for your own hygiene but owe a duty of care to your clients/ patients. Don't be afraid to remind your colleagues of their duty of care. Consider how you make people feel, do they feel safe?
N
Never compromise and cut corners in maintaining high standards of infection control – bacteria and viruses look for every opportunity to spread themselves.
H
Hand washing
The number one most effective way to prevent the spread of infection. A thorough hand wash will take at least 20 seconds – wet, soap, lather, (ALL of fronts, backs, sides, fingers and fingertips) and dry - preferably with a disposable paper towel.
HYGIENE
E
Ensure that when wearing face masks people can see your smiling eyes and hear your calm, concerned voice.
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PROFESSIONAL POWER & CO-PRODUCTION BARTLE & TOPPS 2022
Professional power can get in the way of partnership working
People in receipt of care services are more likely to give up power if they don't believe they have any
Professional power is:
Impacted by the systems in which the person represents: such as gatekeeping resources
Impacted by legislation, agency duties or organisational procedures, that lead individuals to take particular decisions & actions
Increased where someone has support needs that are unsupported
Increases when assessments are undertaken in a professional place, such as an office instead of the person's own home
Perpetuated when knowledge is owned & not shared
Strategies
Minimise professional jargon
Introduce yourself by name & not by title
Provide reasonable adjustments so people can participate
Let yourself be vulnerable as it aids connection to others
Acknowledge you are not an expert in the person's life they are
Be aware of how bias impacts opportunities
Accept that it may be uncomfortable to give up power but do it anyway
Recognise & celebrate all contributions
Recognise people as assets & build on capabilities
Highlight mutual goals & cultivate mutual trust
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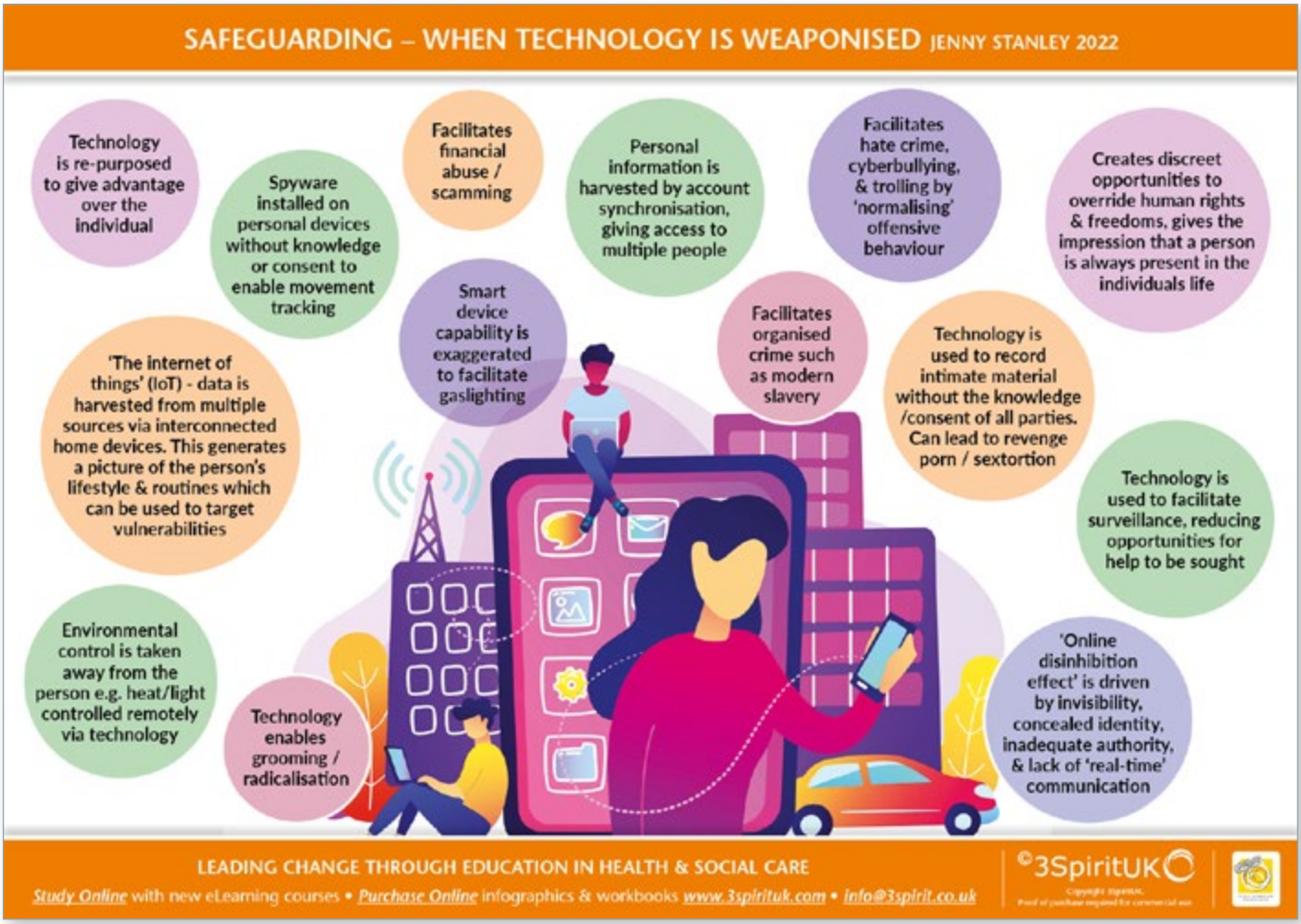
SAFEGUARDING – WHEN TECHNOLOGY IS WEAPONISED JENNY STANLEY 2022
Technology is re-purposed to give advantage over the individual
Spyware installed on personal devices without knowledge or consent to enable movement tracking
Facilitates financial abuse / scamming
Personal information is harvested by account synchronisation, giving access to multiple people
Facilitates hate crime, cyberbullying, & trolling by 'normalising' offensive behaviour
Creates discreet opportunities to override human rights & freedoms, gives the impression that a person is always present in the individuals life
Smart device capability is exaggerated to facilitate gaslighting
Facilitates organised crime such as modern slavery
Technology is used to record intimate material without the knowledge /consent of all parties. Can lead to revenge porn / sextortion
'The internet of things' (IoT) - data is harvested from multiple sources via interconnected home devices. This generates a picture of the person's lifestyle & routines which can be used to target vulnerabilities
Technology is used to facilitate surveillance, reducing opportunities for help to be sought
Environmental control is taken away from the person e.g. heat/light controlled remotely via technology
Technology enables grooming / radicalisation
'Online disinhibition effect' is driven by invisibility, concealed identity, inadequate authority, & lack of 'real-time' communication
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"With many nuances in our sector, to avoid stereotyping through design we reflective a broad society. Resources are inclusive, diverse and vibrant."

Caroline Bartle

DOLL THERAPY BUNTER & BARTLE 2022

Doll therapy is a non-drug therapy that enables those to express emotions. It can trigger natural instincts of nurture & self-purpose, facilitating communication from where a person is, in a way that's effective for them.

There is criticism surrounding doll therapy, particularly that it is child-like behaviour. This is not limited to dolls but can extend to huggable dolls, robotic animals, or other objects.

BENEFITS

- Can be used a strategy to reduce anxiety & distress: "searching behaviour" may be eliminated
- Obsessive behaviours may diminish
- Reduces need for pharmacological intervention, reducing side effects or drug interactions
- Takes a validation therapy approach placing emphasis on emotions
- Engaging & encourages communication
- Reinforces identity & may improve self esteem
- Provides activity & attachment – John Bowlby's "Attachment Theory"

CONSIDERATIONS

- Are we misleading the person & is it deceitful?
- Be aware that not every person living with dementia will benefit
- Consider capacity, ensure consent and choice
- Attachment can create distress e.g., obsessive behaviour surrounding the doll
- Listen & look at the way a person engages with doll, don't be critical from the outset
- Train staff to be open minded & encourage staff to "participate" in caring for the doll
- Allow acceptance & attachment at own pace

MOTIVATIONAL INTERVIEWING FOR MANAGERS

As part of our Overarching Vision we want to have positive conversations about what people can do for themselves & their ambitions, rather than focusing on what is not going so well in their life. Motivational Interviewing will enable managers to achieve this vision.

What people are saying about the MI course

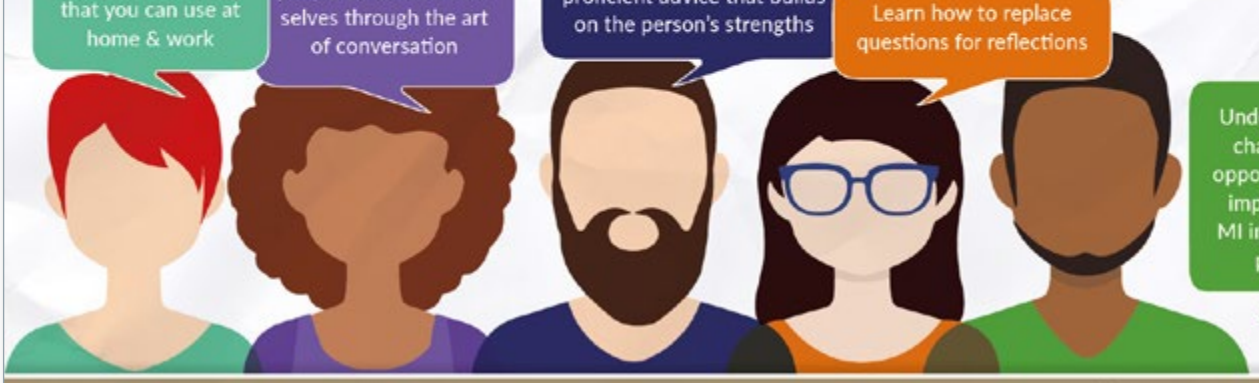
"Did not know anything about Motivational Interviewing & I thought it was really helpful & inspirational - I stop & think more now & I am using the MI Spirit more , ask offer ask & reflection - it has really helped me"

"Good sessions which will improve my practice with supporting colleagues & personal life too"

" This was by far the best training I have attended this year. One that I will remember not only for what I learned but also for how it was delivered. It was even fun, we laughed, cried with laughter & laughed again."

What are the benefits of doing the course?

- Learn practical skills that you can use at home & work
- Learn how to support people to be their best selves through the art of conversation
- Learn how to give MI proficient advice that builds on the person's strengths
- Learn how to replace questions for reflections
- Understand the challenges & opportunities for implementing MI in day to day practice



ALLYSHIP (INSPIRED BY 'THE ANTI-RACIST SOCIAL WORKER' ED. MOORE & SIMANGO. 2021)

A Authentic allyship starts with movement from awareness to action

L Learn from each other, with open mind and heart. Create opportunities for conversations but learn that this conversation is not about you

L Listen and lean into the discomfort. Sit with the shame. Let this be the impetus to act. Be critically reflective, curious and courageous

Y You can't do activism alone. It involves building relationships with both white people and people of colour

S Start with holding yourself to account. Allyship is about sharing privilege, power and vulnerability

H Hope for a better future. Be the change you want to see

I It's a constant, listening, reflecting, unlearning. It requires you to 'embody' anti-racism. Consider how you can counteract daily microaggressions

P Powerful activism uses position, power and platforms to make change

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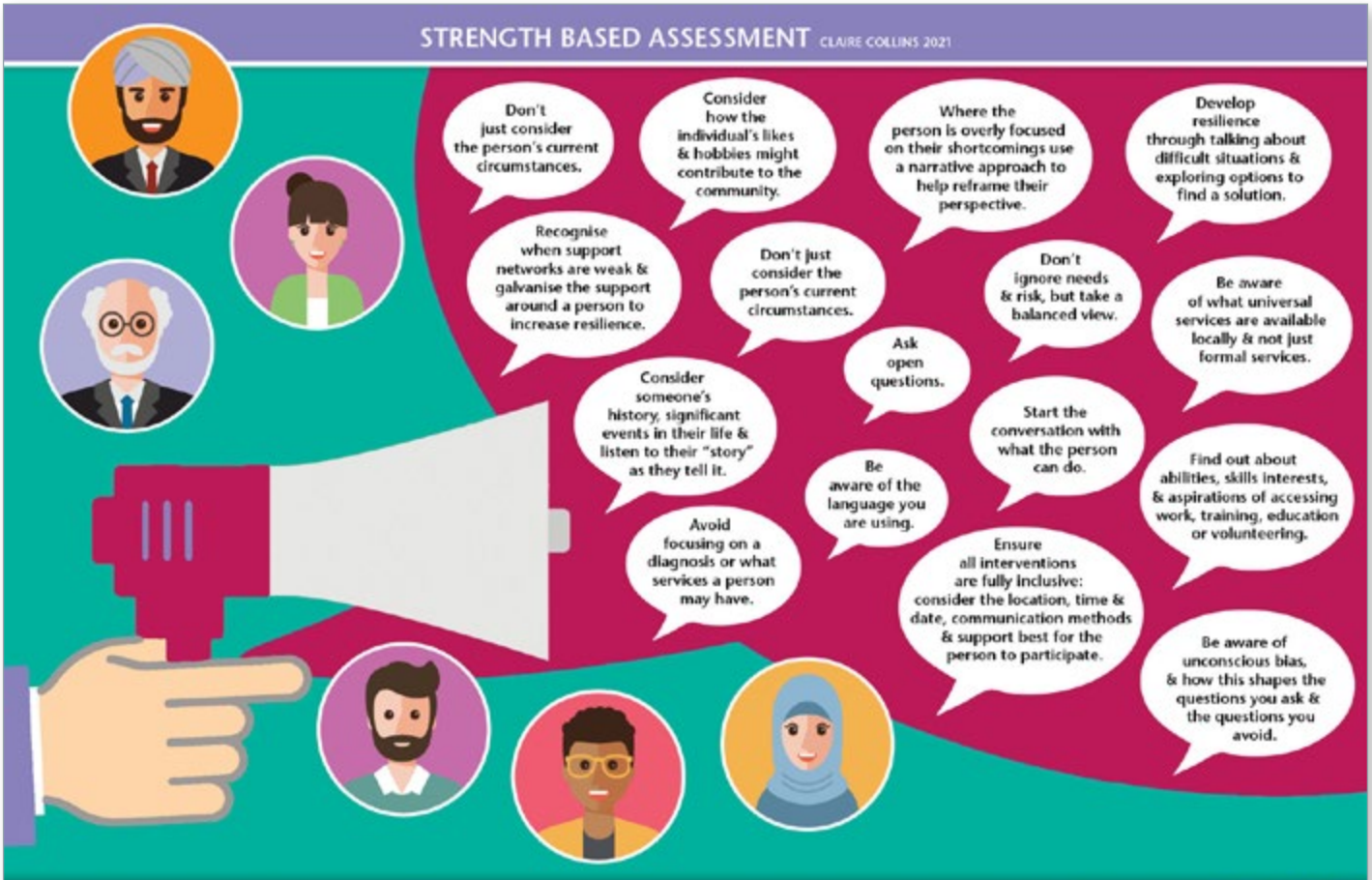
STRENGTH BASED ASSESSMENT CLAIRE COLLINS 2021



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MOVING INTO A CARE HOME (GUIDANCE FOR STAFF) COXON & BARTLE 2021

Care homes don't have "admissions" they are not hospitals. A planned transition can help the person adjust & cultivate a sense of belonging.

On Arrival

Have positive body language, a welcoming smile (first impressions count!). Consider how to meet comfort & safety needs for that individual

Initial Assessment

Getting to know someone takes time, early info gathering may be overwhelming, pace it. Find out 'what matters to the person' & how to uphold identity, autonomy & control

Important Conversations

Adapt communication to meet the needs of individuals. Find out how the person is feeling, what do they fear & what do they need to feel safe? Involve a person meaningfully in decisions. Share what service to expect, how to raise concerns, advanced care planning

What to Bring

Consider how to counteract experiences of loss, bring objects of significance. Consider how environment can help reinforce identity

First 3 Days

Get the person involved in what is going on in the home, actively introduce them to peers, establish communication with family, friends. Try to maintain continuity between past & present roles & relationships

ANTI-RACISM (INSPIRED BY 'THE ANTI-RACIST SOCIAL WORKER' ED. MOORE & SIMS. 2021)

A Anti-racism isn't a verb. It's a noun.

N Not enough to be non-racist. We need to be anti-racist.

T Take a risk. Speak out if you see an injustice.

I Inactivity supports existing racist structures.

-

R Racism is many peoples' reality, we must all tackle it.

A Anti-racist activism requires courage & emotional commitment to difficult work.

C Change begins at an individual level.

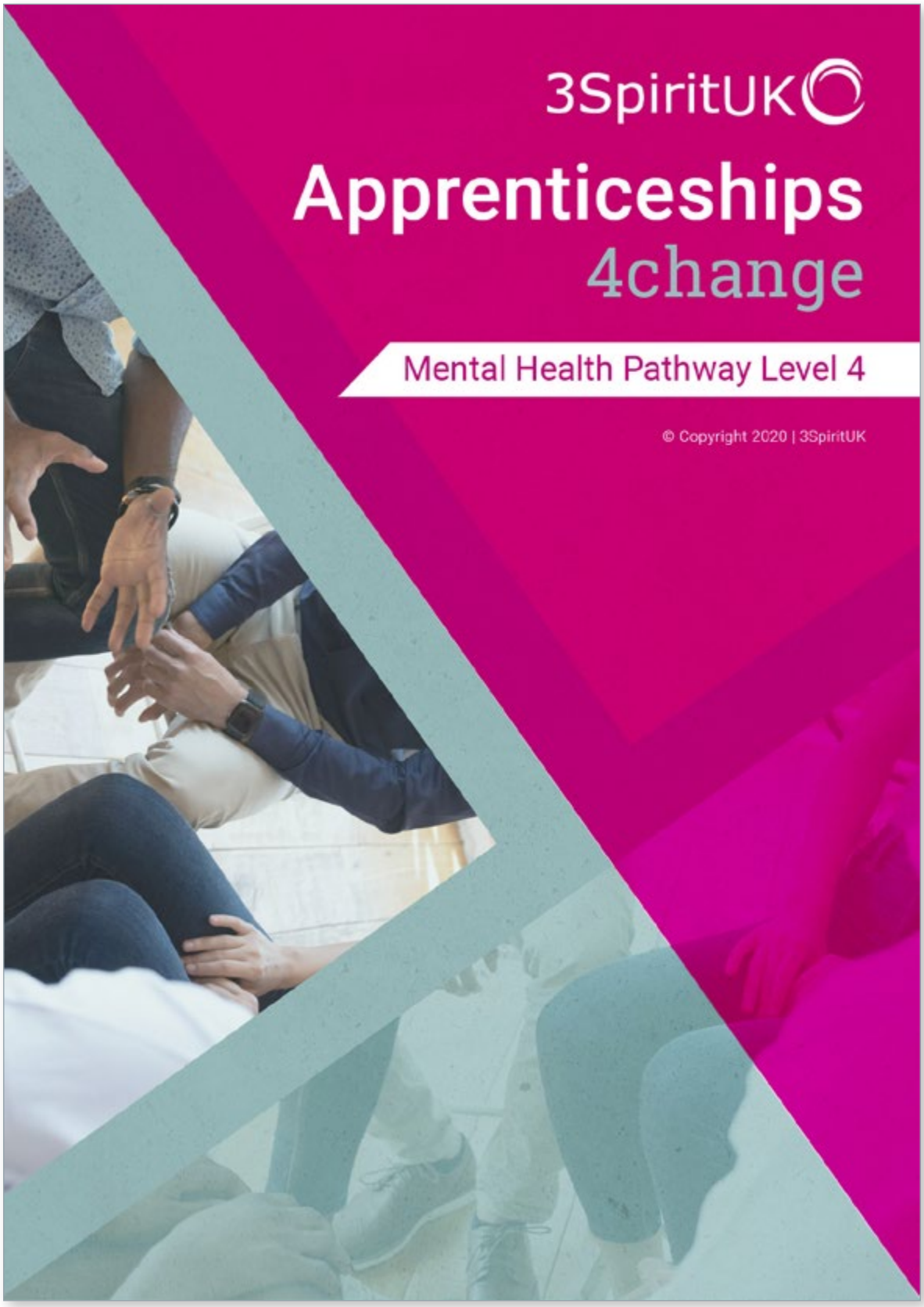
I Insight & awareness will inform action.

S Stories (our own & other people's) are a helpful way to engage with complex ideas & develop understanding of similarities & difference.

M Micro-aggressions - be aware of these indirect, subtle, or unintentional acts of discrimination.

"Developing our apprenticeship brochures, saydesignUK really understood our business needs. The digital designs represent our programmes to a high standard and deliver good engagement"

Caroline Bartle



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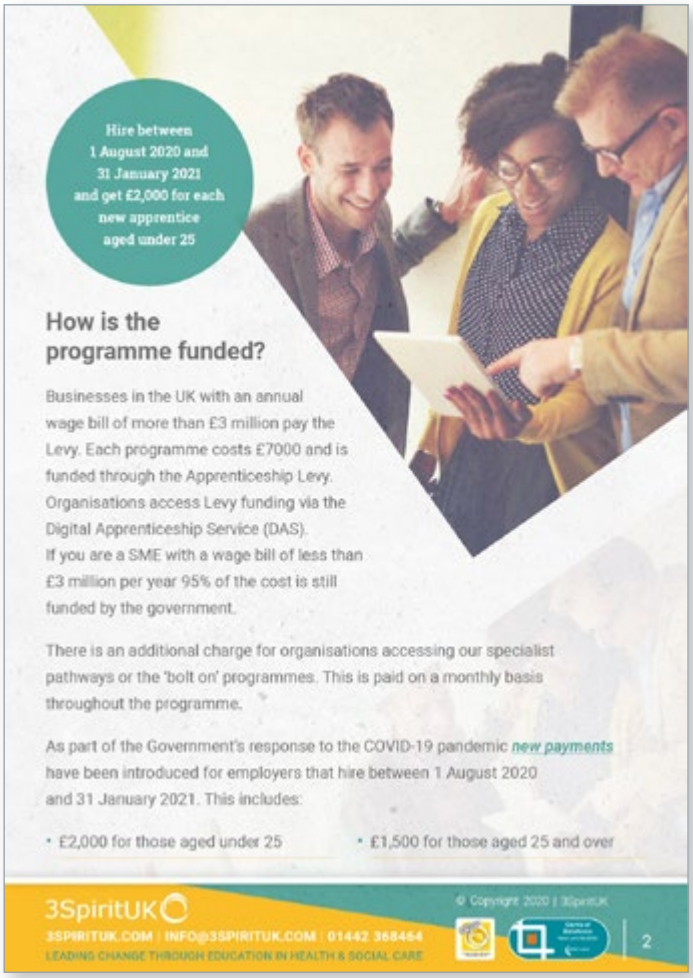
Apprenticeships 4change

Getting Started



Hire between 1 August 2020 and 31 January 2021 and get £2,000 for each new apprentice aged under 25

How is the programme funded?

Businesses in the UK with an annual wage bill of more than £3 million pay the Levy. Each programme costs £7000 and is funded through the Apprenticeship Levy. Organisations access Levy funding via the Digital Apprenticeship Service (DAS).
If you are a SME with a wage bill of less than £3 million per year 95% of the cost is still funded by the government.

There is an additional charge for organisations accessing our specialist pathways or the 'bolt on' programmes. This is paid on a monthly basis throughout the programme.

As part of the Government's response to the COVID-19 pandemic *new payments* have been introduced for employers that hire between 1 August 2020 and 31 January 2021. This includes:

- £2,000 for those aged under 25
- £1,500 for those aged 25 and over

What is an apprenticeship?

An apprenticeship means learning on the job, at any age. Apprenticeships are not just for young people. In the health and social care sector older apprentices often have great life experiences to contribute.

For apprenticeships of a higher level, individuals can already be working in the sector, and need to do an apprenticeship to advance career opportunities. However, to complete an apprenticeship, the learner is required to complete 20% "off the job" learning.

This 20% is likely to include the following activities:

- Attending virtual classrooms
- Contributing to forums
- Completing assignments
- Guided reading
- Reflective diaries
- Shadowing other members of the team
- Participating in audits
- Feedback/learning sessions with some of the people the learner supports
- Meetings

Employers who sign up for this, must be committed to this. Our programmes create organisational change but development time is required for data review, learning, reflection and planning.

How we will work with you

To achieve good outcomes from an apprenticeship, strong partnership between employer and training provider is required. We appreciate that managers are busy which is why we have developed innovative, easy-to-use engagement methods to ensure that key people keep connected throughout the programme. Employers can choose to engage by email, Zoom meeting or by directly logging into the learner's E portfolio.

Our aim is that our employers feel supported and engaged throughout the programme by ensuring that the employer and training provider have a consistent and harmonious understanding.

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Apprenticeships 4change

Dementia Pathway / Level 4

LEAD PRACTITIONER IN ADULT CARE
Dementia Pathway (Level 4)

Who is the programme for?

Individuals that are either searching to develop their skills once they've completed their Level 3 diploma or have taken on new responsibility in their organisation for **project development**. This programme encourages learners to support the person to lead a life that makes sense to them, and provides a platform to champion innovative practices. This course is delivered in partnership with **Life Story Network CIC.**

Additionally, individuals in the following job roles would fit well with this programme:

- Assistive Technology Co-ordinator/Officer
- Brokerage Worker
- Care Assessment Officer
- Community Care/Support Officer
- Dementia Lead
- Independence Support Assistant
- Keeping in Contact Worker
- Occupational Therapy Assistant
- Physiotherapy Assistant
- Public Health Associate Worker
- Reablement Support Workers/Officer
- Reablement Worker
- Rehabilitation and Reablement Assistant
- Social Care Assessor
- Social Services Officer
- Telecare Assistant

our key values

CARING
Teach people to value the importance of human connection in their work. Show how to empower and safeguard. Demonstrate through practical examples what good care and support looks like

How will the service benefit?

Apprentices will be required to undertake one case study approach whereby they will need to identify a client and bring them (anonymously and with consent) to the wider community of practice. The client will discuss challenges and possible interventions. This technique cross fertilises organisational knowledge and can provide practical solutions to common challenges.

All apprentices will participate in our '**Expert by Experience Month**'. This will involve engaging with projects like DEEP and individuals within own service and reporting and sharing those reflections with the wider peer community. It will involve engaging, admiring, and elevating the 'voice' of the lived experience, considering how this can be used to shape their service.

All apprentices are required to undertake one **Service Improvement Project**. This could be something that has been identified at inspection / local audit, something that is part of an organisation-wide improvement strategy, or from feedback from people who use the service. Apprentices are supported by the 3SpiritUK team to design and champion their project.

Apprentices will consider the equality, diversity, and inclusion from a micro and macro perspective to demonstrate how to **challenge stigma** and discrimination both at an individual and organisational level. They will explore practically how to make the organisation a better place to work and live, considering for example ageism, Black Lives Matter and LGBTQIA.

Apprentices will undertake a 'lessons learnt' from COVID -19 and will participate in the development / review of contingency planning. Apprentices will be required to share and learn from a wider community of practice. They will explore what worked, what didn't and how to improve preparedness.

Apprentices will actively explore risk reduction strategies which will apply to a broader group than those living with dementia, for example individuals living with high risk co-morbidities, including those experiencing social isolation and depression.

Apprentices will develop skills in reablement and strength-based approaches with the aim to mentor others and facilitate a whole team approach to promoting independence. Apprentices will learn how to take a **relationship-focused** approach, be present and connected to enable therapeutic intervention.

Apprentices will also undertake the dementia pathway which is embedded throughout. The pathway is tailored to develop the skills in **co-production** and in promoting quality of life.

our key values

COMMUNICATION
Support learners to develop good communication skills, to foster connection where there are walls. Teach people to feel deeply and connect.

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Apprenticeships 4change

Dementia Pathway / Level 5

End point assessment (EPA)

There will be an external assessment at the end of the programme, once the apprentice has achieved the 'gateway' requirements. This includes achieving the Level 5 Diploma in Leadership and Management for Adult Care.

s

The end-point assessment consists of two distinct assessment methods

- Observation of leadership
- Professional discussion

The end-point assessment must be completed over a maximum period of three months after the apprentice has met the EPA gateway requirements.

What the apprentice will achieve:

- Level 5 Diploma in Leadership and Management for Adult Care.
- Level 2 English and Maths (if not completed prior to starting the programme). For those with an education, health and care plan, or a legacy statement, the apprentice's English and Maths requirement is Entry Level 3 at a minimum. For those whose primary language is British Sign Language (BSL), the qualification BSL is an alternative and viable qualification.
- Dementia Pathway (see overleaf)

The qualification that is required for 'Registered Manager' status is included in the apprenticeship

Which virtual classrooms are included?

The apprentice will also have access to the following virtual classrooms:

- Self-Awareness for Leadership in Adult Care
- Communication and Information Management
- Leadership in Dementia Care
- Outcome Based Person Centred Practice
- Resource Management in Adult Social Care
- Governance and Regulatory Processes
- Leading and Managing a Team
- Strategic Approaches to Safeguarding
- Positive Risk Taking
- Leading an Inclusive Service
- Preparing for and Managing Inspections
- Managing Continuous Improvements
- Maximising the Use of Technology in Care
- Innovation and Entrepreneurship
- Risk Reduction in Dementia Care
- Sexuality and Intimacy in Dementia Care
- Developing Capable Environments
- Multimorbidity and Dementia

Supporting Multi-morbidity and Dementia

- Understanding the concept of multi-morbidity
- Exploring disorders which may co-exist with dementia.
- Exploring how managing these identified conditions may present additional challenges for people living with dementia
- Person-centred strategies to support a person with dementia and co-morbidity

End of Life Care

- Explore belief systems, including religious and cultural that impact end of life care.
- Understand what makes death a 'good' or 'bad' experience
- Challenges when supporting a person with dementia at the end of life.
- How to overcome potential barriers when supporting an individual with dementia at the end of life
- Understand advance care planning
- Working with families
- How to work with other professionals at end of life
- Putting in support systems – understanding the impact of death and dying

The programme is supported by

- Experienced assessors who are occupational and competent in dementia care
- The 3SpiritUK Cascade resources
- An active peer community of practice
- Reflective practice tools
- Access to the 3SpiritUK quality improvement tools

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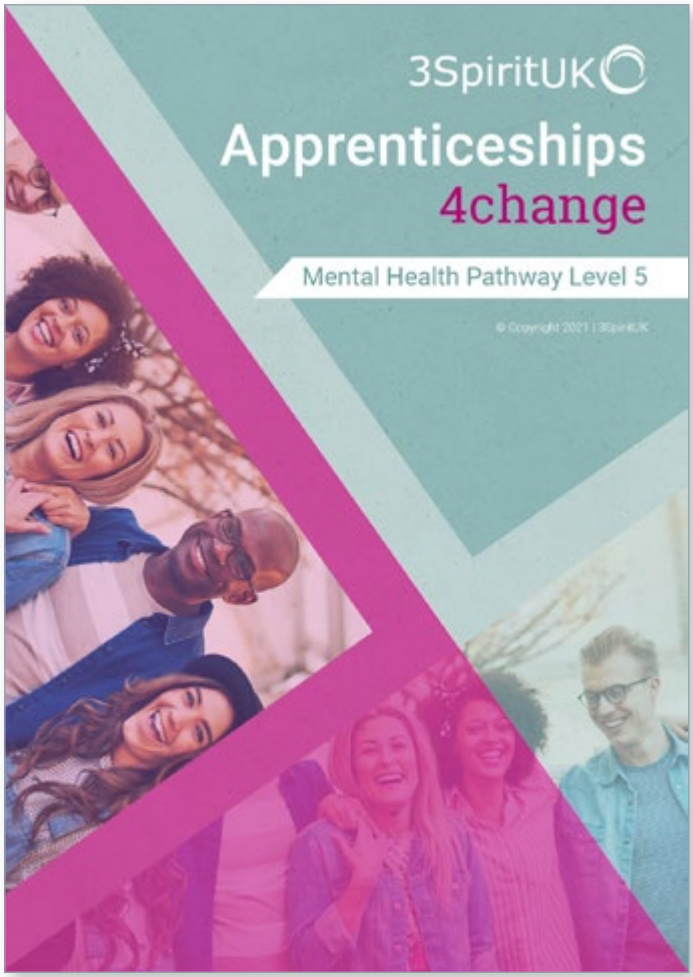
Apprenticeships 4change

Mental Health Pathway Level 5



How long will the programme take & what is involved?

This programme is delivered over 18 months. It incorporates the **Apprenticeship Standard Leader in Adult Care** but is extended to include a robust development programme for best practice in Mental Health services.

Apprentices are required to complete 20% off the job. Commitment is important, as the programme will be tightly structured. The following activities can be expected as part of the individual learning process:

- Attending virtual classrooms
- Contributing to forums
- Completing assignments
- Guided Reading
- Reflective diaries
- Shadowing other members of the team
- Participating in audits
- Meetings
- Feedback/learning sessions with some of the people the learner supports

Apprentices will meet with their assessors once a month to review progress and access support and guidance. Apprentices will also have access to communities of practice and will be required to contribute and learn from these communities as part of the assessment process. They will have the opportunity to collaborate and learn from peers undertaking similar pathways. Apprentices will be required to actively participate in the virtual classrooms.

Technology and Mental Health links to Subject 14 CSTF

- Describe how technology can be used to support mental well being
- Explain how the application of technologies, tools and techniques may be used in supporting individuals experiencing mental health problems
- Explain how to use information and communications technology in observations and assessments in supporting individuals experiencing mental health problems
- Explain how to maintain a healthy and safe environment for individuals experiencing mental health problems and staff using on-line facilities
- Give examples of how information and communications technology may be used to enhance practitioner knowledge and skills
- Give examples of unhealthy behaviours in the use of technology
- Review the evidence base for the links between technology and self-harm
- Explain e-safety and issues with regards to data protection

The apprentice will also get the opportunity to review CQC reports from other services and consider the difference between what makes a service 'good' and what makes a service 'outstanding'. To develop a broad understanding within their staff team, the apprentices will learn how to plan and execute a mock inspection, as well as how to undertake thematic supervisions focused on the different key lines of enquiry.

The apprentice will undertake a stakeholder mapping exercise to identify relationships that are important to the service and how to strengthen these. There will be an extensive amount of work on how to work in partnership with families to support them to look after themselves and the individuals they support.

our key values

COLLABORATION
Learn from each other, across boundaries, listen & respect other people's experience & perspectives. Embrace diversity.

Within the programme apprentices will explore contingency planning for a major incident or business disruption (a pandemic, or the climate crisis, for example). Fundamentally, contingency planning will include how to diversify the business, which will be linked to their final project, a business plan.

Apprentices will get the opportunity to review and debate on the use of technology to support social care. This is further supported by a unit focussing on the strengths and challenges of technology and mental health.

Towards the end of the programme apprentices will carry out a broader analysis of organisational performance in the context of the adult social care market. This will include determining current strengths, weaknesses, opportunities, and threats. To meet the requirements for modules in Entrepreneurial Skills, Innovation and Change in Adult Care, the final project will undertake stakeholder mapping and market analysis to produce a business plan.

Embedded throughout the programme apprentices will complete the **mental health** pathway.

Which virtual classrooms are included?

The apprentice will also have access to the following virtual classrooms:

- Introduction to social prescribing
- Professional development
- Safeguarding
- Working in partnership with others
- MECC training
- Develop, maintain, and use records and report
- Managing quality
- Risk reduction in dementia care
- Dementia capable communities
- General health and well-being for mental health
- Resilience, stress, and vulnerability
- Research skills
- Health and safety
- Person centred support planning
- Equality, diversity, and inclusion
- Support the use of Assistive Technology
- Understand personalisation in care and support services

our key values

CRITICAL THINKING
To encourage learners to reflect and think for themselves. Encourage them to uncover unconscious bias and explore how this impacts practice

Sample Pathway

COURSE STARTS
Induction & onboarding

WEEK 1
Access provided to forum & peer networks

MONTH 1
Mapping core capabilities & personal development
PATHWAY ONE
Social Prescribing

MONTH 2
Safeguarding practice

MONTH 3
Advanced communication & working in partnership
PATHWAY TWO MECC
Observation 1

MONTH 4
Using records & reports

MONTH 5
Managing quality
Project identified for service improvement
Observation 2

MONTH 6
Expert by experience month
PATHWAY THREE
Risk reduction in dementia
PATHWAY FOUR
Dementia capable communities

MONTH 7
Expert by experience month
PATHWAY FIVE
General health & wellbeing for mental health
PATHWAY SIX
Resilience, stress, & vulnerability

MONTH 8
Research skills – evidenced based practice in social prescribing

MONTH 9
Health & safety

MONTH 10
Person centred planning & case study presentation
Observation 3

MONTH 11
Equality, diversity, & inclusion

MONTH 12
Assess & implement new technologies

MONTH 14
Personalisation

MONTH 15
Optional units

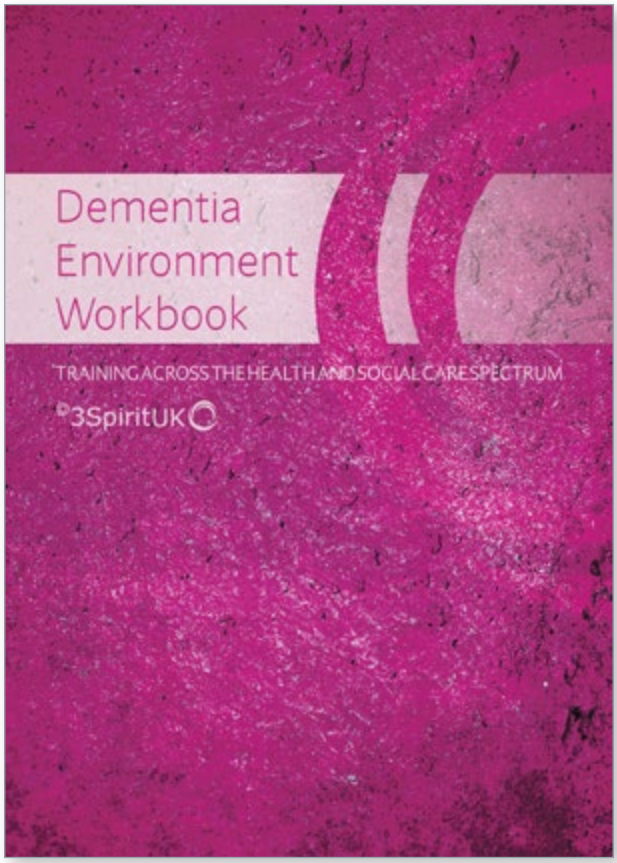
MONTH 17
Preparation for Gateway

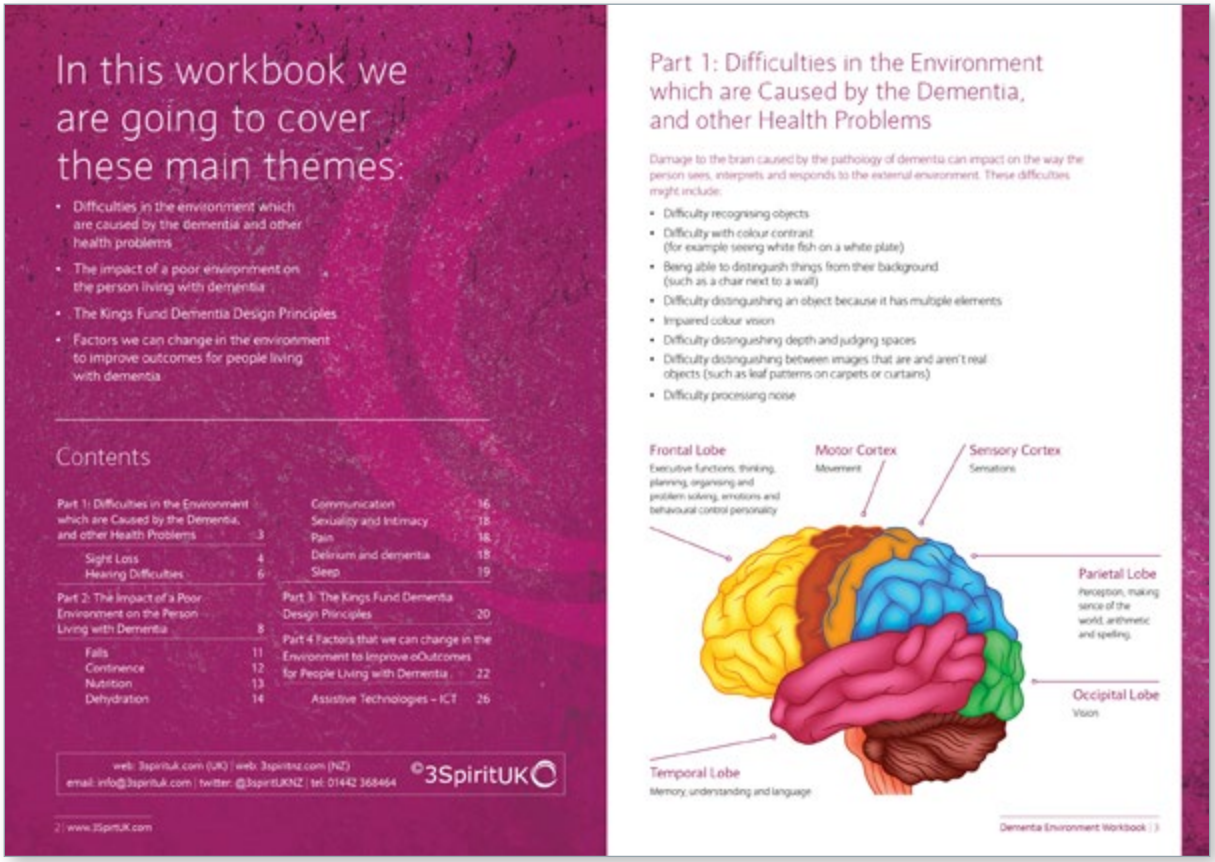
MONTH 18
End Point Assessment

This pathway does not show the core learning modules, only the sessions and impacts related to the Mental Health Level 5 Pathway

"Stephanie developed our interactive workbooks so that you could not wait to turn over the page. Equally the design drew you in walking past our stall"

Caroline Bartle





As age is the biggest risk factor for getting dementia, many people living with dementia are over the age of 65. 1 in every 14 people over the age of 65 currently have dementia. This means that often people have another medical condition alongside their dementia. Approx 72% of people living with dementia also live with another condition. A common condition that many people have alongside is sensory loss; this can include difficulties with sight, hearing or even taste and smell.

When the brain has an impairment such as dementia it relies more heavily on the quality of the information.

When the brain has an impairment such as dementia it relies more heavily on the quality of the information that is being inputted from its senses. For example, if a person is struggling to distinguish an object such as a chair because it is the same colour as the wall, they will find it even more difficult if they have sight loss.

Sight Loss

Some common sight problems include:

- Cataract
- Glaucoma
- Macular Degeneration
- Visual field loss
- Eye conditions related to diabetes

It's easy to mistake problems with sight with the symptoms caused by dementia.

There are a number of age related eye diseases which impact on the way in which we navigate the environment. For example with **Cataracts** a person will experience a cloudy picture. This can be resolved through treatment, however without regular eye tests can go undetected. There is no treatment for **Age Related Macular Degeneration (dry);** it is a condition which causes damage to the middle part of the retina called the macula which can result in devastating loss of detailed sight, making it difficult to read or watch television. **Glaucoma** is a disease which causes irreversible damage to the optic nerve and can cause tunnel vision. **Visual field loss** can be caused by a stroke or CVA, it means that person's visual field will be affected. It's important to know which side and make sure that you stand on the correct side (within their visual field) when communicating and carrying out support tasks. Changes in blood sugar levels can affect the lens in the eye, causing a cloudy effect. A more serious eye condition caused by diabetes is diabetic retinopathy which affects the blood vessels in the eye.

Activity 1: What signs might there be that someone has sight loss?

It is important to understand the differences between difficulties caused by sight loss and difficulties caused by damage to the brain. This information is important in determining the right treatment and support. For example, there is a difference between what is a misinterpretation and what is a hallucination.

Problem	How the environment might cause this
Dependence	
Incontinence	
Problems Eating and Drinking	
Increased Pain	

Falls

Individuals living with dementia are 3 x more likely to fall – even higher in LD communities. Changes in the brain may cause Apraxia, Gait Disturbance, Visual Perceptual Difficulties, which may lead to a person falling.

Potential consequences of hip fractures include:

- Mortality is high – approximately one in ten people with a hip fracture die within 1 month and about one in three within 12 months (NICE CG36 hip fracture 2012)
- Fat embolism or deep vein thrombosis
- Pressure ulcers
- Infection
- 50% may never properly walk again
- Depression
- Anxiety

Even if the fall does not cause serious injury a person may be frightened of falling again.

The Fall Cycle

Falls are usually multifactorial and include:

- Intrinsic factors, for example age and dementia and...
- Extrinsic factors, for example the environment and footwear

Consider the environment to reduce falls risk. For example:

- Flooring, for example patterned carpets
- Lighting
- Uncluttered area

Dehydration

Water is needed to:

Eliminate toxins (by removal of waste products), aid digestion, lubricate joints, to regulate temperature, for respiration, to transport nutrients around the body, for energy conversion and vitally is needed to help our brains work properly.

On average an adult loses 1500-3000mls of fluid daily. Approximately 20% of fluid intake comes from food ingested.

Potential impact of dehydration:

- Dehydration reduces the padding over bony points and may lead to pressure sores
- Inadequate fluid intake is a common cause of constipation
- Older people's blood pressure may drop on standing, which may lead to falls
- Feeling tired, and if prolonged can impact on other cognitive functions in the brain such as memory and perception

An older person may have difficulty rehydrating because:

- Cognitive difficulties or physical abilities, may forget or lack skills or ability to get a drink
- Have a higher percentage of body fat which contains less water than lean tissue
- People who experience incontinence may try to minimise their fluid intake
- Sense thirst more slowly and less intensely than younger people
- Medications, diuretics and laxatives, may compound the problem
- Certain disorders, such as diabetes, may increase excretion of urine

We need to:

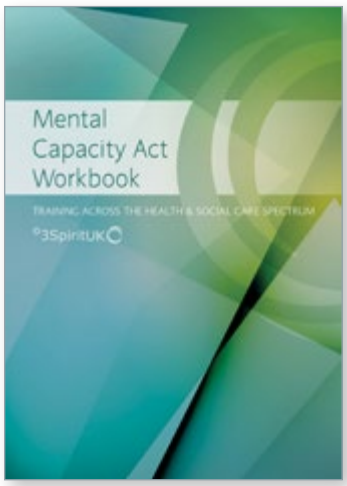
- Educate and inform people of the risks. Identify when someone is at risk
- Observe for signs of dehydration; dry mouth and eyes, dark urine
- Prompt people more to drink and offer them foods with a high fluid content
- Offer people fluids of choice and sit with people while they drink, if their choice. Prompt people to drink offering fluids of their choice
- Offer foods with high water content. For example, soup, melon, cucumber, ice lollies, jellies
- Accommodate for sensory loss

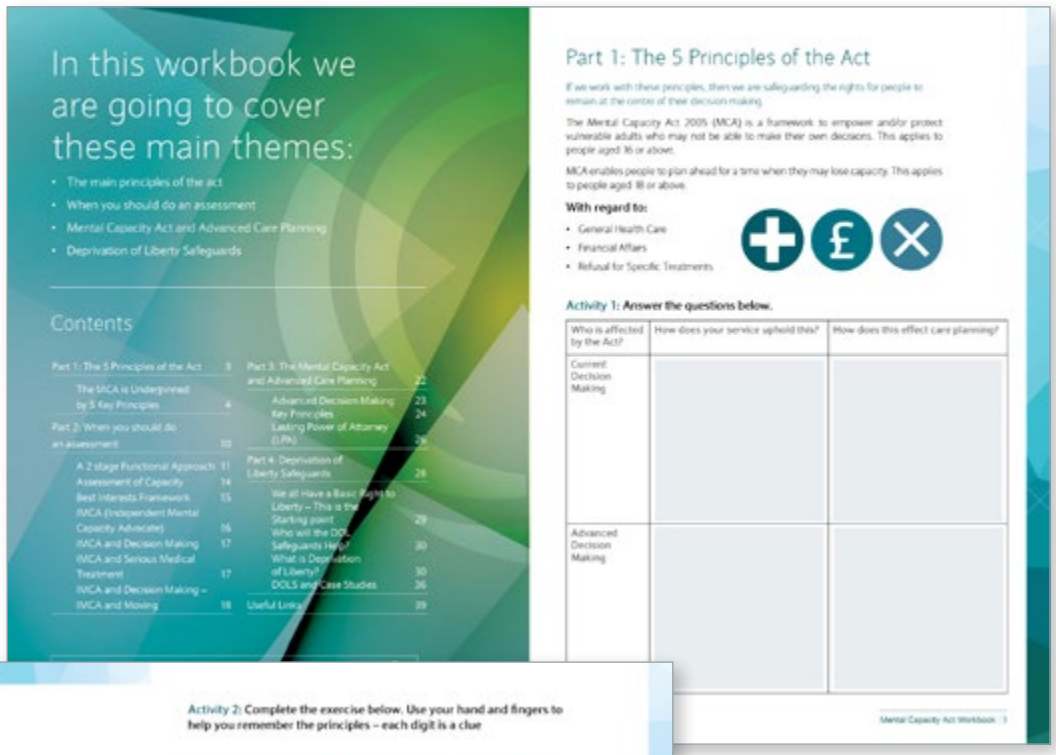
On average an adult loses 1500-3000mls of fluid daily.

Dehydration and the environment:

- If a person is able to find the toilet easily, they might be less concerned about drinking fluids
- Clear water in a clear glass might be difficult to see
- Use a person centred approach to cups: light weight cups can maintain a person's dignity
- Consider the lighting – can a person see glass/cup/jug
- Think about the positioning of water jugs, particularly for people with visual field loss
- Half fill jugs enabling people to lift them independently
- Appropriate seating/chairs: is the person in an optimal position?
- In the summer months, and when it is hot, a person will need an increased amount of fluid

Half fill jugs enabling people to lift them independently.





In this workbook we are going to cover these main themes:

- The main principles of the act
- When you should do an assessment
- Mental Capacity Act and Advanced Care Planning
- Deprivation of Liberty Safeguards

Contents

Part 1: The 5 Principles of the Act

If we work with these principles, then we are safeguarding the rights for people to remain at the centre of their decision making.

The Mental Capacity Act 2005 (MCA) is a framework to empower and/or protect vulnerable adults who may not be able to make their own decisions. This applies to people aged 16 or above.

MCA enables people to plan ahead for a time when they may lose capacity. This applies to people aged 18 or above.

With regard to:

- General Health Care
- Financial Affairs
- Refusal for Specific Treatments

Activity 1: Answer the questions below.

Who is affected by the Act?	How does your service uphold this?	How does this effect care planning?
Current Decision Making		
Advanced Decision Making		

The MCA is Underpinned by 5 Key Principles

- Presume capacity unless proved otherwise
- Right for individuals to be supported to make their own decisions given all possible help
- Individuals retain the right to make what might seem as eccentric/unwise decisions
- Those involved in the decision making process must always work in the 'best interests' of the person
- A less restrictive intervention must be adopted. Respecting rights and freedoms of the individual

Self-determination is an important aspect of wellbeing.

Self-determination is an important aspect of wellbeing. However, many people do not have their rights respected, and upheld in the way that they should. The impact of this can be far reaching for the individual, their family and the community.

If we prescribed medication, most of us tend to monitor how it affects us. If we feel an unpleasant side effect from the tablet, we are likely to go to our doctor and discuss this and expect him/her to change the type of medication used. Many people we support have been on a myriad of medication for large parts of their lives and may not have ever been given the opportunity to question this. We want to encourage each individual to be aware of their rights to challenge their care and treatment.

If we are in control of our lives, we are more likely to self-actualise, take positive risks and develop coping strategies when things go wrong. An increase in our well-being is likely to increase our physical health along with our confidence to act upon feelings of ill health.

Activity 2: Complete the exercise below. Use your hand and fingers to help you remember the principles – each digit is a clue

Principle 1
Thumbs Up

Presume capacity unless you have assessed a person does not have capacity to make a specific decision at a specific time

Principle 2
Index or Pointy Finger

Point people in the right direction to make their own decision giving all practicable help – information, education, opportunity and choice

Principle 3
Hold up your Middle Finger

...but beware that you do not offend. This reminds us that people have the right to make unwise decisions and repeated unwise decisions do not mean the person does not have capacity

Principle 4
The 4th Finger

...needs help to stand up, representing a person who does not have capacity and decisions are made in their best interests

Principle 5
The Little Finger

...is our weakest finger and reminds us to use the less restrictive approach – respecting rights and freedoms

Activity 3:

The 5 statements below cross-reference to the 5 principles, and are all stories from films. Can you identify which principle applies to which statement? Can you apply the principles to solve the scenario?

- Vito is in hospital and his son realises that his enemies are coming to assassinate him. He thinks that his only chance to protect his father is to move him to another room. However, his father is unable to make the decision for himself because he is in a coma.
- A rich king decides that he is going to divide his kingdom between his daughters according to how much they say they love him.
- Randle McMurphy tells Nurse Ratchet that he does not want to take his medication. Nurse Ratchet thinks it is in his best interests to take his medication but has not yet assessed his capacity. Can the nurse give Randle his medication against his wishes?
- Christy Brown at first lacks capacity to make complex decisions because he is unable to communicate them. His family realise that he can write with his left foot and provide him with the writing materials. Christy can now make his own decisions.
- A person who lacks capacity is keeping her mouth closed when the staff try to administer medication – the stakeholders decide that because her medication is essential, there are guidelines where she is held down and medication is forced into her mouth, followed by water.

Activity 4: Answer the questions below.

Principle	Give an example from your workplace	How did this change the persons care plan?	What was the impact on the policies AND protocols adopted within the service?
Presume Capacity			

Part 2: When you should do an assessment

Although the 2 stage capacity assessment is simple in theory, it can be very complex to put into practice.

A 2 Stage Capacity Assessment

Stage 1: Diagnostic Assessment

An individual can only be considered unable to make a particular decision if:

There is an impairment of, or disturbance in, the functioning of the mind or brain. This may be permanent or temporary. This may include:

- Dementia
- Learning Disability
- Abnormal mental state–delirium, coma, psychosis
- Mood or anxiety disorders
- The consequences of sedation, or illicit drug or excessive alcohol use etc

Stage 2 : Functional Assessment

- Broadly understand information relevant to the specific decision
- To retain information long enough to make the specific decision
- To weigh risks and/or benefits of the options and use the information in the process of making the specific decision
- To Communicate the specific decision by any means

Key Principles

- Effective communication, with compassion and sensitivity
- Care planning is the first step
- Person's participation in ACP is voluntary
- If person with capacity chooses not to participate in care planning, their adequately informed consent must be gained in any decisions about their care or treatment
- Only a person with capacity who chooses to do so can take part in ACP
- Balance between duty of providing information a person wants to ensure their adequately informed consent over burdening person with too much
- Care provider may respond to cues which indicate a person's desire to make specific wishes or concerns known
- Care and treatment decision making by a person with life limiting illness requires that the individual has the capacity to understand, discuss options available and make decisions
- Where a person lacks capacity to decide, care planning must focus on determining their best interests
- Any information given by an individual during any care planning discussion should be recorded and used correctly
- ACP is an aspect of care planning and can only be undertaken if the person has capacity to decide. No pressure should be put on the person or their family to take part
- Should an individual with capacity wish to record choices about their care and treatment, or an advance decision to refuse treatment in advance of losing capacity, they should be guided by a professional with appropriate knowledge and be documented according to the requirements of the act
- Any choices or advance decisions to refuse treatment recorded in advance of loss of capacity only become relevant when a person loses capacity
- Where a person has capacity then they must check and agree the content of any care planning record
- Staff should share records of any discussion, only with the person's permission or if they lack capacity, this is to be judged in their best interests
- Locally agreed policies about where care planning documentation including ACP is kept and systems in place to enable sharing with professionals such as ambulance workers
- The person concerned should be encouraged to regularly review any plans

Only a person with capacity who chooses to do so can take part in ACP.

Activity 6: Answer the questions below.

How are advanced care plans supported in your organisation?

Give two examples of how the difficult conversation about end of life be prompted by staff.

Who will the DOL Safeguards Help?

- All must apply to the Local Authority (Supervisory Body) or the Court of Protection
- One who lacks capacity in relation to the specific decision
- Who is 18 years and over
- In hospital, nursing or residential care
- Any applications for those living in their own homes must be through the Court of Protection

All who may lack capacity will need to be reviewed by the organisation.

Your service needs to identify people for whom restrictions and/or deprivation of liberties may apply.

What is Deprivation of Liberty?

Following the ruling by the supreme court - P v Cheshire West

Is the person objectively deprived of their liberty or is there risk that cannot be sensibly ignored that they are objectively deprived of their liberty?

- Is the person subject to continuous supervision or control?
- Is the person free to leave?
- Does the person have the mental capacity to decide whether or not to live or remain at the care or nursing home or hospital?

For a person to be deprived of their liberty, they must be subject both to continuous supervision and control and not be free to leave.

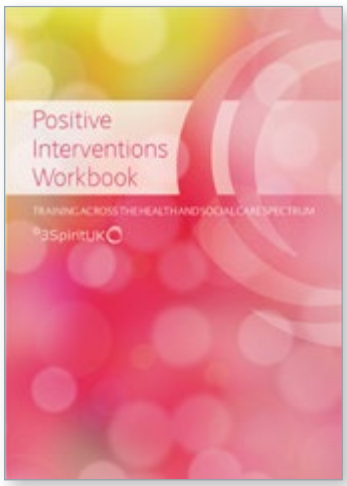
In all cases, the following are not relevant to the application of the test

- The person's compliance or lack of objection
- The relative normality of the placement, whatever the comparison made
- The reason or purpose behind a particular placement

Your service needs to ask:

- Are there clients living in your service who lack capacity to decide to live there and are not free to leave who are in constant supervision?
- Are all circumstances being considered for any type of restraint?
- What measures are being taken to clearly identify needs for restraints? When are they required? For how long? The reason(s) they are necessary? How this affects the person?
- Are restrictions for the shortest possible time?
- Are the opinions of carers/family/advocates/ friends and other professionals part of the decision and support process?
- Has a structured and consistent approach has been used?
- Is there a proper assessment of the person's capacity following the MCA principals?
- Have less restrictive interventions been used or considered and recorded?
- Have you recorded guidelines, risk assessments within care plans?
- Are you reviewing, monitoring and reassessing?
- Are all decisions clearly explained and reviewed with reasons for actions given?
- Are incidences of Challenges being responded to as communications?

Has a structured and consistent approach has been used?



Behavioural symptoms occur as a direct result of changes to the brain, sometimes referred to as organic changes. Understanding about organic changes is essential to ensure appropriate treatment, as medication may be used inappropriately.

Behavioural changes may also occur as a result of social-psychological factors. For example, how a person is treated or how they cope with emotional demands. Some of these changes may be mistaken for organic changes in the brain caused by the dementia. For example, stress can cause difficulty with concentration. 'Challenging behavior' may be caused by unmet needs, or a feeling of a lack of control rather than direct damage to the brain caused by the dementia. Incorrectly attributing the cause of the behaviour may lead to inappropriate treatments. The term 'challenging behaviour' is not a useful term when describing emotional distress. It can lead to labels and seriously affect the opportunities and support people are provided.

Behavioural changes may also occur as a result of social-psychological factors.

Whilst some medications play an important role, others can exasperate the dementia, by causing problems with thinking processes. Thinking processes are referred to as cognitive skills. Organic changes in the brain result in problems with thinking skills which may include:

- Planning and sequencing
- Language skills
- Judgment and reasoning
- Memory loss
- Attention and calculation
- Problem solving skills

Some medications act directly on the brain, so can have side effects which may impact on brain function:

Medication class	Examples	Side effects that contribute to cognitive decline
Antipsychotic medications	Chlorpromazine, Olanzapine Clozapine	Sedation, mental slowing, effect of anti-cholinergic properties affecting cognition
Anti-epileptic medications	Phenobarbitone, Phenytoin, Sodium Valproate	Sedation and mental slowing
Antidepressants	Clomipramine	Same as above
Benzodiazepines, particularly long acting preparations	Clonazepam Temazepam Diazepam	Sedation, confusion, mental slowing
Older generation antihistamines	Diphenhydramine Hydroxyzine Promethazine	Sedation
Pain medications	Meperidine Propoxyphene	Confusion, dizziness, tiredness Meperidine can cause seizures

Anti-Psychotic Medication

The majority of antipsychotic medication is not licensed to treat dementia. The Banerjee report (2009) found that the prescription to people with dementia was often the result of factors other than the symptoms of dementia.

The Banerjee Report (2009) found only 20% of those treated derive some benefit: contributed to 1800 deaths and 1620 CV adverse events. Adverse events may include: Parkinsonism, Sedation, Gait disturbance (risk of falls), accelerated cognitive decline and stroke (1.9 fold risk of stroke in the first four weeks (Kleyer, 2009)). Increased mortality rate.

Only 20% of those treated derive some benefit.

There has been a drive nationally to reduce the use of anti-psychotic drugs. Antipsychotic prescriptions for people with dementia has reduced by 52% between 2008 – 2011 with strong regional variations.

Royal College of Psychiatrists (2015) Dementia and People with Intellectual Disabilities www.bps.org.uk/system/files/Public%20files/rep77_dementia_and_id.pdf

and reporting and side effects or adverse reactions are important. Having too many drugs, sometimes known as polypharmacy, can lead to reduced appetite and has been directly linked to avoidable hospital admissions and malnutrition.

So what other interventions are there available to us? We need to consider the social model of care. Medical models of care seek to treat the 'problem', whereas a social model of care considers the 'problem' as a natural diversity. Instead of trying to fix the problem, social model approaches will ask not how do we change the person, but rather how do we change the environment, so that the person functions optimally within it.

The way we treat people within a social environment will affect the way they feel.

There is a further dimension to this because the way we treat people within a social environment will affect the way they feel, and ultimately the way they respond and function so we need to consider the 'psychology' in the exchange. That is, how do our interventions make the person feel? And how do they/might they respond to different interventions? This approach is more commonly known as a biopsychosocial approach.

Activity 1: **Why can't this man get up the stairs?**

If you answered because he is in a 'wheelchair' this may be considered as a medical model response. If you answered 'because there is no ramp', you are working within a social model perspective.

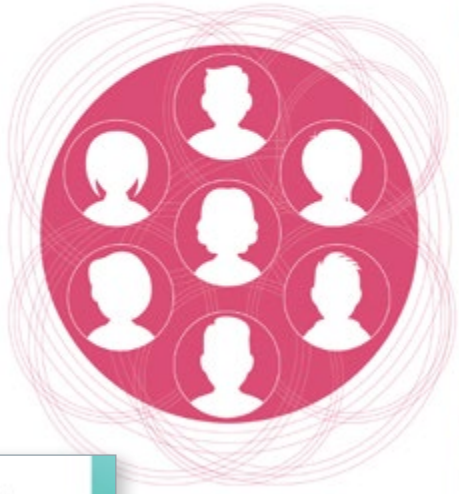
Sometimes a medical approach is more appropriate than a social approach. However, we should always strive to reduce pharmacological interventions, and always try to determine the true cause of the presenting symptom. For example, is someone agitated because they are in pain? Or are they agitated because they want to be at home, possibly because they are living in a different reality? Giving someone pain medication when they are not in pain is not helpful and may disorient and confuse a person further. So identifying the cause of distress is critical to determining the best course of treatment. ▸▸

Scenario	Possible medical solution	Possible non-medical solution
A person walks a lot around the building and will not sit still, and this is impacting on their weight		
A person becomes agitated at lunch times, disrupts meal times for others, and often complains she can't find her baby		
A person appears upset when being supported to the toilet, and always complains that other people are in the bathroom		
A person does not sleep at night and is often found walking around the home entering other people's bedrooms		
A person is disruptive during sessions, often collecting paperwork from other people		
A person appears more agitated in the front activity room. When in this room, they are always asking to go home		
A person does not sleep at night and is often found walking around the home entering other people's bedrooms		

Alternative Interventions/Therapies to Medication

Low Mood	Low mood may be experienced because of feelings of loss of control and independence. Respecting an individual's rights, engaging with them and developing sound relationships will have a positive effect on mood.
Agitated Behaviour	Research indicates that some complementary therapies may be effective in reducing incidents of agitation. Poor environmental clues may make a person agitated, for example if a person is unsure where they are. Making simple changes to the environment might reduce agitated behaviour.
Challenging Communication	Aggressive behaviour is not a useful term for explaining how an individual is communicating. The behaviour may be related to a number of factors. Try to identify the issues that they are communicating by observing body language and the emotions underlying their behaviour. This will help you to prevent the repetitive challenge.
Sleep Problems	Sleep problems may occur because of day and night disorientation, anxiety at night, lack of activity during the day or because of the use of medication during the day. They may also be caused by lack of access to natural light, and fresh air. Sleep problems at night can also be due to a person's normal sleep pattern, e.g. has the individual's working life included night shifts?
Walking Around a Lot	Sometimes unhelpfully labelled, 'wandering' can represent searching behaviour, which can range from looking for the toilet, a need to find a loved one, or if the person is feeling unsafe, a strong urge to return home. It may also indicate that the person used to attend specific activities at certain times of the day. The person's life story may provide a solution. Sometimes unhelpfully labelled, 'wandering' can represent searching behaviour, which can range from looking for the toilet, a need to find a loved one, or if the person is feeling unsafe, a strong urge to return home. It may also indicate that the person used to attend specific activities at certain times of the day. The person's life story may provide a solution. Wandering can also be a sign of boredom because the person cannot find their way or because they are searching for something. Providing meaningful activity during the day will reduce this. Supporting an individual to navigate their environment by using environmental cues can reduce anxiety. Talk to the person about the feelings that underlie their searching need. Measures should be taken if the person leaves the

Increased Confusion from Inappropriate Environments	Confusion arises when the environment and its activities are designed in a way that does not account for the individual's perceptions and needs. Simple changes to the environment can boost a person's confidence, reduce confusion and encourage greater independence.
Anxiety	Anxiety can be a result of the person feeling unsafe, scared of being left alone or unsettled with group living. Life stories can provide answers as to why the person is feeling anxious. Providing organised daily activities to reduce time spent alone can help. Understanding the cause of the anxiety will help identify the best intervention.



Self Identity and Self Esteem

Self-identity – 'The recognition of one's potential and qualities as an individual, especially in relation to social context'

Self-identity and self-esteem are closely linked. We may undermine a person's self-esteem by not supporting or reinforcing their identity.

The way we socially position people could undermine their self-identity. Stigma, oppression and objectification may drive this.

'We may have different identities in different social environments. For example, mother, worker, wife, husband or work colleague. Identities are co-constructed in the social environment. The way a person responds to what we project will influence the way we see ourselves.' (Oxford: Blackwell Publishers).

Personhood, 'A standing or status that is bestowed upon one human being, by others' (Kitwood (1997) Dementia reconsidered pb Buckingham: Open University Press)

'A person is a person through others'' (Zulu saying quoted by Christine Bryden).

The physical environment can powerfully enhance or erode a person's self-identity. Life-story work, and reminiscence can powerfully enhance self-identity. Music may be used to support a person to recall who they are.

The physical environment can powerfully enhance or erode a person's self-identity.

Sometimes when we are trying our best we can still get things wrong. Tom Kitwood identifies a number of negative behaviours he names as Malignant Social Psychology. These behaviours may be present in today's care. Malignant social psychology may lead to individuals becoming disempowered, and can significantly damage self-esteem.

If we are able to recognise them, and also the driving forces behind them, for example stigma and limited understanding, we may start to redress them.

- **Treachery:** Using forms of deception and lies.
- **Disempowerment:** Not giving enough choices and reducing the abilities of the individual.
- **Infantilisation:** Patronising and treating like a child.
- **Labelling:** Using negative language such as 'wanderer'.
- **Stigmatisation:** Treating an individual as a diseased object.
- **Outpacing:** Giving information or choice too quickly.
- **Invalidation:** Non-acknowledgment of feelings being real to the individual.
- **Objectification:** Treating the individual like an object without feelings.
- **Banishment:** Excluding an individual.
- **Ignoring:** Not acknowledging their presence.
- **Intimidation:** Using threats to make them comply.
- **Imposition:** Forcing an individual to do something.
- **Withholding:** Holding back attention and choices.
- **Accusation:** Blame culture. Individual's lack of ability.
- **Disruption:** Intruding on the individuals train of thought or action.
- **Mockery:** Making fun of an individual. Humiliating them.
- **Disparagement:** Telling the individual that they are incompetent.

Sometimes when we are trying our best we can still get things wrong.

Severe Constipation	
Urine Infection	
Dehydration	
Fractured Rib	

Prevention of delirium

- The following steps can help reduce the chances of someone developing a delirium:
- Adequate nutrition and hydration will reduce the chances of developing a delirium.
- Reporting the side effects of medication and reporting.

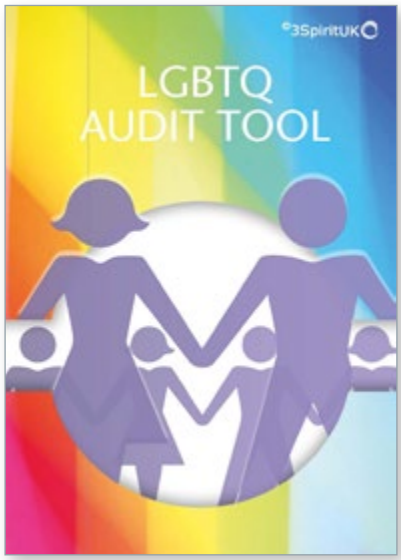
…e questions below.

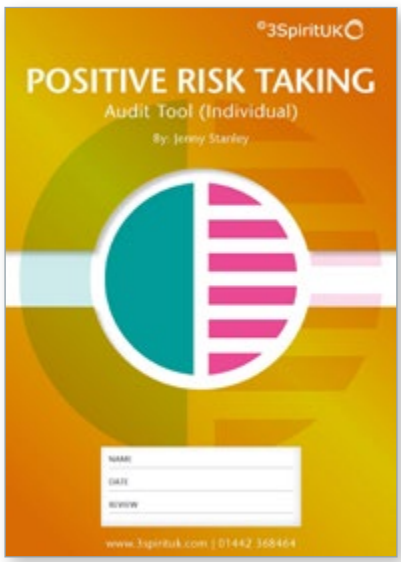
	…ase loss of brain …ions resulting in decline of day-to-day cognition and functioning. A terminal condition. ☑ Depression ☑ Delirium ☑ Dementia	An acute or sudden onset of mental confusion as a result of a medical, social, or environmental condition. ☑ Depression ☑ Delirium ☑ Dementia	A change in mood which lasts at least 2 weeks and includes sadness, negativity, loss of interest, pleasure and decline in functioning. ☑ Depression ☑ Delirium ☑ Dementia
Duration	Years (usually 8 to 20). ☑ Depression ☑ Delirium ☑ Dementia	Hours to months, dependant on speed of diagnosis. ☑ Depression ☑ Delirium ☑ Dementia	At least 6 weeks, but can last several months to years, especially if not treated. ☑ Depression ☑ Delirium ☑ Dementia
Thinking	Fluctuates between rational state and disorganized, distorted thinking with incoherent speech. ☑ Depression ☑ Delirium ☑ Dementia	May be indecisive and thoughts highlight failures and sense of hopelessness. ☑ Depression ☑ Delirium ☑ Dementia	Gradual loss of cognition and ability to problem solve and function independently. ☑ Depression ☑ Delirium ☑ Dementia
Mental Status Testing	Capable of giving correct answers, however often may state "I don't know." ☑ Depression ☑ Delirium ☑ Dementia	Will attempt to answer and will not be aware of mistakes. ☑ Depression ☑ Delirium ☑ Dementia	Testing may vary from poor to good depending of time of day and fluctuation in cognition. ☑ Depression ☑ Delirium ☑ Dementia
Memory	Recent and past memory impaired. ☑ Depression ☑ Delirium ☑ Dementia	Generally intact, though may be selective. Highlights negatively. ☑ Depression ☑ Delirium ☑ Dementia	Recent and immediate memory impaired. ☑ Depression ☑ Delirium ☑ Dementia

Source: Island Health, Seniors Health Education and Practice Support.

"Interactive audit tools complement our training, are well designed for ease of use and have been utilised by students to deliver service improvement projects."

Caroline Bartle






1 | DIFFICULT CONVERSATION TOOL

WHEN TO USE THE TOOL

Use this tool when having conversations with staff, team members or clients when approaching difficult conversations.


2 | DIFFICULT CONVERSATION TOOL

WHAT TO DO


7 | DEBRIEFING AUDIT TOOL

Post Incident Reflection – This should be a non-blame review and actions are agreed that reduce the likelihood of future incidents. The ABC form or other record relating to the incident should be used to provide initial structure to the discussion.

1. HOW TO AVOID FUTURE INCIDENTS				
QUESTIONS	YES	NO	COMMENTS	ACTIONS
Do staff receive support with their emotional and physical needs (Post Incident Support) prior to the Post Incident Reflection?				
Is there a discussion about what staff were trying to achieve when the incident occurred?				
Is there a discussion about what 'actually' happened?				
Is there discussion about what worked well and what didn't?				


1 | LGBTQ AUDIT TOOL

WHO	WHAT	0	0.5	1
PERSON	• We will ask you for your preferred name, pronoun and how best you want to identify			
	• We will ask you how you want to dress and present yourself			
	• We will offer you the support you need to look how you would like to look			
	• We will ask you about your sexuality and how you best want to express it			
	• We will ask you about any needs or concerns and make sure it is part of your care plan			
	• We will listen if you do not want to talk about your sexual preferences or needs and make it clear on your care plan that you do not want to answer questions about sex. We will occasionally check to see if you still feel the same			
	• We will respect your gender, sexual orientation and preference and ensure you are supported where necessary			
	• We will respect your gender identity and use pronouns that you prefer			
	• We will maintain your dignity with regard to your body, privacy, sexuality and your sexual orientation			
	• We will endeavour to offer you choice in which gender staff member supports you in the bathroom and bedroom			


2 | LGBTQ AUDIT TOOL

WHO	WHAT	0	0.5	1
PERSON	• We will respect your right to access sexual health support services and support you to do so where necessary			
	• We will enable choice of expression that does not impinge upon the rights of others			
	• We will ensure sexual aids, equipment and visuals are respected for use by you in the privacy of your room and cleaned afterwards as part of your personal care support where necessary			
	• We will ensure any chemical/physical restraint is not used to control sexual expression except in crisis situations			
	• We will ensure any medication prescribed that may affect your libido or sexual function is described to you			
	• We will offer you information and support where you make a request or signpost you to the relevant services			
SCORE OUT OF A POTENTIAL 16				


3 | POSITIVE RISK TAKING AUDIT TOOL (INDIVIDUAL)

EXPERIENCE OF THE INDIVIDUAL

Ask the individuals in your care to rate their perspectives and experiences in all the areas below:

EXPERIENCE OF THE INDIVIDUAL	FULLY MET	PARTIALLY MET	UNMET	OUTCOME
I feel listened to and respected				
My wellbeing and quality of life is the focus of risk discussions				
People supporting me use tools that help me to understand risks and share my views				
People supporting me use my strengths and help me to build upon these				
People supporting me are consistent, so I am always supported well.				


3B | POSITIVE RISK TAKING AUDIT TOOL

WHAT WE NEED TO DO NOW

AREA FOR DEVELOPMENT	WHAT NEEDS TO HAPPEN	WHO NEEDS TO DO THIS	WHEN WILL IT BE ACHIEVED BY

DATE OF COMPLETION	
NAME	
DATE OF NEXT PLANNED AUDIT	


2 | PREVENTION AUDIT TOOL

P FOR POLICY

R FOR RESPECT RIGHTS AND FREEDOM

E FOR EXPERIENCE

V FOR VISION

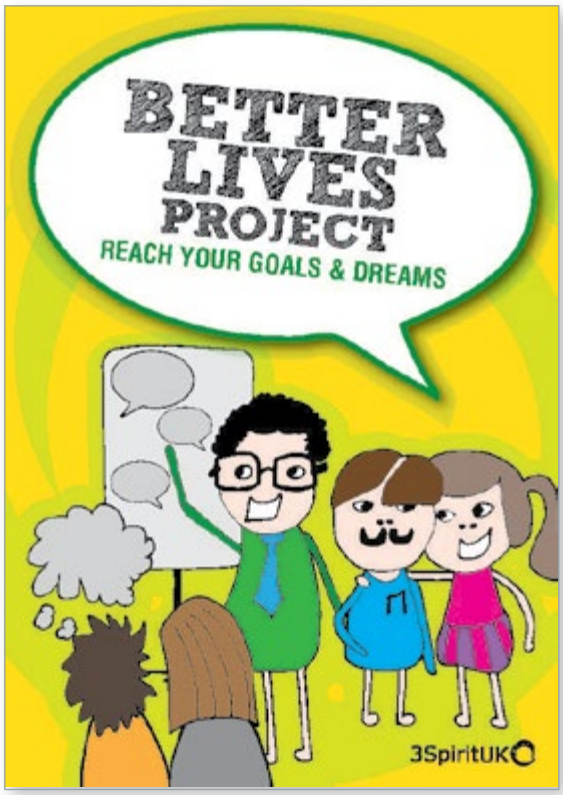
E FOR EQUALITY AND DIVERSITY


1 | LOOK AT ME LISTEN TO ME TOOL Written by Jenny Stanley

WHAT I AM DOING	DETAILS OF THIS	WHAT THIS MEANS
VOCALISATIONS	• Laughing • Shrieking • Screaming • Sighing • Huffs breath out • Takes deep breath in • Breathing quickens • Breathing slows • High pitch sound • Low pitch sound • Short sounds • Long sounds • Combination sounds • Repetitive Sounds • Other	
TOTAL BODY MOVEMENT	• Will go to desired area independently • Goes to desired area when prompted • Will lead others to desired area independently • Leads others to desired area when prompted • Moves quickly out of the room independently • Runs towards an item / area when motivated • Jumps up and down • Lays flat on the floor • Curls body up into a ball • Pushes self into a corner • Makes repetitive total body movements • Other	

"Working with us to develop a number of different mediums, Stephanie ensured the representation of our values where consistent and engaging."

Caroline Bartle



SOCIAL WORK

CONTINUED PROFESSIONAL DEVELOPMENT

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CONTENTS

ADULT CARE SERVICES FINANCIAL ASSESSMENT RESPONSIBILITIES

ONE FULL DAY

This course is suitable for financial assessment officers, social care assessors and safeguarding practitioners.

AIM To understand legal responsibilities in financial assessment and reduce risk of financial abuse.

COURSE OUTCOMES:

- Identify the key risks and challenges when carrying out financial assessment duties
- Identify safeguarding responsibilities around financial abuse and scams
- Describe the local authority's responsibilities for financial assessment in Care Act
- Explain the core principles in underpinning decision making for ASC charging decisions, including under the Mental Capacity Act
- Identify key roles and responsibilities in financial decisions
- Examine practical difficulties interpreting the Charging regulations and guidance in relation to:
  - a. Disregards- properties, personal injury awards, trusts, assets held abroad, pensions
  - b. Top-ups
  - c. Deprivation of assets- gifts, equity release
  - d. Debt recovery

ADVANCED MCA

ONE FULL DAY

AIM: To develop strategies to the challenges of implementing MCA.

COURSE OUTCOMES:

- List of recent case law updates and explore most relevant to social work practice
- Describe the good practice guidelines around recording MCA and give examples of this
- Give examples of possible disputes in MCA practice, and explain protocol for good decision making
- Identify common challenges and strategies in good practice in decision making and finances
- Explain the interface between the MHA and MCA

HOARDING

HALF DAY

AIM: To raise awareness of the impacts and risks of Hoarding.

COURSE OUTCOMES:

- Identify the main mental health classification for hoarding
- Identify who the disorder may affect and potential triggers
- Describe the main risks to individuals that hoard
- Explain the impact and potential experience of hoarding on individuals and families
- Identify strategies to support individuals

HOARDING INTEGRATED WORKING

ONE FULL DAY

AIM: To understand ways of working of fostering multi agency working to support Hoarding.

- Describe the key principles of Hoarding and Self Neglect guidance
- Identify own role in referral and support and how to appropriate multi agency involvement
- Explain the links between Hoarding and Mental Health and where these apply to own role
- Explain common Safeguarding concerns/protocols when working within Hoarding
- Describe ways to utilise the toolkit to ensure best practice approaches

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Social Impact Report

Leading change through education in health and social care

38%

Health and Wellbeing in Dementia Impact Assessment

Which of the following activities did you deliver/improve upon because of the course?

Support a person to achieve one, or more, of the five ways to wellbeing: give, connect, keep learning, take notice.	57%
Raise awareness of potential impact loneliness	71%
Use an assessment to identify if a person is lonely	14%
Adopt strategies to address loneliness	43%
Adopt strategies to support sleep	24%
Raise awareness of the importance of exercise	62%
Identify ways to support a person to exercise	48%
Report early signs of delirium	38%
Use the STOP and WATCH tool to identify early signs of delirium	33%
Report potential dehydration and malnutrition concerns	52%
Promote healthy eating and hydration	62%
Adapt the physical and social environment to improve nutrition and hydration	29%
Raise awareness of the potential impact of incontinence upon a person	24%
Adapt the environment to promote continence	24%
Take action to reduce the risk of falls in the workplace	48%
Modify the physical and/or social environment to support ADL's	19%

Mandatory Courses

Training Brochure

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LEADING CHANGE THROUGH EDUCATION IN HEALTH & SC

Content

email to book:
info@3spirituk.com

Mental Health

Training Brochure

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LEADING CHANGE THROUGH EDUCATION IN HEALTH & SC

05 Conflict Resolution

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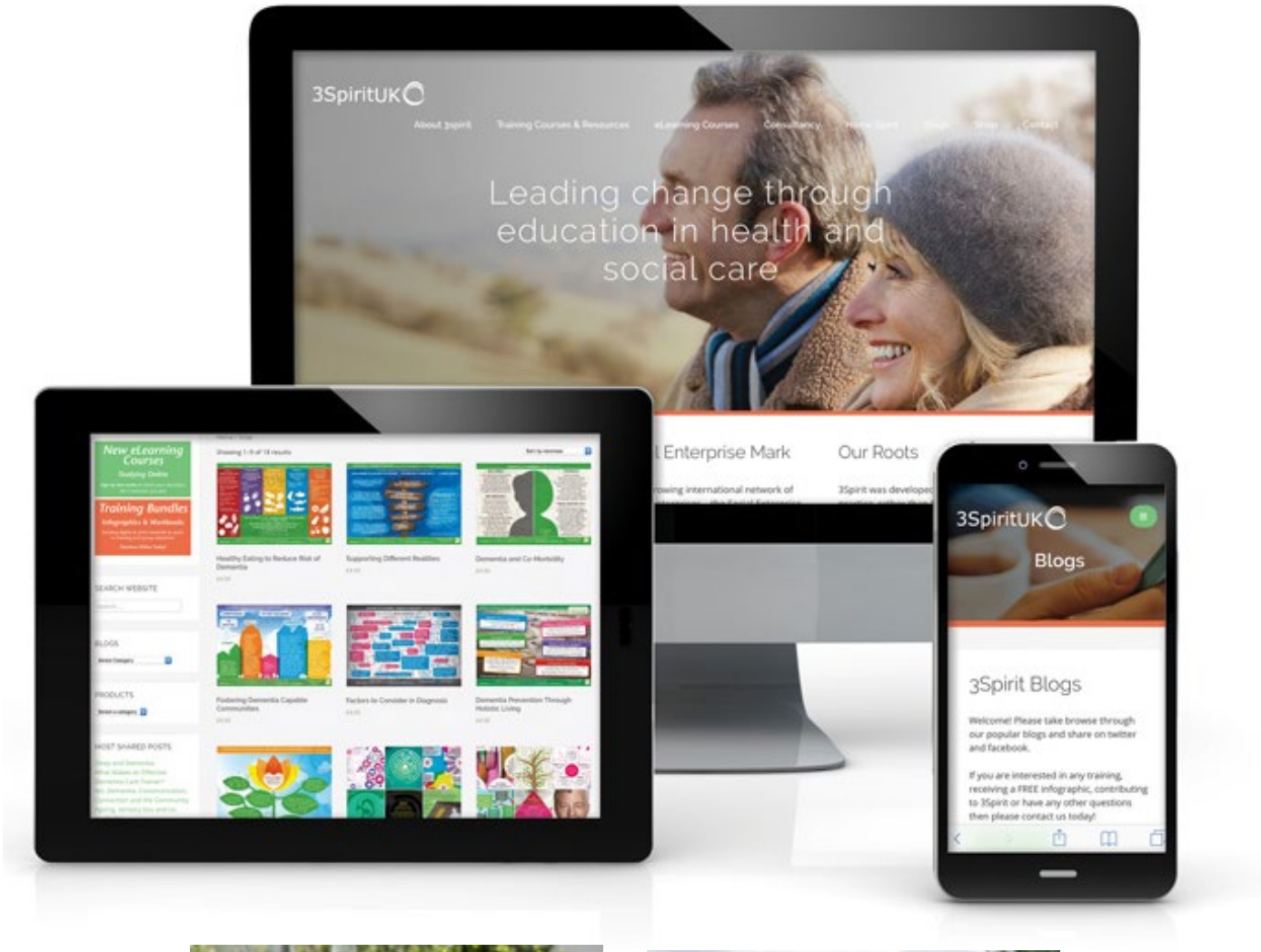
- Explain the importance of establishing rapport and building respectful, trusting, honest and supportive relationships with individuals experiencing a mental health problem
- identify factors which are known to trigger certain kinds of behaviour in individuals
- Explain how an individual's feelings and perception may affect their behaviour
- Identify how own behaviour, and that of others might affect the individual experiencing a mental health problem
- Explain how an individual's behaviour may be a form of non-verbal communication
- Describe ways in which acute illness and the emotions caused by it can affect communication with an individual
- Describe the effect that behaviour that challenges has on individuals and others in the vicinity
- Describe strategies to maintain calmness and safety and enable individuals to find alternative ways of expressing their feelings such as:
  - de-escalation
  - diversion
- Explain ways to encourage individuals to review their behaviour and interaction with others and assist them to practise positive behaviours in a safe and supportive environment.

"As our market changed Stephanie kept pace. We really loved the CCVC - Care Connections design. Moving to a virtual platform, it gave us a fresh look that appropriately reflected our new service."

Caroline Bartle

"Our website was created by saydesignUK to ensure it reflected our values with inclusive imagery, and easy to find topics."

Caroline Bartle



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Stephanie Young

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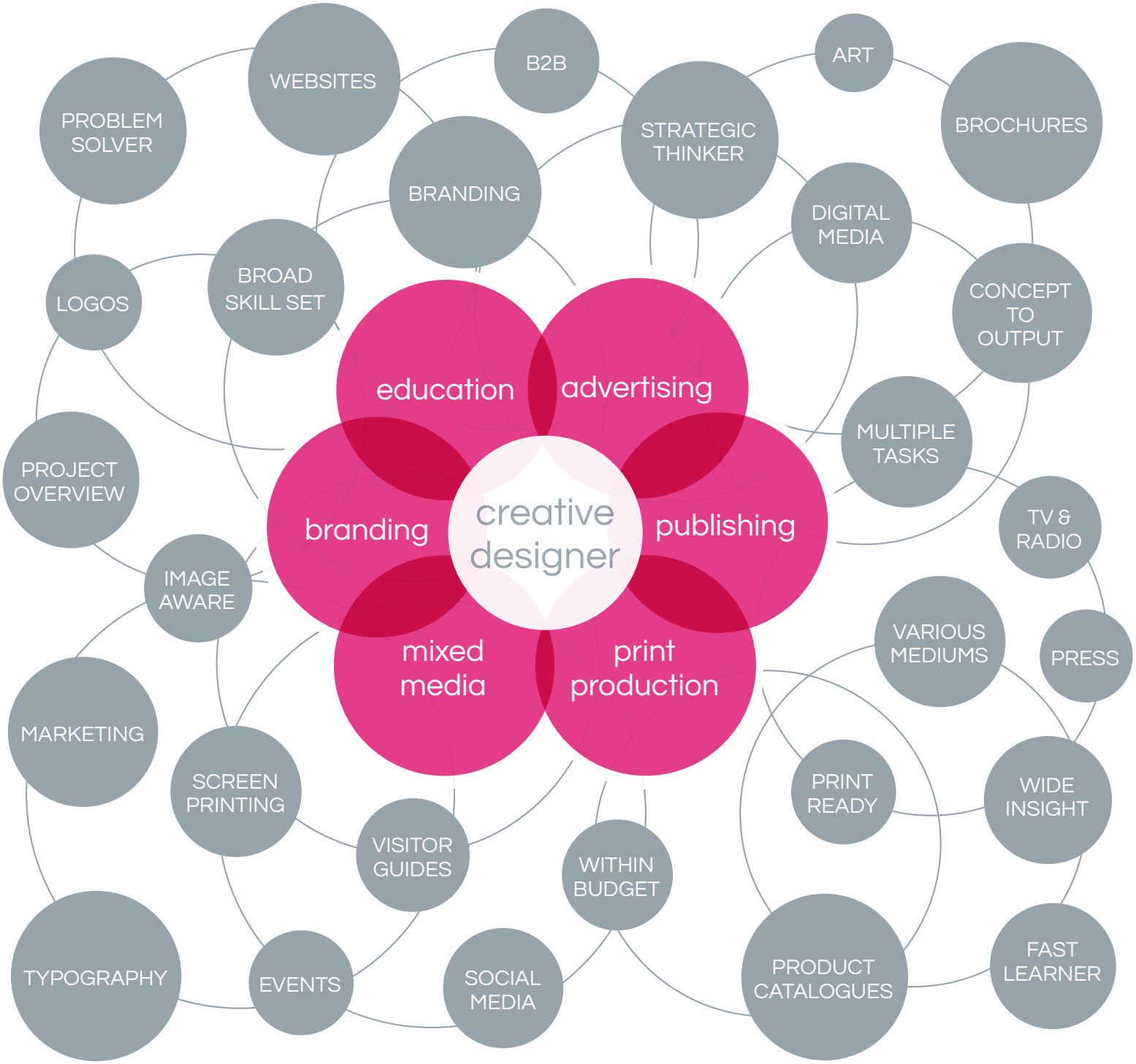

say design UK

GRAPHIC & DIGITAL DESIGN