



Scottish Further Education Unit

Skills for Work:
**Health and Social Care
Higher**

Health, Safety and Protection Issues
in Care Settings



Support Material

August 2007

 scotland's colleges

Acknowledgements

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Health and Social Care (Higher)

Health, Safety and Protection Issues in Care Settings

F1C8 12

Introduction

These notes are provided to support teachers and lecturers presenting the Scottish Qualifications Authority Unit F1C8 12, *Health, Safety and Protection Issues in Care Settings (Higher)*.

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Class Sets

Class sets of this pack may be purchased direct from the printer. Costs are dependent on the size of the pack and the number of copies. Please contact:

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How to Use this Pack

None of the material in this pack is mandatory. Rather, it is intended as a guide and an aid to delivery of the Unit and aims to provide centres with a flexible set of materials and activities which can be selected, adapted and used in whatever way suits individual circumstances. It may also be a useful supplement to tried and tested materials that you have developed yourself. The pack is available on the SFEU website in Word format to enable you to customise it to suit your own needs.

The pack is organised into several sections:

The **Reference Section** provides information on the rationale for, and ethos behind, Skills for Work courses; the course rationale and contains the Employability Skills Profile for Health and Social Care (Higher), showing where the specified employability skills and attitudes can be evidenced and assessed throughout the Course and in this unit.

The **Tutor Support Section** contains a suggested approach to teaching the Unit, advice on learning and teaching with under-16s, guidance on unit delivery and advice on integrating the development of employability skills throughout the unit. Finally, this section suggests resources which may be useful for tutors and students.

The **Student Support Section** contains guidance and teaching and learning material and activities related to:

- the health and safety responsibilities of employers and employees in health and social care settings
- risk assessment
- managing incidents involving aggressive behaviour in health and social care settings
- helping to protect service users who have been abused.

The activities and notes in this section contain a range of relevant websites that are designed to keep service users, carers and service providers up to date with current health and social care practice while providing an opportunity to promote positive and evidence based practice.

Activities are identified with the symbol:



Reference Section

What are Skills for Work Courses all about?

Skills for Work Courses are designed to help candidates to develop:

- skills and knowledge in a broad vocational area
- Core Skills
- an understanding of the workplace
- positive attitudes to learning
- skills and attitudes for employability.

A key feature of these Courses is the emphasis on **experiential learning**. This means learning through practical experience and learning by reflecting on experience.

Learning through practical experience

Teaching/learning programmes should include some or all of the following:

- learning in real or simulated workplace settings
- learning through role play activities in vocational contexts
- carrying out case study work
- planning and carrying out practical tasks and assignments.

Learning through reflecting at all stages of the experience

Teaching/learning programmes should include some or all of the following:

- preparing and planning for the experience
- taking stock throughout the experience - reviewing and adapting as necessary
- reflecting after the activity has been completed - evaluating, self-assessing and identifying learning points.

The Skills for Work Courses are also designed to provide candidates with opportunities for developing **Core Skills** and enhancing skills and attitudes for **employability**.

Core Skills

The five Core Skills are:

- Communication
- Numeracy
- Information Technology
- Problem Solving
- Working with Others

Employability

The skills and attitudes for employability, including self-employment, are outlined below:

- **generic skills/attitudes valued by employers**
 - understanding of the workplace and the employee's responsibilities, for example timekeeping, appearance, customer care
 - self-evaluation skills
 - positive attitude to learning
 - flexible approaches to solving problems
 - adaptability and positive attitude to change
 - confidence to set goals, reflect and learn from experience.

- **specific vocational skills/knowledge**

Course Specifications highlight the links to National Occupational Standards in the vocational area and identify progression opportunities

Opportunities for developing these skills and attitudes are highlighted in each of the Course and Unit Specifications. These opportunities include giving young people direct access to workplace experiences or, through partnership arrangements, providing different learning environments and experiences which simulate aspects of the workplace. These experiences might include visits, visiting speakers, role play and other practical activities.

A Curriculum for Excellence (Scottish Executive 2004) identifies aspirations for every young person. These are that they should become:

- successful learners
- confident individuals
- responsible citizens
- effective contributors.

The learning environments, the focus on experiential learning and the opportunities to develop employability and Core Skills in these Courses contribute to meeting these aspirations.

The Course in Health and Social Care (Higher)

Course Rationale

The primary target group for the Higher Health and Social Care Course is candidates who have reached an appropriate point in their secondary education although adult returners may also find it a useful stepping stone to employment or further study.

The Higher Health and Social Care Course is an introductory Course designed to equip candidates with the knowledge and skills relevant to the health and social care sectors. The NHS, local authorities, voluntary and private organisations make up these sectors and provide care to people in a variety of establishments such as nursing homes, residential homes for older people, hospitals and resource centres for people with a learning disability. The demands of both these sectors are increasing and as a result the need for health and social care professionals is also increasing. This Course has been designed to allow candidates to develop the knowledge and both generic and vocational employability skills relevant to these sectors. It has also been designed to help candidates develop an understanding of the nature of health and social care work in order that they can make informed decisions about whether or not they wish to gain employment in these sectors.

The structure of this Course has been designed to cover the essential knowledge and skills needed to go into employment or further study at further/higher education institutions. Candidates will begin by investigating who may need care, what provision is available and the roles and responsibilities of a care worker. This knowledge will give candidates a good introduction to what care work consists of. It is also essential that care workers operate from a sound ethical value base. Therefore, candidates will be investigating the principles underpinning the National Care Standards, to enable them to understand the nature and importance of such a value base if they choose to work with people in need of care. Candidates will also study, from psychology, how people develop through life and how to manage stress. This will help prepare candidates for further training or working with any service user (patient or client receiving care) in any setting. Candidates will also learn about essential procedures in relation to health and safety and carry out a risk assessment which is invaluable experience before working in health and social care establishments. They will also learn about protection issues in relation to aggressive behaviour and service users who have experienced abuse.

The emphasis throughout the Course is on experiential learning through real or simulated work settings. Candidates will, therefore, have the opportunity to learn about and practise essential generic employability skills such as working with others, good timekeeping and a positive attitude to learning. They will also be learning about and practising skills particularly valued by the health and social care sectors such as listening skills, verbal and non-verbal communication skills and planning.

The **general aims** of the Course are to:

- allow candidates to experience vocationally related learning
- provide candidates with a broad introduction to the health and social care sectors
- encourage candidates to foster a good work ethic, including timekeeping and a positive and responsible attitude to work
- provide opportunities to develop a range of Core Skills in a realistic setting
- encourage candidates to take responsibility for their own learning and development
- facilitate progression to further education or employment.

The **specific aims** of the Course are to:

- prepare candidates for work within the health and social care sectors
- help candidates to communicate effectively with a range of service users for example older people in residential care, patients in a hospital, children with a disability or people with dementia in a nursing home
- develop a caring and understanding attitude towards service users
- develop an awareness of health, safety and protection issues in health and social care settings
- develop skills of reflection and evaluating in relation to practice
- promote a positive and responsible attitude to health and social care work
- develop the skills to become a valued team member
- build candidates' confidence as they develop their own knowledge and skills
- develop essential knowledge for working with people in health and social care settings
- give candidates practical experiences in health and social care contexts and allow them to develop skills within these practical contexts.

In this Course it is important that a variety of learning environments are available to allow candidates to learn and develop skills in practical contexts. It will be important that candidates have access to, for example, real or simulated health and social care environments, work placements or visits to health and social care settings and visiting speakers. It is, therefore, important that centres delivering the Course build on existing partnerships between schools, Further Education colleges, employers and other training providers. Partnerships of this nature will allow the Course to be delivered in appropriate learning environments.

The Higher Health and Social Care Course builds on material covered in the Unit *Understanding Care Skills (Intermediate 2)* which is part of the Care (Intermediate 2) Course and builds on material covered in the Unit *Child Development and Health (Intermediate 2)* which is part of the Early Education and Childcare (Intermediate 2) Course. It also complements material covered in the Units, *Psychology for Care* and *Values and Principles in Care* which are part of the Care (Higher) Course. Unlike other Care Courses at this level it is not only developing knowledge in an experiential way, it is also developing employability skills.

The Course reflects National Occupational Standards for Health and Social Care and so helps prepare candidates to progress to:

- Scottish Vocational Qualifications (SVQs) in Health and Social Care
- further/higher education courses
- training/employment.

Unit Outcomes, PCs and Evidence Requirements

National Unit Specification: statement of standards

Unit: Health, Safety and Protection Issues in Care Settings (Higher)

Acceptable performance in this Unit will be the satisfactory achievement of the standards set out in this part of the Unit specification. All sections of the statement of standards are mandatory and cannot be altered without reference to the Scottish Qualifications Authority.

Outcome 1

Explain the health and safety responsibilities of employers and employees in health and social care settings.

Performance Criteria

- a) Explain the main responsibilities of employers under current health and safety legislation.
- b) Explain the main responsibilities of employees under current health and safety legislation.

Outcome 2

Carry out a risk assessment in a health and social care setting.

Performance Criteria

- a) Identify the hazards present in a given care setting.
- b) Explain the risks associated with these hazards.
- c) Evaluate these risks in terms of likelihood and impact.
- d) Describe appropriate control measures that will minimise these risks.

Outcome 3

Explain how to manage incidents involving aggressive behaviour in health and social care settings.

Performance Criteria

- a) Explain the reasons why a specific service user may be displaying a particular type of aggressive behaviour.
- b) Explain how a worker should manage this aggressive behaviour in a supportive manner.
- c) Describe appropriate reporting procedures a worker should follow after an incident involving aggressive behaviour.

Outcome 4

Explain how health and social care workers can help protect service users who have been abused.

Performance Criteria

- a) Explain what is meant by the term abuse in a health and social care context.
- b) Describe the possible indicators of specific forms of abuse.
- c) Explain appropriate ways workers should respond to service users who disclose abuse.
- d) Describe appropriate reporting procedures workers should follow if abuse is suspected.

Evidence Requirements for this Unit

Written and/or recorded oral evidence which covers all Outcomes and Performance Criteria is required for this Unit.

Outcomes 1 and 4

Candidates will produce written and/or oral evidence which may be in response to structured questions. The evidence will be produced under closed-book, supervised conditions within a time limit of one hour. The evidence should be produced towards the end of the Unit and include:

- **five** responsibilities an employer has under current Health and Safety legislation. General safety, equipment safety, information, training and risk assessments should be included.
- **four** responsibilities an employee has under current Health and Safety legislation. General instructions, materials/equipment, clothing and cooperation with employers should be included.
- a clear explanation of what is meant by the term abuse, including an example of each form of abuse including physical, sexual, emotional, financial, neglect and inexplicable failure to thrive
- **three** possible indicators of each of the forms of abuse
- **four** ways of appropriately responding to disclosure of abuse
- appropriate reporting procedures a worker should follow if abuse is suspected.

Outcome 3 – Risk Assessment

Written and/or oral evidence is required to demonstrate achievement of this Outcome. Candidates should undertake a risk assessment in **one** specific health and social care setting on **one** occasion. They will be given an appropriate risk assessment template. The risk assessment will be carried out in a real or simulated setting under supervision at an appropriate point in the Unit.

Outcome 3

Written and/or oral evidence is required for this Outcome. The evidence may be generated in response to a series of structured questions based on scenarios set in health and social care contexts. The evidence will be produced by candidates at an appropriate point in the Unit, under supervision in open-book conditions with candidates having access to notes totaling no more than 150 words. Candidates may be given the scenarios being set in advance of the assessment, but not the questions. The structured questions will allow candidates to generate evidence covering:

- **three** reasons why a service user may be displaying specific forms of physically or verbally aggressive behaviour
- **three** ways a care worker should manage physically or verbally aggressive behaviour in a supportive way
- appropriate reporting procedures workers must follow after an incident of aggressive behaviour

The National Assessment Bank (NAB) pack provided for this Unit illustrates the standard that should be applied. It contains appropriate structured questions, case studies accompanied by structured questions and a risk assessment template. If a centre wishes to design its own assessments for this Unit, they should be of a comparable standard.

NB Centres must refer to the full Unit Specification for detailed information related to this Unit.

Employability Skills Profile

In addition to the specific, vocational skills developed and assessed in this Course, employability skills are addressed as detailed in the table below. For the purposes of the table, the Units are referred to as A, B, C and D as indicated.

Understanding and Supporting People in Health and Social Care Settings	=	A
Care Principles and Practice	=	B
Working in Health and Social Care Settings	=	C
Health, Safety and Protection Issues in Care Settings	=	D

Employability skill/attitude	Evidence
• positive attitude to learning	C
• verbal and non-verbal communication skills	C
• listening skills	C
• good timekeeping	C
• ability to reflect on own abilities	C
• demonstrate reliability by completing tasks	C, B, D
• respect for others	B, C, D
• ability to work on feedback from others	C
• organisational skills	A, B, C
• planning skills	A, B, C
• willingness to carry out instructions	B, C, D
• ability to work with others	B, C
• health and safety awareness	C, D
• understanding roles and responsibilities	B, C, D
• awareness of care values	A, B, C, D

Assessment evidence in all Units:

- A = Case study based on Carl Roger’s theory of self-concept and investigation into stress and stress management.
- B = Group investigation and presentation on the National Care Standards and the production of a care plan.
- C = Investigation of health and social care provision, the production of a CV for a specific job role, participating in an interview for a specific job role and candidate reviews of employability skills.
- D = Closed book test on health and safety responsibilities and protecting service users, case study on managing aggressive behaviour and carrying out a risk assessment in a real or simulated health and social care setting.

Careers Scotland Support

for School-College Collaboration for Scotland's Colleges in the Scottish Enterprise area



In August 2006 Careers Scotland (SE and HIE areas) received funding from the Scottish Executive to support college/school collaboration and encourage and promote vocational educational choices for pupils in schools. Following consultation each area produced a local action plan outlining how they intended taking forward key activities. Careers Scotland's focus is to support the career guidance needs of all S2-5 pupils involved in the opportunities which school/college collaboration brings, supporting them to make vocational educational choices, and with particular consideration for those young people at risk of becoming not engaged in employment education or training.

Skills for Work (SfW) courses are a key aspect of enhanced school/college collaboration and Careers Scotland has an important role in selection and recruitment and pre-entry career guidance, as well as ongoing support and pre-exit career guidance, to ensure the pupils' experience of SfW is capitalised upon in any future career planning. Careers Scotland also supports the career guidance needs of pupils involved in other vocational/pre-vocational programmes where relevant. Career Box delivery is a valuable tool in helping meet the needs of school pupils and lessons reflect options available within colleges; both at school and post school.

Careers Scotland activity takes place at local and national levels. This may involve a combination of any of the following services which can be tailored to local needs:

- awareness raising of Skills for Work courses (and other vocational programmes where relevant) – for pupils, teachers and parents - demonstrating how these educational choices have implications for future career options, and support the achievement of future career goals
- careers guidance support for individuals and groups, before, during and after involvement in SfW courses, resulting in better informed career decisions and effective transitions
- providing support for pupils who have been unsuccessful in attaining a place on a SfW course
- providing transitional skills development for those completing SfW courses
- capacity building through relevant shared CPD events, for Careers Scotland staff, teachers and college lecturers
- capacity building through the development of resources to support pupils, parents or teachers
- delivery of relevant Career Box lessons, where appropriate

- making connections with other existing support for pupils
- participation in local planning and management arrangements
- contributing to local and national discussions on provision and strategic development
- capturing good practice and evaluating effectiveness, using the community of practice site on our website (www.careers-scotland.org.uk) and sharing successes and concerns

In addition there are opportunities for developmental activities which can help to take forward CPD, good practice, resource development and learning opportunities for Skills for Work for young people, teachers, college lecturers, parents, Careers Scotland Advisers and employers.

For further information on Careers Scotland (SE)'s involvement in school/college collaboration in your college, please get in touch with one of our Careers Scotland Regional contacts:

South East Region (Edinburgh and Lothians; Forth Valley; Borders)

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West Region (Glasgow; Dunbartonshire; Renfrewshire)

Sandra Cheyne 0141 204 8338 sandra.cheyne@careers-scotland.org.uk

Tutor Support Section

Learning and Teaching with Under 16s

Scotland's Colleges have made significant progress in meeting the needs of young learners. Our knowledge of the learning process has increased significantly and provides a range of strategies and approaches which gives us a clear steer on how lecturers can add to their skill repertoire. Lecturers can, and do, provide a stable learning environment where young students develop a sense of self-respect, learn from appropriate role models and see an opportunity to progress. There are basic enabling skills for practical application which can further develop the learning process for this group of students. So what are the characteristics of effective learning and teaching which will help to engage young learners?

Ten ways to improve the learning process for under 16s

(This list is not exhaustive!)

1. **Activate prior knowledge and learning** – ascertain what the learner knows already and teach accordingly. Young people do have life experience but it is more limited than adult learners and they may not always be aware of how it will assist them in their current learning.

Tips - Question and answer; Quick Quiz; Quick diagnostic assessment on computer; present key words from the course or unit and see how many they recognise or know something about.

2. **Tune learners into the Big Picture** – the tutor knows the curriculum inside out and why each lesson follows a sequence, however the young learner does not have this information and is re-assured by being given the Big Picture.

Tips – Mind map or concept map; use visuals, for example wall displays of diagrams, photographs, flow charts; explain the learning outcomes in language they will understand; We Are Learning Today (WALT) targets and What I'm Looking For (WILF) targets; give clear and visible success criteria for tasks.

3. **Use Advance Organisers** – these are lists of the key concept words that are part of the course or unit.

Tip – Highlight on any text the concept words that you will be using; make a visible list and put it on display – concept words can be struck off or referred to as they occur (NB this helps with spelling and independent learning as they do not have to keep checking meaning); highlight essential learning and action points.

4. **Vary the teaching approaches.** The two main approaches are instructing and demonstrating, however try to provide opportunities to facilitate learning.

Tips – Ask students what they know now that they did not know before, or what they can do now they could not do before, at appropriate points in the lesson or teaching block; ensure there are problem solving activities that can

be done individually or in groups; ask students to demonstrate what they have learned; use a range of question and answer techniques that allow participation and dialogue, eg. provide hints and cues so that they can arrive at answers themselves.

5. **Preview and review of learning.** This helps to embed previous learning and listening skills and provides another opportunity to elicit learner understanding. Consolidates and reinforces learning.

Tips – At the beginning of each lesson, or session, review previous learning and preview what is coming up; at the end of each lesson or session, review what has taken place and what will be focussed on next time – these can both be done through question and answer, quizzes and mind mapping activities.

6. **Language in the learning environment.** Do not assume that the language which is used in the learning environment is always understood by young learners, some words may be familiar but do not have the same meaning when used vocationally.

Tips - At appropriate points ask students what words mean; explore the various meanings of words to find out if they may have come across this language in another context; by looking at the structure and meaning of words there is an opportunity for dialogue about learning and to build vocabulary.

7. **Giving instructions in the learning environment.** This is one of the most difficult tasks a tutor has to do whatever the curriculum area. With young learners this may have to be repeated several times.

Tips – Ask a student to repeat back what you have asked them to do before beginning a task; ask them to explain the task to one of their peers; use the KISS principle – Keep It Short and Simple so that they can absorb and process the information.

8. **Effective feedback.** Feedback is very important for the learner to assess their progress and to see how and what they can improve. Provide opportunities to engage in dialogue about the learning function of assessment – provide details of the learner’s strengths and development needs either in written or spoken form. With younger learners identifying one or two areas for development is sufficient along with acknowledgement of what has been done well.

Essentially, learners are helped by being given a **specific** explanation of how work can be improved. You can also use summative assessment formatively, ie. as an opportunity to identify strengths, development needs and how to improve.

Tips – Ask students themselves to identify their own strengths and development needs – self evaluation; peer evaluation of work can be successful once they have been taught how to do it; the tutor can produce a piece of work and ask students to assess it anonymously; have a discussion about the success criteria for the task and ensure the students are clear about

them; allow learners to set criteria for success and then measure their achievements against these.

9. **Managing the learning behaviour.** Under 16s are coming into Scotland's Colleges and training establishments from largely structured and routine-driven environments in schools and early feedback from those undertaking Skills for Work courses indicates that they very much enjoy the different learning environment that colleges and other training providers offer. Remember though that these are still young learners. They will still expect tutors to provide structure and routine, and will perform best in a calm, orderly learning environment. Young students will respond to firm, fair, and consistent management. Such routines have to be established quickly and constantly reinforced.

Tips - Health and safety is non-negotiable and consequences of non-compliance with the regulations should be made clear and adhered to at all times; set out your expectations from day one and provide a consistent message; have clear beginnings, middles and endings for each session; be a positive role model for your students, ie. be there before they are and manage the learners with respect; always deliver what you promise; build up good relationships and get to know the learners, make the curriculum interesting and stress the relevance of the learning; set up a positive behaviour management system. By following these guidelines you will build up two-way respect, which, while sometimes challenging to achieve, can be very powerful and work to everyone's benefit.

10. **Care and welfare issues.** School/college partnerships mean increasing numbers of young learners in college. Tutors have to be aware of their professional responsibilities and mindful of young people's rights. However tutors have rights too, in terms of feeling safe and secure in working with young people and there are basic steps staff can take to minimise risks. It is essential that colleges ensure that tutors have a working knowledge of the Child Protection policies (local authority and college documentation) and follow procedures and policies diligently. School/College Liaison Officers will be familiar with these documents and can provide support and advice. There are also training sessions on Child Protection available from SFEU (see the following page).

Tips - Avoid one-to-one situations with young students in a closed area; do not do or say anything that could be misinterpreted; if the opportunity arises, do some observation in schools to see and discuss how teachers use the guidelines for their own protection as well as the young person's.

Most young people are a delight to work with and they will positively enjoy the experience of learning in college. However, there will inevitably be some who are disengaged, disaffected and who have not yet had an opportunity to experience success. 'Skills for Work' is a unique educational initiative that young people can be motivated to buy into – you as the tutor are key to the success of these programmes.

Skills for Work Workshops

To take this 10 point plan forward and to add to it, you can attend one of SFEU's 'Get Skilled Up' half day workshops for tutors delivering Skills for Work Courses, when we explore further the learning process and look at a range of specific teaching and learning techniques to use with the under 16 age group. To find out when the next event is visit our website www.sfeu.ac.uk or contact the Learning Process team at SFEU on 01786 892000.

Child Protection Workshops

These are run on a regular basis by staff at SFEU in Stirling and also in colleges. For more information on these workshops please contact members of the Access and Inclusion team at www.sfeu.ac.uk or contact the team at SFEU on 01786 892000.

General Guidance on Unit Delivery

It is suggested that this Unit is delivered after *Care Principles and Practice*. Concepts such as human needs are covered within *Care Principles and Practice* and this would allow additional time to be spent on Outcomes 3 and 4 in this Unit.

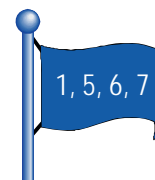
Hours	Content	NABS
0 – 2 hours	<ul style="list-style-type: none"> • Introduction to the unit and employability skills • Introduction to unit content and NABS • What is Health and Safety? • What does Health and Safety mean in a Care Context? 	
3 – 7 hours	<p>Legislation relating to Health and Safety in Care Settings</p> <ul style="list-style-type: none"> • The Health and Safety at Work Act, 1974 • Safety Representatives and Safety Committees Regulations, 1977 • Health and Safety First Aid Regulations, 1981 • The Food Safety Act, 1990 • Manual Handling Operations Regulations, 1992 • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995 • Management of Health and Safety at Work Regulations, 1999 • Control of Substances Hazardous to Health Regulations, 2002 • The Fire (Scotland) Act, 2005 	
8 – 12 hours	<ul style="list-style-type: none"> • What is Risk Assessment? • Risk Assessment Form • Estimating Risk Level • Case Studies (3) 	NAB Outcome 2
13 – 16 hours	<ul style="list-style-type: none"> • Types of behaviour that might be considered aggressive • Promoting a positive environment linked to values, National Occupational Standards and Codes of Practice (Unit: <i>Care Principles and Practice</i>) 	

17 – 19 hours	<ul style="list-style-type: none"> • Reasons why people display aggressive behaviour • Unmet needs (linked to ‘needs’ in Unit: <i>Care Principles and Practice</i>) • Theories of aggression: <ol style="list-style-type: none"> a) Instinct theory b) Frustration theory c) Social learning theory 	
20 – 22 hours	<p>Models of supporting behaviour:</p> <ul style="list-style-type: none"> • Antecedent, Behaviour and Consequences Model (ABC) • Therapeutic Crisis Intervention • CALM (Crisis and Aggression Limitation and Management) 	
23 – 25 hours	<ul style="list-style-type: none"> • Agency guidelines, policies and procedures about incidents involving aggressive behaviour 	NAB Outcome 3
26 – 30 hours	<ul style="list-style-type: none"> • What is abuse? • Types of abuse • Signs and symptoms of abuse • Causes of abuse 	
31 – 34 hours	<ul style="list-style-type: none"> • Abuse in care practice • Policies and procedures relating to abuse • Guest speaker to look at agency policies re incidents of abuse 	NAB Outcomes 1 and 4
35 – 37 hours	<ul style="list-style-type: none"> • Remediation and re-assessment • Review and evaluation of unit 	

Signposting of Employability Skills

In addition to the specific vocational skills developed in this Unit, students will have opportunities to develop and apply their knowledge and understanding of the employability skills.

Throughout the pack there are numbered flags, like the one shown here, showing which specific employability skill can be highlighted and/or assessment evidence recorded when students are busy with the various activities in the Unit.



1	Positive attitude to learning	6	Demonstrate reliability by completing tasks*	11	Willingness to carry out instructions*
2	Verbal and non-verbal communication skills	7	Respect for others*	12	Ability to work with others
3	Listening skills	8	Ability to work on feedback from others	13	Health and safety awareness*
4	Good timekeeping	9	Organisational skills	14	Understanding roles and responsibilities*
5	Ability to reflect on own abilities	10	Planning skills	15	Awareness of care values*

* The employability skills marked with an asterisk* are directly assessed in this Unit.

As well as the employability skills and attitudes that are assessed in this Unit, candidates should be made aware there are other specific personal qualities and attitudes of care workers that are valued by the health and social care sector.

Although these qualities and attitudes are not assessed in this Unit, they contribute towards a good working relationship between health and social care workers and service users. For example candidates should be aware of the importance of compassion, friendliness and empathy to enable service users to feel comfortable enough to discuss personal issues of concern to them. Candidates should also be made aware of the central place given to self-awareness in health and social care training.

Encouraging candidates to become more aware of the impact they have on people, the way they feel about things and the impact of experiences on themselves will help prepare them for future training or employment in the health or social care sector.



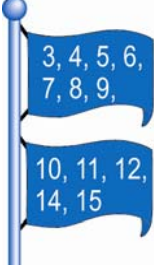
Guidance on Integrating Employability Skills

Opportunities for learning about and developing these skills and attitudes must, however, be integrated throughout all the Units in the Course. Since workplace placements are not mandatory, students may be developing the employability skills through class exercises or assessments for the various Units.

It is strongly advised that course teams meet together to discuss and agree a co-ordinated approach to the teaching and development of the employability skills throughout the Course and to ensure that the team has a common interpretation of the skills and attitudes.

Opportunities for highlighting and developing some of these skills in this Unit are detailed in the following table:

Generating Evidence and Assessment Opportunities for Employability Skills

Employability Skills	Delivery Advice	Possible Activities/Contexts
	<p>Students research individually and in small groups; listening to and asking questions of visiting speakers, within a range of health and safety activities. This provides an opportunity to demonstrate a positive attitude to learning; verbal and non-verbal skills; respect for and an ability to work with others and an understanding of roles and responsibilities within care settings.</p>	<ul style="list-style-type: none"> • Activities 1, 2, 3, 4, 5, 6, 7 provide opportunities to research and understand health and safety policies and procedures within Care organisations. • Activities 9, 10, 11 are more specific to roles and responsibilities specific to health and safety.
	<p>Students work in small groups and present their findings to the larger class group providing opportunities to work with others; demonstrate respect, listen to others; complete tasks within a timescale; carry out instructions. All activities demonstrate an understanding of care values.</p>	<ul style="list-style-type: none"> • Activities 12, 16 and 17 provide opportunities to work in groups and present findings to others. • Activities 18 and 19 develop an understanding of care values in practice and reflecting on practice.
	<p>Students work in pairs and in role play situations, to gain a more empathic perspective of Care practice. Visiting speakers provide an opportunity to devise and ask questions in relation to values and roles and responsibilities in Care settings.</p> <p>Finding out about abuse reporting procedures provides an opportunity to demonstrate planning, organisation, communication and ability to work with others while reinforcing the roles and responsibilities and values within Care practice.</p>	<ul style="list-style-type: none"> • Activities 20 and 23 demonstrate listening skills, respect for others, and an ability to work with others. • Activity 21 provides an opportunity to work on feedback from others and an awareness of care values. • Activity 22 - visiting speaker. • Activity 26 - finding out about abuse reporting procedures.

Resources

Books



Thomson, Neil (2002) **People Skills**, published by Palgrave.

Hawkins, Richard and Ashurst, Adrian (ed) (2006) **How to be a Care Assistant**, published by Hawker Publications.

Miller, Janet (ed) (2005) **Care Practice for S/NVQ 3**, ed Janet Miller. Published by Hodder Arnold

Staddon, Gail et al (2005) **Psychology for Higher**, published by Unity Publications Ltd.

Cardwell, Clark and Meldrum 3rd edition (2004) **Psychology**, published by Collins

MacLean, Siobhan; MacLean, Iain and Shiner, Mark (2006) sixth edition **Social Care and the Law in Scotland**: an SVQ reference guide (ISBN 978-1-903575-49-9. Kirwin Maclean Associates, Rugeley, Staffs
Section 7 in this book covers legal aspects of health and safety issues in social care settings. Section 9 covers legal aspects relating to the protection of adults from abuse.

Hayes, N (1993) **A First Course in Psychology**, Nelson. Croatia.
Introductory psychology book with information on stress.

Journals

Community Care

Social work news and social care articles from *Community Care*

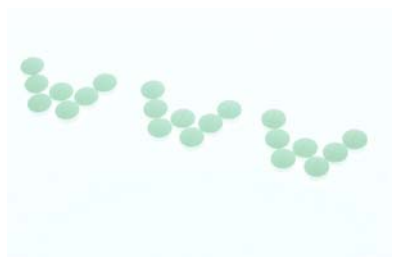
<http://www.communitycare.co.uk/Articles/List.aspx?NavigationID=1>

Social Care Online

From the Social Care Institute for Excellence

<http://www.scie-socialcareonline.org.uk/>

Websites and Online Resources



National Learning Network: NLN Material Topics

<http://www.nln.ac.uk/>

You must first register (for free) and log-in.

Select '*Health Care, Medicine, Health and Safety*' from the subject categories listed; then go to '*Caring Skills*' topic and double click; the first topic is '**Allegations of Abuse**' – click the hyperlink to open the material.

Move back to results 56 – 60 in the '*Caring Skills*' topic and

access: '**The Home from Heaven**' URL:

http://nln.mimas.ac.uk/view.jsp?unit=adval_PT22_The%20Home%20from%20Heaven

and then '**The Home from Hell**'

http://nln.mimas.ac.uk/view.jsp?unit=adval_PT22_The%20Home%20from%20Hell

Maslow's Hierarchy of Needs

<http://chiron.valdosta.edu/whuitt/col/regsys/maslow.html>

Disclosure of Child Sexual Abuse ('What Does the Research Tell Us About the Ways That Children Tell?') – an American Psychological Association article (2005)

<http://www.apa.org/journals/features/law111194.pdf>

NSPCC leaflet: 'Protecting Children from Sexual Abuse' – a guide for parents and carers (2005)

http://www.nspcc.org.uk/inform/publications/downloads/ProtectingChildrenFromSexualAbuse_pdf_gf25324.pdf

A good look at the causes and consequences of anger and how to deal with it by Dr Tom Stevens (2005) of California State University

<http://www.csulb.edu/~tstevens/b-anger.htm>

MentalHelp net – Psychological self tools – online self-help book

http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=9852&cn=353

Useful factsheets on Challenging Behaviour

<http://www.thecbf.org.uk/Factsheets.htm>

UK Health and Safety Executive

<http://www.hse.gov.uk>

Sense Scotland: Challenging our approaches to Behaviour (2003)

<http://www.nud.dk/A56CC941-5794-45E4-A055-65F1732B00EF>

The Strategic Importance of Positive Management of Challenging Behaviour in residential and day social care services (East Riding of Yorkshire Council) (good PowerPoint presentation)

http://www.socialeurope.com/pdfs/edinburgh/workshoppresentations/Tuesday%20morning/Atkins_Rhodes_final.ppt#256,1

Student Support Section

Tutor Note on Student Activities

This section includes both student notes and activities. These materials are offered to centres as a flexible set of notes and activities which can be selected, altered and used in whatever way suits individual centres and their particular situation. For example, in the case of the student activities you might want to talk through the instructions with the learners and then give the instructions out on paper as reminders.

Some of the activities are suitable for individual or group investigation and research and can usefully be followed up by whole class discussion.

The following are newspaper articles referred to within the support pack. You can access these via hyperlinks. You may wish to print them off and store a hard copy within your teaching pack.



Activity 3

E coli nursery outbreak blamed on failure to follow basic hygiene rules

Ian Johnston (17 May 2006)

Extract from News.Scotsman.com

<http://thescotsman.scotsman.com/index.cfm?id=732612006>

Activity 8 (2 articles)

Article 1:

Nurse tells of care home fire alarm error

Dan McDougall and Jim McBeth (2 Feb 2004)

Extract from News.Scotsman.com

<http://news.scotsman.com/topics.cfm?tid=130&id=129682004>

Article 2:

Faulty fuse blamed for Rosepark tragedy

Ian Johnston (15 Feb 2004)

Extract from News.Scotsman.com

<http://news.scotsman.com/topics.cfm?tid=130&id=182142004>

Activity 26

Whistleblower accuses staff of 'appalling' abuse at care home

Anthony Barnett (19 Feb 2006)

http://observer.guardian.co.uk/uk_news/story/0,,1713125,00.html

Welcome to Health, Safety and Protection Issues in Care Settings!

This unit is designed to familiarise you with health, safety and protection issues in health and social care settings. You'll learn about health and safety responsibilities and typical hazards and risks. You'll also explore supportive approaches to managing aggressive behaviour and learn how to respond appropriately to service users who may have experienced abuse.

The Unit is divided into four outcomes:

1. Explain the health and safety responsibilities of employers and employees in health and social care settings.
2. Carry out a risk assessment in a health and social care setting.
3. Explain how to manage incidents involving aggressive behaviour in health and social care settings.
4. Explain how health and social care workers can help protect service users who have been abused.



Outcome 1

Explain the health and safety responsibilities of employers and employees in health and social care settings.

This outcome is designed to introduce you to the responsibilities of both employers and employees in health and care settings in terms of the steps they must take to protect workers and make the work environment as safe as possible.

Legislation Relating to Health and Safety in Care Settings

Health and safety is one of those subjects which people often regard as fairly mundane and boring, but the reality is that if you don't pay sufficient attention to these matters then the consequences can be disastrous. Consider the following headlines:

- **Care Home Fire Kills 14**
(Rosepark Nursing Home, January 2004)
- **Deadly E Coli Outbreak Hits 37 Children at Nursery**
(Careshare Nursery, Lauder College, Dunfermline, May 2006)
- **Three nurses are attacked on average every day in Glasgow hospitals**
(October 2005)



Healthy and Safety Legislation



The table below gives an overview of major legislation in this area:

The Health and Safety at Work Act, 1974	This is the major piece of legislation covering health and safety matters in the UK. As new legislation is introduced to provide protection in the workplace it tends to be added to this act in the form of supplementary regulations.
Safety Representatives and Safety Committees Regulations, 1977	Makes it mandatory for employers to consult with trade union safety representatives.
Health and Safety First Aid Regulations, 1981	Concerned with the training and appointment of first-aiders in work settings.
The Food Safety Act, 1990	This act sets out a number of requirements concerning the safe production and preparation of food for public consumption.
Manual Handling Operations Regulations, 1992	Concerned with all aspects of 'moving and handling' and related risk assessment.
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995	Makes it a legal requirement to report certain events and situations.
Management of Health and Safety at Work Regulations, 1999	Introduced mandatory risk assessments to be carried out by employers in all work situations.
Control of Substances Hazardous to Health Regulations, 2002	Intended to provide protection for employees and service users from a whole range of potentially hazardous substances in the workplace.
The Fire (Scotland) Act, 2005	Makes employers take measures to reduce the risk of fire on premises.

The Health and Safety at Work Act, 1974



The Health and Safety at Work Act, 1974 is the main piece of health and safety legislation in the UK. As new laws in this area are introduced they are often added to this act as regulations or statutory instruments. This means that in effect this act is constantly changing and being updated. The Health and Safety Executive website always has the most up to date legislation available and material is usually free to download (www.hse.gov.uk).

This Act outlines a number of responsibilities for employers, managers and employees which are summarised in the table below:

Responsibilities of Employers	Responsibilities of Managers	Responsibilities of Employees
Employers must, as far as reasonably practicable, ensure the health and safety and welfare of all employees	Managers must provide and maintain a safe working environment for staff	Employees must cooperate with employers in relation to health and safety
Employers must prepare a written statement of safety policy	Managers must ensure that all staff adhere to policies and procedures	Employees must adhere to safety policies and procedures
Employers must provide and maintain equipment which is safe	Managers must provide training in methods and practices	Employees must make sure they use equipment according to guidelines, including personal protection equipment.
Employers must provide information, training and supervision relating to health and safety matters at work	Managers must record and report accidents	Employees are accountable for their own health and safety and that of those they are working with (staff and service users)

This act was designed to try and ensure that everyone in the workplace was accountable for health and safety issues. Employers and managers have to ensure that the working environment is safe, but workers must also work in a safe manner.

Safety Representatives and Safety Committees Regulations, 1977

This Act sets out a requirement for employers to consult with trade union safety representatives on all issues relating to health and safety matters in the workplace.

Under these regulations trade union safety representatives can:

- Investigate possible hazards at work and convey employees' concerns to management
- Inspect workplaces following any accident or dangerous occurrence
- Represent employees in discussions with health and safety inspectors

It should be noted that there are some work locations and environments in health and social care settings where there are no trade unions and some indeed where unions are actively discouraged. This can pose challenges for staff who might find themselves and their interests poorly represented in connection with this legislation.



Activity 1



Check out a number of care organisations with regard to their policies towards trade unions and health and safety matters in general. You will often find information on their company websites about their policies in this area. There may be the opportunity to speak to organisation representatives if on placement, or during talks by visiting speakers, to find out more about this.

Share your findings and discuss how employees' interests might best be represented in general terms in health and safety matters.

Health and Safety First Aid Regulations, 1981



The Health and Safety First Aid Regulations, 1981 require employers to provide adequate and appropriate equipment, facilities and personnel to enable first aid to be given to employees if they are injured or become unwell at work. You are not required to undertake any first aid training for the purposes of this unit but you might want to consider this as it is an important and potentially life saving skill to have and extremely useful in all areas of health and social care. You may hear people say that ‘a little knowledge is a dangerous thing’, but when it comes to first aid, ‘a little knowledge can save a life’.



Activity 2



Visit the ‘*Frequently Asked Questions*’ part of the first aid section of the Health and Safety Executive website (www.hse.gov.uk/firstaid/faqs.htm) and answer the following questions.

1. What is legally required to be in a First Aid box?
2. Is it a legal requirement for workplaces to provide first aid facilities for members of the public?
3. Do first aiders at work need to be trained?
4. Can ‘appointed persons’ give first aid?
5. Can first aiders give medicines or tablets to people at work?

Activity 2 Answers

1. No legal requirement with regards to content, although some advice is available, which essentially states that content should be related to assessment of first aid needs.
2. It is not a legal requirement, but the Health and Safety Executive strongly recommends that those workplaces to which the public have access should provide such facilities. The only legal requirement is to provide facilities for their employees.
3. First aiders are required to undertake training on a course by an HSE approved training organisation.
4. Appointed persons should not attempt to give first aid for which they have not been trained. They are responsible for ensuring emergency help is called and that first aid boxes are kept stocked. There are no legal requirements for appointed persons to have any approved training in order to carry out their responsibilities. However, there are courses available for appointed persons.
5. HSE guidance in the Approved Code of Practice and Guidance states that first aid at work does not include giving tablets or medication to treat illness and such items should not be kept in the first aid box. However, strictly speaking, there is no legal bar to employers making such items available to employees, if the assessment of first aid needs indicates they should be provided. HSE has no objection to paracetamol or aspirin being made available in the workplace. Some employers however, have strict regulations instructing that no employee can give any form of tablets or medicines to a fellow worker.

The Food Safety Act, 1990



The provisions of this act apply wherever food is prepared or served to people who are not in a family situation. This therefore covers all health and social care settings and means that absolutely everyone involved must receive appropriate training on safe handling, storage and preparation of food.

They must also ensure that good practice is followed at all times. Again, the consequences of not following good practice guidelines in this area can be devastating. Outbreaks of food poisoning in care and health establishments have sometimes been found to be caused by the bad practice of one **individual**.



Activity 3



Using the link below; read the account of a food poisoning outbreak at a Scottish nursery and working in small groups, answer the questions that follow.

E coli nursery outbreak blamed on failure to follow basic hygiene rules

Extract from News.Scotsman.com by *Ian Johnston*

<http://thescotsman.scotsman.com/index.cfm?id=732612006>

1. What was said to be the basic cause of this outbreak of potentially very dangerous food poisoning?
2. What would have probably prevented this outbreak from spreading?
3. Carry out an Internet search and make a list of complications which can result from infection with E coli 0157.
4. Imagine you were in charge of a similar type of establishment. What steps would you take to reduce the chances of a similar outbreak occurring?



Activity 4



Visit the **Food Standards Agency** website (<http://www.food.gov.uk/>) and obtain access to information leaflets about rules for food preparation. Summarise the main rules you find in the box below:



Manual Handling Operations Regulations, 1992

These regulations govern activities which are involved with moving and handling. In the field of health and care they are most often concerned with the moving and handling of people and the use of appropriate equipment or aids.

The main points are:

- All moving and handling tasks must be properly assessed
- Employers should provide information, training and supervision on safe and efficient methods
- Employees must adhere to recommended ways of working

You are not allowed to move or assist in the movement of people until you have received proper training in this area.



Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995

These regulations are often referred to as RIDDOR and place a legal duty on:

- employers
- self-employed people
- people in control of premises

to report work-related deaths, major injuries or over 'three day' injuries, work related diseases, and dangerous occurrences.

Most organisations will have policies in place for the reporting of such occurrences, but if you are in any doubt you can always call the HSE's Incident Contact Centre (ICC) on 0845 300 99 23.



Activity 5



Visit the HSE website (www.hse.gov.uk). Locate and list below the exact definitions of **reportable occurrences**.

Activity 5 Answer

You must report:

- deaths
- major injuries
- over 3 day injuries – where an employee or self-employed person is away from work or unable to perform their normal work duties for more than 3 consecutive days
- injuries to members of the public or people not at work where they are taken from the scene of an accident to hospital
- some work-related diseases
- dangerous occurrences – where something happens that does not result in an injury, but could have done.

Management of Health and Safety at Work Regulations, 1999



These regulations state that employers have to carry out risk assessments in their workplaces.

The HSE recommends that this be done in five stages:

1. Identify the hazards
2. Decide who might be harmed and how
3. Evaluate the risks and decide on precautions
4. Record your findings and implement them
5. Review your assessment and update if necessary

The HSE defines a **hazard** as:

- anything that may cause harm, such as chemicals, electricity, working from ladders, an open drawer etc

and a **risk** as:

- the chance, high or low, that somebody could be harmed by these and other hazards, together with an indication of how serious the harm could be.

Control of Substances Hazardous to Health Regulations, 2002



These regulations are often referred to as **COSHH rules** and require employers to take precautions to minimise harm to employees from any potentially hazardous substances in the workplace.

Employers are responsible for carrying out the following:

- Assess risks to health from substances
- Make decisions as to what precautions are needed
- Prevent exposure to hazardous substances
- Make sure employees are trained and supervised in handling and storage of substances.



Activity 6



Employers are obliged to hold information on file concerning hazardous substances in the workplace. Very often they will have notices at locations where substances are stored giving advice on safe storage and use. If you can, find one of these notices and copy its main points into the table below.

Substance	Recommendation

The Fire (Scotland) Act, 2005



This act details the following responsibilities of employers and employees.

Employers must:

- Carry out risk assessments in the workplace
- Implement any necessary fire safety measures (including risk reduction and staff training)

Employees must:

- Take all reasonable care to reduce risks of fire
- Co operate with fire safety procedures



Activity 7



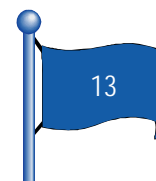
You should always be aware of how to escape from any situation where you might encounter a fire. You should consider how you would escape from the room you are in right now. If this is a class or other similar room it should have a fire notice on display. Find it and read it.

The next thing you need to consider is how you might escape in the event of a real fire when you can't see in front of you for thick smoke; it's hot, noisy and people around you are panicking.

A useful exercise is to see how difficult this is by simulating conditions using some form of blindfold and ear phones. You might want to try this, but only with support and supervision. We don't want anyone falling downstairs or out of a window while carrying out a health and safety course!



Activity 8



Case Study

The following links will give you access to two accounts of a fire which broke out very early in the morning of Saturday 31st January 2004 in Rosepark Care Home in Uddingston resulting in the deaths of 14 residents.

The first extract, written a few days after the tragedy, tells in graphic detail of the responses of staff on discovering the fire and the second, which was written two weeks later, gives an explanation of the probable cause of the fire. Read both accounts and then answer the questions that follow.

Nurse tells of care home fire alarm error

Extract from *The Scotsman* 2nd February 2004 by *Dan McDougall and Jim McBeth*

<http://news.scotsman.com/topics.cfm?tid=130&id=129682004>

Faulty fuse blamed for Rosepark tragedy

Extract from *Scotland on Sunday* 15th February 2004 by Ian Johnston

<http://news.scotsman.com/topics.cfm?tid=130&id=182142004>

Questions

1. How would you have reacted had you been the nurse in charge and the fire alarm went off? Would you have done anything differently?
2. After the fire it was said that many residents died because their room doors were open. Did this make any difference?
3. What steps could be taken to reduce the chances of a similar incident happening again?



Activity 9

Health and Safety Check



As part of an exercise to help her learn about health and safety issues in the workplace, Helen is asked to carry out a health and safety check (sometimes referred to as a health and safety audit) of her workplace. Read her audit account below and identify as many potential hazards as you can. List these on the table provided and then state what action you think should be taken to reduce the risks from these hazards.

On Thursday morning, my unit manager asked me to carry out a health and safety inspection of my workplace, which is a small group home for adults with learning difficulties. I started at the front door by ringing the bell and waiting for someone to let me in. Nobody came after a few minutes so I opened the door, which was not locked anyway, and entered the hall. I noticed a large pile of empty cardboard boxes piled up in the hall and also a bicycle belonging to a colleague. Apart from these articles, the hall was generally tidy and there didn't appear to be any trip hazards.

I went into the hall cupboard where the main electrical fuse box was located. This is also being used as a temporary storage room for cleaning materials, and there were boxes of kitchen rolls and packs of toilet paper there too. It was in rather an untidy state, so I stacked things up a little neater, making sure I put bottles of bleach out of harm's way at the top of a pile of boxes of cleaning powder. I then made sure the cupboard was locked and put the key on the little hook above the door where it was normally kept.

I then went into the main communal room which is used as a sitting and recreational area by all the residents. It had been tidied up but I noticed that there was a rug on the wooden floor which was curling up at the edges. The television and music centre had both been left overnight on standby, and someone had forgotten to turn off the computer in the corner.

The next room I checked was the kitchen. I checked all the electrical equipment as I had been instructed, by looking for little green labels which indicated that 'Portable Appliance Tests' had been carried out. I only found two of these, one on the toaster and one on the microwave. The kettle, radio and the iron under the sink had no labels. I checked the fire blanket on the wall and the fire extinguisher which was in the cupboard under the sink. The fire extinguisher's 'next inspection' date was over two years ago. Someone had left dishes and cups in the sink so I made a point of washing these, drying them with a towel and putting them away in the cupboard. I then put the drying towel in the laundry basket as it was a bit stained and smelly. On checking the ceiling, I saw that the cover had been

removed from the smoke detector again and the battery removed because it kept going off when people were cooking. I made a note to inform the manager of this.

I opened the fridge and checked the expiry date of all the foodstuffs in there. Everything was fine, although I wasn't sure if it was okay to have uncovered bacon in there next to the cold meat. I checked the cleaning cupboard next to the sink and made sure everything was arranged neatly on the shelves. Someone had put some paint and brush cleaner in here so I left it on the table with a 'post-it' note asking for it to be returned to where it should be stored.

I then checked the small room at the back which is used as an office and sleep over accommodation. As usual it smelled musty and I opened the window wide to let some fresh air in. As I did so I leaned out and checked my car was okay in the car park three floors below. Someone had left their phone charger plugged into the socket and when I touched it, it was warm even though there was no phone attached to it. For safety's sake I switched the wall socket off.

This concluded my safety inspection. I didn't think it was right to go into the residents' rooms as that would be an infringement of their privacy and confidentiality. I then wrote an e-mail to my manager informing her of the results of my inspection.

Complete the following health and safety inspection form using your judgement to identify as many hazards as possible from the account given.

Area	Hazard	Action

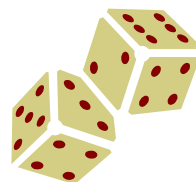
Health and Safety Form – Suggested Responses

Area	Hazard	Action
Entrance Door	No one responded to the doorbell and the door was unlocked, therefore no screening of visitors and inadequate security.	Door should be secure at all times. Staff and residents should have their own key. Door bell should be responded to as soon as possible.
Hall	Flammable material stored in hall is a fire hazard. Bike and boxes in hall could impede escape route in event of fire.	Have flammable material removed immediately, ideally to proper storage or a disposal facility outside of building. Have bike removed immediately.
Hall cupboard	Flammable material in the electrical cupboard is an extreme fire hazard.	Have all flammable material removed immediately and stored somewhere more appropriate.
Hall cupboard	Storing liquids above powders could result in leakage into powders leading to the production of dangerous gases. Totally unsuitable storage space for material of this type.	Remove to another location and store in safe manner. Always store powders above liquids.
Hall cupboard	It might be necessary to keep this cupboard locked to prevent people accessing electrical equipment, in which case, keeping the key on a hook at door is inadequate.	Issue a key to this cupboard to each member of staff. Remember that access to the main electrical board might be required urgently in the event of a serious electrical fault.
Living room	Rug may be trip hazard.	Secure safely to the floor or remove.
Living room	Electrical appliances left on standby or left switched on.	All electrical appliances should be switched off at the wall outlet when not in use.
Kitchen	Kettle, radio and iron have not been tested.	Remove from use until 'PAT' tested.
Kitchen	Fire extinguisher service is overdue.	Arrange service urgently.
Kitchen	Dirty dishes in the sink.	Issue instructions that dishes should be cleaned after use.

Kitchen	Use of dirty dish towel.	Dishes are best left to dry on draining board.
Kitchen	Raw and cooked meat stored together in fridge.	Discard cooked meat immediately. Issue instructions about safe storage of foods in the fridge.
Kitchen	Smoke detector taken out of use.	Replace battery and test immediately. Seek advice from Fire Service about more suitable type of smoke/fire detector for this area. Review placement and policy re smoke detectors. Instruct staff that removal of a smoke detector battery will result in severe penalty.
Kitchen	Potentially hazardous substances (paint and brush cleaner) left out.	Substances should have been stored safely in an appropriate safe location. A 'post-it' note is no protection.
Office	Phone charger plugged into live socket.	Remove from wall socket.
Office	Window opening wide three floors up.	A fully opening window represents a potential fall hazard to all possible occupants of the building. An opening restrictor needs to be fitted as a matter of urgency.
Residents' Rooms	Not inspected	Represents negligence in regard to duty of care. Suggest inspection of rooms in the company of residents as soon as possible – could represent a good learning opportunity.

Outcome 2

Carry out a risk assessment in a health and social care setting.



What is Risk Assessment?

A **risk assessment** is simply a careful examination of a work environment, situation or activity to determine potential hazards and the likelihood of these occurring.

It is best carried out following the five steps outlined by the Health and Safety Executive in their publication *Five Steps to Risk Assessment*. You should look at the full document which is available as a free download from the HSE website using this link: <http://www.hse.gov.uk/pubns/indg163.pdf>

In summary, the five steps identified by the HSE are:

Step 1: Identify the Hazards

- Walk around the work environment and talk to the people involved. They may spot things you don't. Get as much information as you can. This might mean checking data or referring to experts.

Step 2: Decide who might be harmed

- Remember that in a health and care setting some people may be more vulnerable to harm than others, because of disabilities or sensory impairments.
- Also consider members of the public and people whose use of facilities might not be so obvious, such as cleaners.

Step 3: Evaluate the risks and decide on precautions

- The law requires that you do everything 'reasonably practicable' to protect people from harm. This will depend on your assessed level of risk (see the next page for how to do this) but there are some things you should always address. Ask yourself:
 - Can I get rid of the hazard altogether?
 - If not, how can I reduce the risks?

Step 4: Record your findings and implement them

- Write down your findings in the appropriate form. Share your findings and recommendations with all concerned.

Step 5: Review and Update Your Risk Assessment

- Make sure that you keep your assessment up-to-date and in line with changes that occur. Remember in health and care settings that individuals can lose capacity as their condition or disability may change or worsen, or indeed, improve.

Estimating Risk Level

The risk level associated with any activity is obtained by multiplying the possible severity of harm by the likelihood of the hazardous event occurring.

Possible Severity Ratings	
Minor Harm – (resulting in less than 3 days off work)	1
Moderate Harm – (resulting in more than 3 days off work)	2
Serious Harm – (major injury or death)	3

Likelihood Ratings	
Hazardous event is unlikely to occur	1
Hazardous event is reasonably likely to occur	2
Hazardous event is very likely to occur	3

Risk Levels	
6 - 9	High risk – immediate action required
4 - 5	Medium risk – action required
1 - 3	Low risk – continue to monitor

For example:

In a situation where there is the possibility of moderate harm and it is felt that it is very likely to occur, the risk level would be: $2 \times 3 = 6$, making it a 'high risk' situation where immediate action is required.



Activity 11

Risk Assessment



The Risk Assessment form which follows has been designed for health and social care situations to serve as a template for effective Risk Assessment.

Use copies of the form to make separate risk assessments of the two case studies that follow. After completing these and receiving feedback from your tutor, you should complete a third Risk Assessment form to carry out a similar exercise in a real or simulated health or social care setting.

Case Study 1: Mary



Mary is eighty two and has dementia which causes her to be very confused. She lives at home in a second floor tenement flat in a fairly run down part of the city. She has home care workers who visit her twice a day to help with personal care tasks and to supply her with pre-cooked meals. Often they arrive to find her not at home. In the last few months she has been found out wandering the streets at all times of the day and night, often in her night clothes. A couple of weeks ago she was found on the London train with a suitcase full of plant pots.

Her daughter lives nearby and is at her wit's end. She is so concerned for her mother's safety that she now locks the flat door from the outside at night so she can't get out. She also shuts off the gas supply at the mains so that Mary can't cook meals as she has been leaving the gas cooker on and unlit.

Case Study 2: Jack



Jack has moderate learning difficulties and has also been diagnosed with a form of autism. He is twenty three years old and lives in a small group home with two other people where he is supported by staff. He used to attend a day care facility but left because he was bored there.

He attends a local college twice a week and has been accompanied there by one of his support workers. This journey involves a bus and underground rail journey. Jack is fed up being 'escorted' everywhere and has stated that he now wishes to travel on his own or he is going to quit college. Support workers are concerned because last week he punched someone who he said was sitting on his seat on the bus and he also pays little attention when crossing roads, or to pedestrian safety.

Risk Assessment Form

1. Activity or situation to be assessed – give full details of activity, frequency and duration and also benefits of participation.

2. Who will be involved in this activity? (*Identify all possible groups and individuals.*)

3. Identify all possible/potential hazards relating to this activity. For each possible hazard you must make an assessment of the level of risk and give details of the action necessary.

Hazard	Possible Severity Rating (A)	Likelihood Rating (B)	Risk Level AXB	Action

Risk Assessment Form continued:

4. Recommendations:

5. Detail monitoring procedures you consider necessary.

Outcome 3

Explain how to manage incidents involving aggressive behaviour in health and social care settings.

Supporting People

When people need care, difficulties and conflicts can arise that put individuals, their carers and those around them under great stress. If these situations are not supported constructively, aggressive and abusive behaviour can result.



Supporting and contributing to the prevention and management of aggressive or abusive behaviour is part of the role of a care worker.

Behaviour could be identified as '**problematic**' if it meets two of the following three criteria:

- unacceptable by the social standards relevant to the person's age, class and cultural background
- imposing (or threatening to impose) a significant cost on the person him/herself (e.g. physical damage, social rejection, limiting opportunities for living their life)
- imposing (or threatening to impose) a significant and unreasonable cost on the lives of others.

Some psychologists have argued that an excessive focus on the 'problem' behaviour can divert attention away from important issues of how people who use services can be supported to live full and valued lives. There is also the concern that the people who challenge should be seen in terms of their strengths, skills, development and quality of life as well as their 'problem' behaviour.

People who use services do not constitute a homogeneous group. They often experience **disempowerment** and are potentially vulnerable to abuse or neglect in our society. Their lack of power reduces their ability to challenge poor practice and restricts their access to redress.

Health and Social Care practice is guided by:

- the law – legal requirements, duties and restrictions
- National Care Standards and Codes of Practice
- policies and procedures such as: complaints procedures and abuse policies
- personal and professional values.



Supporting Behaviour in a Positive Environment



There are certain core values of Health and Social Care such as:

- respect
- equality and diversity
- reaching potential
- safety
- choices.

In addition to these, the following values, skills and knowledge need to be evident to provide an environment that supports a person to live his/her own life:

- The importance of life history/[identity](#)
- Implementation of a [care plan](#) which takes full account of the person's strengths and abilities and personal choices
- The importance of promoting positive health and well being within a positive environment
- Encourage inclusion in all aspects of the care environment and within the community
- Identify opportunities to enhance well-being by working imaginatively to unravel each individual's potential
- Validation of a person's experience and feelings
- Understand and explore 'challenging behaviour' as an expression of a meaningful message of some kind
- View all actions and expression as potentially meaningful messages of some kind and not just symptoms within a 'label'
- Recognise the contribution of families and significant others, to engage them
- Proactively address staff needs/support issues promptly
- Provide regular supervision
- Establish a learning culture and environment to support and promote best practice and continuous professional development
- Recognise power and equality in relationships in the care environment
- It is important that the person is supported to maintain positive relationships with their network of support including family and friends
- Establish and maintain links within the community

- Work in partnership with the individual, family, community and other support agencies
- Knowledge of National Care Standards and Codes of Practice

Understanding Behaviour

People with perceived challenging behaviour have the same needs as everyone else. Within the Unit: *Care Principles and Practice* you gained an understanding of human needs. To review your learning, click onto the website below:

Maslow's hierarchy of needs:

<http://chiron.valdosta.edu/whuitt/col/regsys/maslow.html>

Some of the person's challenging behaviour may be due to unmet needs and should be viewed within this context.



Activity 12



This activity can be completed in small groups of 4 or 5.

Read the case study below and answer the following questions. Put all your answers on a flip chart to share with your class group

Case Study

Mohammad, aged 36 had lived in a long stay hospital for people with learning difficulties. He moved into his own flat 2 years ago. As part of his care plan, Mohammad receives 24 hour support from a voluntary sector care agency.

Support includes:

- social activities
- food preparation
- shopping
- supervised personal care
- general housework and upkeep of the house and garden
- financial support
- emotional support.

Mohammad's Mum and sister visit him only occasionally. They do not like him visiting them and he does not know where his family live. They specifically requested that the care agency did not give him their telephone number as he would phone them regularly.

After his family visits, Mohammad often becomes emotionally distressed with occasional verbal and physical outbursts aimed exclusively at care staff.

Mohammad's [social network](#) consists of care support staff.

1. Identify Mohammad's Needs using Maslow's Hierarchy:

Physiological needs	Safety needs	Social needs
Esteem needs	Self actualisation	Identify key people in Mohammad's life

2. Identify a range of factors that might contribute to Mohammad's verbal and physical outbursts.

Theories of Aggression

'**Biological**' explanations suggest that aggression is **innate** while '**behaviourist**' explanations suggest that it is **learned**.



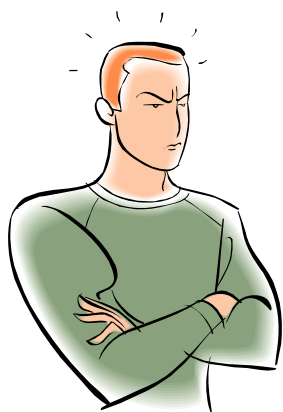
The **biological explanations** include:

- Instinct Theory 'psychodynamic theory' (Freud)
- The Evolutionary theory (Lorenz)
- Frustration Aggression Theory (Dollard 1939)

Behaviourist explanations emphasise learning processes and environmental factors that appear to be linked with aggression.

Behaviourist explanations include:

- Social Learning Theory (Bandura 1973)
- Deindividuation Theory (Hogg and Vaughan 1998)
- Environmental **Stressors**



Biological Explanations

Psychodynamic Approach (Sigmund Freud)

Personality

Freud sees personality as having three aspects, which work together to produce all of our complex behaviours:

- the **Id**
- the **Ego**
- the **Superego**.

All 3 components need to be well-balanced in order to have good amounts of psychological energy available and to have reasonable mental health. However, the Ego has a difficult time dealing with the competing demands of the Superego and the Id. According to the psychoanalytic view, this psychological conflict is an intrinsic and pervasive part of human experience. The conflict between the Id and Superego, negotiated by the Ego, is one of the fundamental psychological battles all people face. The way in which a person characteristically resolves the instant gratification vs. longer-term reward dilemma in many ways comes to reflect on their 'character'.

The **Id** ('It'): functions in the **irrational** and **emotional** part of the mind. The Id is the primitive mind. It contains all the basic needs and feelings. It is the source for [libido](#) (psychic energy). And it has only one rule - the 'pleasure principle':

If the Id is too strong, then we are directed towards self gratification and are uncaring towards others.

The **Ego**: ('I'): functions with the **rational** part of the mind. The Ego develops out of growing awareness that you can't always get what you want. The Ego relates to the real world and operates via the 'reality principle'. The Ego realises the need for compromise and negotiates between the Id and the Superego. The Ego's job is to get the Id's pleasures but to be reasonable and bear the long-term consequences in mind. The Ego denies both instant gratification and pious delaying of gratification.

If the Ego is too strong, then we are extremely rational and efficient, but appear cold and distant.

The **Superego** ('Over-I'): The Superego is the last part of the mind to develop. It might be called the **moral** part of the mind. The Superego becomes an embodiment of parental and societal values. It stores and enforces rules. The Superego has two subsystems: **Ego Ideal** and **Conscience**. The Ego Ideal provides rules for good behaviour, and standards of excellence towards which the Ego must strive.

If the Superego is too strong, then we constantly experience feelings of guilt.

Instinct Theory

Freud considered the **libido** (the life instinct) and the **thanatos** (death instinct) as two conflicting sources of energy. The libido is pleasure seeking while the thanatos drives initially toward self destruction, but is later **displaced** as aggression towards others, or sublimated into physical activities such as releasing aggressive urges in sports.

Freud explains our ability to avoid violence against others as **catharsis**: for example, watching violent events or engaging in mild displays of anger diminishes the aggressive urge and leaves us emotionally calmed. The release can often be achieved by a substitute target. Release produces catharsis or 'letting off steam'.

Aggressive forces build up like water in a dam and these forces have to be released. They can spill over into aggressive behaviour. In order to manage our aggression, we must:

- find a behavioural expression and a target
- find a substitute target (catharsis)
- find **sublimation** in more productive outlets (eg. sports).

Evaluation of Instinct Theory

Berkowitz (1969, 1972) suggested that Instinct Theory made assumptions about behaviour and did not stand up to rigorous scientific scrutiny:

- inadequate controlled systematic research
- use of ambiguous terms
- too simplistic
- certain societies do not display aggressive behaviour or include aggressive games in their culture.



Evolutionary Model of Aggression

According to Lorenz (1950) hostile behaviour towards others is a consequence of innate aggressive energies that build up within the individual and spill over if the level becomes too high.

Lorenz defines aggression as ‘the fighting instinct in beast and man which is directed against members of the same species.’ Aggressive behaviour has evolved because it promotes the survival of the genes onto the next generation.

Evolutionary psychologists argue that women prefer dominant males: hence, males compete for females by being aggressive. Aggression or dominance, will allow males to achieve more, which is attractive to females. The additional assets that the aggressive male has will enable them to successfully raise their children.

According to Campbell (1999), females make a higher parental investment in childrearing than do males, therefore lower rates of aggression in women reflect the importance of her survival for her own reproductive success.

Evaluation of evolutionary model

Green (1998) argues that the contribution of evolutionary [psychology](#) to understanding aggression is limited and that it has little use in the prevention or control of aggression. It is difficult to apply this theory to explain male/female aggression or parent/child aggression and it fails to explain the cultural differences in aggression.



Frustration-Aggression Theory

Dollard et al (1939) state that aggression is always because of frustration and frustration always leads to some form of aggression. (*Psychology*: Cardwell, Clark and Meldrum)

What is frustration?

- the feeling that accompanies an experience of being thwarted in attaining your goals
- an act of hindering someone's plans or efforts
- a feeling of annoyance at being hindered or criticised

The frustration-aggression theory, suggests that **aggression**, rather than occurring **spontaneously**, is a response to the **frustration** of some goal-directed behaviour by an outside source. This **stimulus** must produce not just frustration but **anger** as well in order for aggression to follow, and that anger can be the result of stimuli other than frustrating situations e.g. a car driver reacting very aggressively to another driver who overtakes him may be angry not just at being overtaken but because he thought the other driver was being very disrespectful to him.

The theory suggests that as the amount of frustration increases, so should the amount of aggression. In order to reduce aggression the source of the frustration must be reduced or managed. It can prove difficult to identify a specific source if it derives from social inequalities such as; poverty, unemployment or poor housing.

Evaluation of Frustration-Aggression Theory

The frustration-aggression hypothesis does not specify what kinds of frustration can lead to aggression. Frustration does not always lead to aggression but could lead to **depression** or '**learned helplessness**'.

In this respect, the frustration-aggression theory is too simplistic and doesn't recognise that frustration can lead to apathy or helplessness or alternatively, to the pursuit of positive problem-solving strategies.



Cue-arousal Theory

Berkowitz (1964, 1974) (**Psychology**: Cardwell, Clark and Meldrum) builds on the frustration-aggression theory and proposes that frustration may produce anger if there is a **stimulus** present that acts as a **cue** to aggression.

In this respect, external stimuli can play a role in increasing the chances of an aggressive act occurring. An external stimulus will only act as a cue if the angry person **associates** it with aggression e.g. someone becoming aggressive when their neighbour starts to play very loud music. The loud music is the **stimulus** acting as a **cue** to aggression.

Donnerstein and Wilson (1979) in their research found that people were less likely to become aggressive in quiet situations than in noisy situations. They also found that participants were less aggressive when they thought they had control over noise levels.



The Threatened-egotism Theory

Bentley (2002) (*Psychology*: Cardwell, Clark and Meldrum) suggests that aggression can act as compensation for low self-esteem. In this respect, it is seen as a cry for help. In order to **displace** feelings of **inadequacy** or to feel more **empowered**, the person's behaviour **manifests** in aggression towards others e.g. someone who is bullied by others becomes a bully.

The threatened-**egotism** theory does not suggest that attempting to boost **self esteem** is an effective way to reduce aggression, as there is no research supporting a direct link between low self-esteem and aggression.

Evaluation of the threatened-egotism theory

Bentley (2002) suggests that psychopaths who have inflated self regard, show more violence and that people with depression and low self-esteem are less violent than the **norm**.

Baumeister (2001) found that bullies display higher levels of self-esteem than their victims. He declared that 'conceited, self-important individuals turn nasty towards those who puncture their bubbles of self-love'.

According to Kernis et al (1989), not all people with high self esteem should be grouped together. Some people are arrogant, conceited and overly assertive while others are quietly self-confident and non aggressive.

Rhodewalt et al (1998) suggests the former type feels superior to others and can be described as **narcissistic** in their self esteem.

Social Learning Theory

The social learning theory denies that humans are innately aggressive and that frustration automatically leads to aggression.

Instead **Bandura** 1973 (*Psychology*: Cardwell, Clark and Meldrum) argues that 'social learning theory' is derived from 'behaviourism' which argues that all behaviour is learned through direct experience.

Bandura proposes that aggressive acts can also be learned by vicarious experience via the process of observation and imitation.

He divided 66 nursery school children into 3 groups. All three groups watched a film where an adult kicked and punched a 'Bobo' doll.

Situation 1 – the children saw the adult model being rewarded by a second adult

Situation 2 – the children saw a second adult telling off the adult model for the aggressive behaviour

Situation 3 – the adult model was neither rewarded nor punished.

The children were then allowed to play in the room with the 'Bobo' doll whilst experimenters watched through a one-way mirror.

Results showed that children in Situation 1 behaved more aggressively towards the 'Bobo' doll. Those in Situation 2 behaved least aggressively. Significant in this research is that all the children learnt how to behave aggressively, but those in Situation 2 did not perform as many aggressive acts until later, when they were offered rewards to do so.

Reference: Bandura, et al (1963) experimental research '*Transmission of aggression through imitation of aggressive models*'



Bandura's findings on observational learning provided fuel for critics who argued that graphic representations of violence in films and TV could have consequences for children's future behaviour.

Non-aggressive modelling in the media and the home can contribute to the control of aggression in young people.

We all frequently face an environment that presents frustrating, unpleasant experiences as well as cues that suggest there would be certain payoffs for different courses of action. Inside us are various emotional responses, such as anger, various motivations and urges to seek certain payoffs, and complex [cognitive processes](#) for weighing the pros and cons for different alternative responses, including:

- aggression or violence
- passive withdrawal
- depression
- increased striving to succeed
- reasonable 'assertive' handling of the situation

and other possible responses.

Eventually, the person chooses a response and acts, and then the result of that response is observed and evaluated in terms of its effectiveness. If the response is reinforced, it is likely to be used again.

Aggression is learned in two basic ways:

- from observing aggressive models (**observation**)
- from receiving and/or expecting payoffs following aggression ([reinforcement](#)).

Reinforcement may be in the form of:

- stopping aggression by others,
- getting praise or status or some other goal by being aggressive,
- getting self-reinforcement and self praise
- reducing tension.

Social Learning theorists recognise the importance of [positive role models](#) in the reduction and control of aggression.

Evaluation of Social Learning Theory

Social Learning Theory can account for the lack of consistency in people's aggressive behaviour e.g. someone who is assertive and domineering at home but submissive at work means they are reinforced differently in the two situations. Assertiveness brings rewards in one context but not in the other.

Biological explanations of aggression, such as the presence of higher levels of [testosterone](#) as a primary cause of aggressive behaviour, cast doubt on aggression as being just a **learned** behaviour. Social Learning theorists refer to societies such as the [Amish](#) in the USA as evidence of the prevalent role played by learning and aggression.

Deindividuation Theory

Hogg and Vaughan 1998 (*Psychology*: Cardwell, Clark and Meldrum) describe this as 'a process whereby people lose their sense of socialised individual identity and engage in [anti-social](#) behaviours'.

Zimbardo (1969) distinguished between **individual** behaviour, which is rational and [conforms](#) to acceptable social standards, and **deindividuated** behaviour which is based on primitive urges and does not conform to society's norms.

Being part of a crowd according to Zimbardo, can diminish awareness of individuality.

The **Stanford Prison experiment** (Zimbardo et al 1973) wanted to find out if brutality in American prisons was as a result of the sadistic personalities of the prison guards or more to do with the prison environment. He aimed to investigate how readily people would conform to new roles by observing how quickly they adopt the roles of guards or prisoners in a role playing exercise that simulated prison life.



In the experiment, he took well-adjusted, healthy, male volunteers and paid them to take part in a two week simulation study. They were randomly allocated to the role of prisoner or guard. Local police helped by 'arresting' the 9 prisoners and taking them blindfolded to prison. They were stripped, sprayed with disinfectant, given smocks to wear and given a prison number to memorise. From then on they were referred to by their number only.

There were 3 guards who wore khaki uniforms, dark glasses and carried wooden batons. No physical aggression was permitted.

Findings:

- The guards could devise all the rules, harassed the prisoners and conformed to their perceived roles with such vigour that the experiment had to be discontinued after 6 days.
- Some prisoners became anxious and depressed. One prisoner had to be released after 1 day and two after 4 days.
- Prisoners rebelled against the guards after 2 days. The rebellion was quelled by the guards using fire extinguishers.

Conclusions:

- The prison environment was an important factor in creating the guards 'brutal' behaviour.
- Roles that people play shape their attitudes and behaviour. It took only 6 days to change the behaviour of the participants in the study.
- People will readily conform to [social roles](#), especially if they are [stereotyped](#).

Evaluation of Deindividuation

There were many ethical concerns about the Zimbardo study. The prisoners were not fully informed of the procedure, e.g. they did not know they would be arrested at home and therefore did not know fully what they were consenting to.

Both prisoners and guards experienced psychological distress as a result of the experiment. The guards had to live with the fact that they had humiliated and mistreated others. This was not normal behaviour for them.

This experiment told us how people conform to their perceived understanding of the social role but it did not tell us much about how real guards behave. Instead it told us how people behave when they are asked to act like guards.

There is some evidence that deindividuation may produce pro-social behaviour e.g. at religious rallies - Deiner (1980).

The Effects of Environmental Stressors on Aggressive Behaviour



Activity 14

Complete this activity in pairs.



1. Think back to a recent spell of very hot weather when you were stuck in either school or work. Allow 5 minutes to think about the situation and discuss these questions with your partner.

a) Where were you?

b) What were you wearing at the time? Was it suitable for the weather?

c) Who else was there?

d) How did you feel?

e) Did you experience more irritability and bad temper than normal?

2. What effect does loud noise have on you?

a) Does it depend on what the loud noise is?

b) Does it depend on whether you can escape the noise or not?

c) Does it depend on whether you can control the noise?

3. What conditions make you feel exhilarated or aggressive, e.g. waiting in a queue, in a crowded nightclub, and why?

Environmental Stressors

Environmental stressors may cause an increase in **arousal** (a state of **physiological** and psychological **excitation**). This may bring about negative feelings and consequently hostile thoughts and possibly aggressive behaviour.

Environmental stressors could include:

- increase in temperature (too hot)
- crowds

These stressors may cause stimulus overload, which can interfere with the task the person is trying to complete and therefore lead to frustration, e.g. waiting in a queue for over an hour in very hot weather, only to be told that all the tickets to see your favourite band are sold out.

Crowding

Crowding means a psychological state of discomfort that is brought about when our perceptions of the use of space are violated by the presence of other people, e.g. being stuck in a crowded lift that has broken down.



Crowding

Horn (1994) (*Psychology*: Cardwell, Clark and Meldrum) found that people in crowded situations tend to react more aggressively and less co-operatively with others. Sometimes they withdraw from social contact and avoid social interaction e.g. in a crowded subway.

Stokols (1976) identified ways of explaining why crowding can lead to increased levels of aggression:

- **Stimulus overload** – where we are unable to deal with the amount of stimulation produced by high density.
- **Behavioural constraint** – reduced behavioural freedom e.g. waiting in a queue for the ladies toilet at a concert.
- **Ecological model** – insufficient resources e.g. fighting for food in times of famine.

Some studies have shown that cities contain more stressful environmental features such as; noise, crowding and increased temperatures. City dwellers report being more adversely affected by crowding and increased temperatures than rural dwellers.



Activity 16



This activity can be completed in small groups of 4 or 5.

Each group should examine **two** explanations of aggression and answer the following questions.

Use the chart on the following page to complete your answers. Briefly present your findings to the larger class group.

- 1) Identify the main concepts in each of the theories.
- 2) Identify their strengths and weaknesses.

1st explanation	Strengths
Main concepts	
	Weaknesses
2nd explanation	Strengths
Main concepts	
	Weaknesses



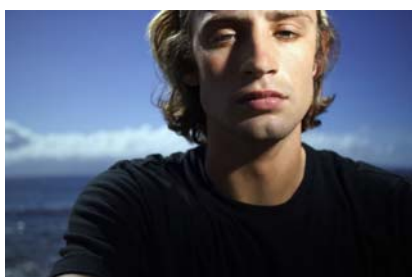
Activity 17



Group Presentation – 5 minutes per group. All group members should contribute to the research, discussion and presentation of your findings.

This activity should be completed in small groups of 4 or 5. Read the Case Study below and answer all of the questions.

Case Study



Jake, aged 22, was in a road accident three years ago. At the time of the accident, he had just passed his driving test and had been given a car as a birthday present. Jake passed his Higher exams and planned to go to university to study engineering. He was considered to be lively, intelligent and very sociable. He spent 9 months recovering from the accident. Although he attends physiotherapy once per week, it is anticipated that Jake will always need the support of a wheelchair.

In addition to physical mobility problems, Jake sustained a head injury that has resulted in some speech and cognitive processing difficulties. He attends a brain injury day centre on a daily basis.

Prior to the accident, Jake and his girlfriend had been together since they were 16. They have since separated. Claire felt unable to cope with his injuries. He still remains in contact with some of his childhood friends but this is decreasing in frequency. Jake feels they have all 'moved on' and he now has little in common with them.

As part of his care plan, Jake moved into supported accommodation for adults with physical disabilities. The flat has been adapted to suit his needs and has the use of assistive technology to help him live as independently as possible. The housing and care agency employ a warden to provide additional assistance if required.

In his *Assessment of Needs*, it was agreed that Jake should receive the support of a care worker for 15 hours a week to assist with some personal care requirements, household tasks, leisure, recreation and educational activities. Jake is supported by his carer to attend a local college 1 day per week and to go to a nightclub every Friday evening. He has made some friends within the local community but still feels a bit isolated. Jake says the only thing he has in common with the people who live beside him is that they all have disabilities.

Pete has been his carer since he moved into the supported accommodation a year ago. He has a very good relationship with Pete. They share some of the same interests.

At a recent Review of his *Care Plan*, Jake seemed to have settled into the supported flat, enjoyed college and stated that he would like to get a girlfriend and perhaps a part time job.

Pete recently advised Jake that he is leaving his job. He has decided to go to university to study social work and will be moving to another city to take up his studies.

Since being informed that Pete is leaving, Jake's general mood has changed. He has become withdrawn, and prone to verbal attacks on Pete. The warden has also noticed a change.

Case Study Questions

1) Why do you think his mood has changed?

2) Identify Jake's needs using Maslow's Hierarchy.

Physiological needs	Safety needs	Social needs
Esteem needs	Self actualisation	Identify key people in Jakes' life

3) Do any of the theories of aggression help explain Jake's behaviour?

Skills Required of Care Workers to Support Behaviour

It is important to recognise that there are many situations in care practice that do not escalate into violent or aggressive outbursts. Often the skills, knowledge and values the carer uses to underpin practice will **defuse** situations before they become problematic. It is important that you contribute to the management and prevention of aggressive or abusive behaviour.

Often behaviour that is perceived or 'labelled' as challenging is not as a result of the person who is challenging, but instead is due to the service challenging the individual.





Activity 18

In small groups of 4 or 5 read the case study and discuss the following questions. You could put your answers on a flip chart to compare your thoughts with other groups in the class.



Case Study

Betty aged 65 has lived most of her life in institutions for people with learning difficulties. She was transferred to hospital at the age of 15 when she became pregnant. It was recognised that she had a mild learning difficulty.

The baby was removed from her care, placed for adoption and Betty was transferred to hospital. It was agreed that this was in her best interests. She was considered vulnerable within the community and living in a hospital would be a 'safer' place for her.

3 years ago Betty moved from the hospital to supported accommodation. She shares a flat with 3 other adults. They each have a bedroom and share the lounge, kitchen and bathroom. As part of Betty's care plan, she is learning a range of skills including shopping, budgeting, cooking and cleaning to enable her to move to a flat of her own. That is her dream.

Betty and the other tenants are supported by a team of 6 staff members from a care agency. Betty likes all of them except Debbie whom she considers to be a bit short tempered with her. Betty thinks that she is a bit clumsy sometimes, but particularly around Debbie.

One evening while Betty was cooking dinner, she smashed a plate. The care worker said it was OK and that they would clean it up. However, Betty became very agitated, started shouting and screaming that it was not her fault and tried to push the care worker.

Feedback:

Were there any common themes in your feedback?

You may have identified a range of feelings including anger, frustration, fear, anxiety and confusion.

You may have wanted to respond:

- defensively by shouting back defensively
- by taking a minute to think about it
- by wanting to leave
- by speaking quietly and asking Betty what was wrong and could you help (calming the situation).

Now here's a bit more background to the situation

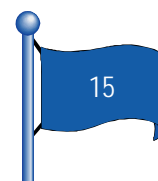
On the previous day, Betty had been cooking a meal while Debbie supported her. Debbie had warned her on several occasions not to drop anything. She told her that she was very clumsy and that she needed to learn to be more careful with her dishes otherwise she would not be able to live by herself in her own flat. Betty felt as if Debbie was looking over her shoulder constantly and felt very nervous. She didn't drop any dishes but dropped some of her dinner.

Debbie immediately reacted by telling her how stupid she was and that she'd never be able to manage on her own. She shouted at Betty and told her to 'clean it up immediately'. Betty was very upset and started to cry and ran to her room. Debbie said she would stay in her room until she had agreed to tidy up her mess. Betty was scared to come out and instead stayed in her room all night. She had nothing to eat until breakfast the following morning.



Activity 19

Re-examine the situation and answer the questions again.



1) Why do you think Betty reacted like this?

2) In what way(s) does this change your perception of the situation?

Labelling

Labelling theory (or **social reaction** theory) is concerned with how the self-identity and behaviour of an individual is influenced (or created) by how that individual is categorised and described by others in their society.

Originating in sociology and criminology, the theory focuses on the tendency of majorities to negatively label minorities or those seen as **deviant** from norms, and is associated with the concept of a self-fulfilling prophecy and stereotyping.



Prejudice

Prejudice may be felt or expressed. It may be directed towards a group as a whole or towards an individual, because he or she is a member of a certain group. It involves attitudes, thoughts, and beliefs that lead to categorical rejections. Therefore, prejudice is not about disliking a person because you find his or her behaviour objectionable.

Three processes of prejudice:

- **Cognitive** - thinking process

This is simply what you think and what you believe. Attitudes of superiority and stereotypes are formed here by a person thinking they are better than e.g. other racial, or ethnic groups or people with disabilities. It is how you **perceive** members of another group or beliefs about the group or characteristics attributed to its members.

- **Emotional** – feeling process

This is how an individual feels about a group (e.g. racial or ethnic), and its members. It can be fear or hatred of other groups, or anxiety caused by being around other groups, and a liking only for your own racial or ethnic group.

- **Action** – acting out process

The acting out process is the tendency to act in certain ways towards a group or its members. The more intensely someone holds a prejudice, the more likely it is that he or she will act on it.

It is important when supporting people who present as challenging to look beyond any labels and prejudices such as:

'Andy is very attention seeking'; 'Isa is very demanding'; 'Ronnie is very aggressive'; 'Imran is very sneaky'; 'older people are like children'; 'people with dementia become aggressive'; 'people with mental health problems are violent' and so on.

If we do this we are looking at the label and not the person and treating people as a homogenous group and not as individuals with dreams, needs and skills the same as you and me.

Communication Skills

Attending and Listening

Attending skills: or being with the person you are supporting.

The following are some useful questions you might use to help you examine how much you are really '*with*' the person.

1. What are my attitudes, perceptions and feelings towards this person?
2. To what extent does my non-verbal behaviour suggest a willingness to be listened to and support the person?
3. What attitudes am I expressing in my verbal and non-verbal behaviour?
4. In what ways am I distracted when listening to the person?
5. What am I doing to handle these distractions?

Active Listening:

According to Mehrabian (1971) non-verbal communication cues are very important. Sometimes bodily behaviour such as, body movements, gestures and posture; facial expressions such as; smiles, raised eyebrows, twisted lips and frowns and voice quality such as; tone of voice, pitch, intensity, emphases, pauses, silences and fluency convey more than their words.

Paraphrasing

What is it?

Restating a message, - but usually with fewer words. Where possible try and get more to the point.

Purpose:

- To test your understanding of what you heard.
- To communicate that you are trying to understand what is being said. If you're successful, paraphrasing shows that you are following the speaker's verbal explorations and that you're beginning to understand the basic message.

When listening, consider asking yourself:

- What is the speaker's basic **thinking** message?
- What is the person's basic **feeling** message?

Clarifying

What is it?

Explaining vague material in a clearer way.

Purpose:

- to get more information
- to identify what is being said
- to check your interpretation.

Perception Checking

What is it?

Request for verification of your perceptions.

Purpose:

- to give and receive feedback
- to check out your assumptions.

Summarising

What is it?

Pulling together all the major aspects of your conversation.

Pay attention to various themes and emotional overtones.

Put key ideas and feelings into broad statements.

Purpose:

- to give a sense of movement and accomplishment in the exchange
- to establish a basis for further discussion
- to pull together major ideas, facts, and feelings.

Reflecting

What is it?

Reflection of content and feelings

Purpose:

- to show that you're understanding the speaker's experience
- to allow the speaker to evaluate his/her feelings after hearing them expressed by someone else.

Benefits of Active Listening

If a person uses **active listening** as part of his or her communication style while supporting people, how would that be good for supporting behaviour, i.e., what are the benefits?

- It feels good when another person makes an effort to understand what you are thinking and feeling. It creates good feelings about the other person and makes you feel better about yourself.
- Restating what you've heard, and checking for understanding, promotes better communication and produces fewer misunderstandings.
- Responding with active listening has a calming effect in an emotional situation.





Activity 20



Take 5 minutes to think about a situation that really bothered you. Think about where it happened, who else was involved and what happened. Try to remember how you felt at the time and how you feel just now thinking about it.

Take it in turns to discuss all of this with a partner. Allow your partner about 5 minutes to talk about it. Your task is to help them open up and talk about it.

When you've finished, reflect on the exchange using the table overleaf and give your partner some feedback on how you felt.

Listening Skills	Demonstrated	Comments
Eye contact		
Body language		
Open questions		
Restating		
Responding		
<p>Did you feel they listened to you?</p> <p>What did they do to make you feel as if you were listened to?</p> <p>How did it make you feel?</p>		

Conflict De-escalation

Everyone has been in an argument that has escalated. Before you know it, it's blown out of proportion. Let's think for a moment about some actions that will help you de-escalate a conflict.



- Stick with 'I' statements; avoid 'you' statements.
- Avoid name-calling and put-downs ('A reasonable person could see that...').
- Soften your tone.
- Take a time-out ('Let's take a break and cool down').
- Acknowledge the other person's point of view (agreement is not necessary).
- Avoid defensive or hostile body language (rolling eyes, crossing arms in front of body, tapping foot).
- Be specific and factual; avoid generalities.

Conflict Prevention Skills

Now that we've talked about how to resolve a conflict, let's look at how to prevent conflicts from happening. Here are a few ideas:

- Bring issues out in the open before they become problems.
- Be aware of triggers and respond to them when you notice them.
- Have a process for resolving conflicts.
- Bring it up at a meeting and get agreement on what people should do in cases of differing viewpoints.

Skills of de-escalation

Staff in health and social care should be aware of non-verbal messages that show how a person is feeling or may respond and should apply the techniques of non verbal communication they are taught in training to help defuse situations.

De-fusion Strategies

- appear confident
- display calmness
- create some space
- speak slowly, gently and clearly
- lower your voice
- avoid staring
- avoid arguing and confrontation
- show that you are listening
- calm the person before trying to solve the problem.

Adopt a non-threatening body posture:

- use a calm, open posture (sitting or standing)
- reduce direct eye contact (as it may be taken as a confrontation)
- allow the person adequate personal space
- keep both hands visible
- avoid sudden movements that may startle or be perceived as an attack
- avoid audiences – as an audience may escalate the situation.

Case Study



Emma is aged 14. Following the death of her mother from a drug overdose 6 months ago, she has been 'looked after' and accommodated within a children's residential unit. There are no other family members able to accommodate Emma.

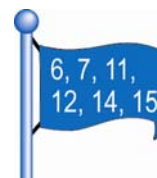
While living at home, Emma had become very independent. She was the main carer for her mother and knew how to cook and clean for herself. Emma was very close to her and devastated by her death.

Staff have recently noticed a change in her behaviour. She has become more withdrawn from them; is staying out late at night and has been brought home by the police under the influence of alcohol and other substances.

When confronted about drinking alcohol and staying out late, Emma has responded by shouting abuse and storming out of the house.



Activity 21



In groups of 4, discuss the case study and then tackle the following:

- 1) **Identify Emma's needs.** You might want to use Maslow's Hierarchy of Needs.

- 2) **Role play activity.**

Imagine you are in the situation where you are confronting Emma in relation to drinking alcohol.

Try to use the skills previously identified to de-escalate the situation.

Allocate the following **roles** to group members:

- 1 person can play Emma
- 1 person can play the care worker confronting Emma about drinking alcohol
- 1 person can play another care worker
- 1 person can observe and feedback to the larger group.

Role of Observer:

Observe the process of the role play.

Identify the emotions expressed by Emma and the care worker

Identify skills used to de-escalate the situation.

Debriefing after the role play:

- a) How did it feel to play the character of Emma or the care worker?
- b) What were your reactions to the situations?
- c) Identify what was happening and why from Emma's perspective.
- d) Identify what was happening and why from the care worker's perspective.
- e) Identify the skills you used to de-escalate the situation.
- f) Does the observer's view of events match that of the participants?

Models of Supporting Behaviour

ABC model or cognitive behavioural approach

A – antecedent

B – behaviour

C – consequences

This approach is based on the premise that by focusing purely on the behaviour, you are unlikely to alter or reduce its frequency. Negative attention tends to reinforce difficult, challenging or unacceptable behaviour.

Identify the **behaviour** considered to be challenging:

This may include specific examples, duration and frequency. Are there any 'early warning signs' or behaviour that occurs prior to the event?

Assess the **antecedents** (i.e. what happens before).

There may be certain things that appear to 'trigger' challenging behaviour. This might include activities, settings, individuals, thoughts, feelings or objects. What antecedent events are most likely to predict the non-occurrence of the behaviour?

Assess the **consequences** (i.e. what happens after).

What is the person getting from the behaviour that motivates them to do it again, and again? Many consequent events are externally motivated e.g. the consequences of shouting may be to get more or less attention from other people. They may also be internally motivated.

A Record Chart is shown on the next page, outlining how to go about applying the ABC approach.



ABC Record Chart

<p>Name: Day, Date and Time of Incident Definition of Behaviour:</p>
<p>Antecedent Events</p> <p>In this row, with the following questions in mind, provide a step by step description of exactly what you observed prior to the behaviour, or at the same time as the behaviour occurred.</p> <ol style="list-style-type: none">1. Where was the person, and exactly what was he/she doing?2. Was anyone else around, or had anyone just left?3. Had a request been made of the person?4. Had the person asked for, or did he/she want something to eat or drink?5. Had the person asked for, or did he/she want a specific object or activity?6. Had an activity just ended, or been cancelled?7. Where were you and what were you doing?8. How did the person's mood appear, e.g. happy, sad, angry, withdrawn or distressed?9. Did the person seem to be communicating anything through his/her behaviour?
<p>Behaviour</p> <p>In this row, provide a step by step description of exactly what the person did, e.g. he ran out of the living room, stood in the kitchen doorway and punched his head with his right hand for approximately 1 minute.</p>
<p>Consequent Events</p> <p>In this row, with the following questions in mind, provide a step by step description of the exact events that occurred immediately after the behaviour.</p> <ol style="list-style-type: none">1. Exactly how did you respond to the behaviour? Give a step-by-step description.2. How did the person respond to your reaction to the behaviour?3. Was there anyone else around who responded to, or showed a reaction to the behaviour?4. Did the person's behaviour result in he/she gaining anything they did not have before the behaviour was exhibited, e.g. attention from somebody (positive or negative); an object, food or drink; or escape from an activity or situation?
<p>Signature:</p>

TCI Model or Therapeutic Crisis Intervention



Therapeutic Crisis Intervention (TCI) is a crisis prevention and intervention system for residential child care facilities. The TCI system assists organisations in preventing crises, de-escalating potential crises, managing acute physical behaviour, reducing potential and actual injury to young people and staff, teaching young people adaptive coping skills, and developing a learning circle within the organisation..

TCI principles are based on the *United Nations (UN) Convention on the Rights of the Child*. This includes:

1. put children first
2. respect children's dignity
3. protect children's personal integrity
4. protect families
5. respect children's rights to a family environment
6. protect and assist children in state care
7. provide abused and neglected children with the opportunity for healing
8. protect children from exploitation
9. focus on prevention
10. listen to children
11. respect 'alien' children's rights
12. promote the principles of the UN Convention.

TCI gives organisations a framework for implementing a crisis prevention and management system that reduces the need to rely on high-risk interventions and should be delivered within the following practice principles.

1. Provide caring and soothing environments in which staff and young people can feel safe and supported.
2. Avoid power assertion and maintain a non-aggressive position to reduce the experience of threat and keep the young people in a non-dissociative and non-aggressive state.
3. Systematically deal with child maltreatment issues as part of the treatment programme. Child maltreatment has led young people to survival strategies that are often antisocial and/or self-destructive.
4. Emphasise communication of feelings between staff and young people. Promote empathy as a principle for day-to-day interaction among staff and young people, as empathy is the enemy of aggression.
5. Acknowledge children and young people's perceptions of justice. Then engage the young people in dialogue to reinterpret any 'violent acts' as justice and model higher stages of moral reasoning.
6. Develop a facility culture based on respect. Young people often feel shame because of their personal and collective experiences.
7. Develop new life narratives and meaning, even in the face of adversity. Traumatized young people who have experienced abandonment are likely to feel life is meaningless.
8. Promote trust in adult authority; adults are in charge and ensure safety. Young people exposed to violence in the home and community do not trust adults' capacity and motivation to keep them safe, so often they take things into their own hands.
9. Demonstrate and promote a new value base, not materialism. Young people involved in the drug culture are likely to have distorted materialistic values.
10. Promote a vision of the future as something worth investing in, a future perspective based on the value of life. Traumatized young people are likely to evidence terminal thinking.

Source: Therapeutic Crisis Intervention System, Residential Child Care Project, Cornell University 2003

C.A.L.M Model (Crisis and Aggression Limitation and Management)

Physical intervention training is a controversial issue. Much has been written and reported about how badly things can go wrong if **restraint** is used without appropriate training, guidance, and monitoring. People who restrain others without an understanding of key safety principles are at risk of hurting both themselves and the person being restrained.

If restraint is going to be used it should be used by people who understand the dangers and appreciate the difference between relatively unsafe and relatively safe techniques.

The CALM system offers crisis and aggression limitation and management:

- No deliberate use of pain
- No pressure on or across joints
- Minimises risk to staff
- Minimises square on contact
- Offers a hierarchy of techniques
- Minimal hand movement between levels
- Ergonomic principles and bio-mechanical evaluation of techniques
- Restraint in a seated position
- External verification of training
- Annual re-accreditation requirement

The CALM system has five levels of intervention and is based upon principles of **de-escalation** – incrementally increasing control over the individual being restrained as necessary, and incrementally returning control to the individual as soon as possible.

This staged approach can help to avoid injuries associated with an 'all or nothing' approach to physical restraint.

Legislation

There are a number of pieces of legislation that support the protection and well-being of people who use services.

Relevant legislation includes:

- Children (Scotland) Act 1995
- Protection of Children (Scotland) Act 2003
- Regulation of Care (Scotland) Act 2001
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Adults with Incapacity (Scotland) Act 2000

Policies, Procedures and Charters

- National Occupational Standards
- Scottish Social Services Council Codes of Practice
- Local Child Protection Procedures
- Protecting Vulnerable Adults: ensuring rights and preventing abuse. Multi agency guidelines on the protection of vulnerable adults.
- *No Secrets*: Department of Health 2000

Agency Policies

Health and social care agencies must have policies and procedures in place to promote the well-being of the people they support. These policies will cover topics including:

- health and safety
- risk assessment
- accident and incident reporting
- complaints and grievances
- abuse.

Visiting Speaker

Invite a representative from a Health and Social Care Agency specifically to discuss policies and procedures as identified.



Activity 22



Class group

Devise a set of questions that you would like the visiting speaker to answer in relation to promoting the health and well-being of the people they support. Pay particular attention to the agency policies and procedures in relation to incidences of abuse and challenging behaviour.

Outcome 4

Explain how health and social care workers can help protect service users who have been abused.

Types of Abuse

Abuse is the improper use of **power** by one person to the detriment of another.

There are 5 types of abuse:

- physical
- emotional
- sexual
- financial
- neglect.

It can occur in:

- households – as child abuse or domestic violence,
- care services
- workplaces – as sexual or racial harassment,
- church organisations – as manipulative power plays
- governments – as arrogant disregard for the needs of disadvantaged persons in the community.



Physical Abuse

Physical abuse is physical force or violence that results in bodily injury, pain, or impairment. It includes assault, battery, and inappropriate restraint.

Physical abuse could include:

- pushing, pulling
- striking with an object
- slapping
- punching
- kicking
- make someone fall, e.g. push downstairs
- strangling
- drowning
- sleep deprivation
- exposure to cold
- exposure to heat, burning or electric shock
- cutting with a sharp object
- withholding food or medication.

Signs to look out for include:

- sprains, dislocations, fractures, or broken bones
- burns from cigarettes, appliances, or hot water
- abrasions on arms, legs, or torso that resemble rope or strap marks
- internal injuries evidenced by pain, difficulty with normal functioning of organs, and bleeding from body orifices
- bruises, such as bruising to the arms, inner thighs or torso, multicoloured bruises (indicating that they were sustained over time),
- previous injuries that did not receive proper care and attention.
- signs of traumatic hair or tooth loss.

Sometimes people who are being physically abused may show some changes in behaviour such as:

- becoming depressed, sad or withdrawn
- having trouble sleeping
- demonstrating a lack of confidence and low self esteem
- using drugs or alcohol
- showing fear of certain people
- behaving aggressively.

Emotional Abuse

Abuse is any behaviour that is designed to control and subjugate another human being through the use of fear, humiliation, intimidation, guilt, coercion, or manipulation. Emotional abuse is any kind of abuse that is emotional rather than physical in nature. It can include anything from verbal abuse and constant criticism to more subtle tactics, such as repeated disapproval or even the refusal to ever be pleased.

Emotional abuse is like brain washing in that it systematically wears away at the victim's self-confidence, sense of self-worth, trust in their own perceptions, and self-concept. Whether it is done by constant berating and belittling, by intimidation, or under the guise of 'guidance', 'teaching', or 'advice', the results are similar. Eventually, the recipient of the abuse loses all sense of self and remnants of personal value.

Emotional abuse cuts to the very core of a person, creating scars that may be far deeper and more lasting than physical ones. With emotional abuse, the insults, insinuations, criticism and accusations slowly eat away at the victim's self-esteem until s/he is incapable of judging the situation realistically. People become so beaten down emotionally that they blame themselves for the abuse. Their self-esteem is so low that they cling to the abuser.

Emotional abuse could include:

- false accusations
- name calling and finding fault
- verbal threats
- playing '[mind games](#)'
- making the person think/feel stupid
- humiliation
- bringing up past issues
- inappropriate expression of jealousy
- blaming the victim for everything
- turning the situation against the victim
- laughing in the victim's face
- silence, ignoring
- neglecting and pressuring the victim
- making the victim feel guilty
- starting arguments
- holding grudges
- lying
- withholding affection
- manipulation

- minimising or disregarding the victim's achievements
- rejecting
- terrorising
- corrupting.

Sometimes a child who is emotionally abused shows signs such as:

- appears overly compliant, passive, undemanding
- appears very anxious or depressed
- attempts suicide
- avoids doing things with other children
- behaves younger than his or her age
- finds it difficult to make friends
- is extremely aggressive, demanding or enraged
- lags in physical, emotional, and intellectual development
- is very demanding or very obedient
- behaves very adult-like
- wets or soils the bed.

Sexual Abuse

Sexual abuse is any misuse of a child or adult for sexual pleasure or gratification.

Sexual abuse of a vulnerable adult

A vulnerable adult is defined by law as:

- a person over the age of 60 who lacks the functional, physical, or mental ability to care for him or herself
- an adult with a developmental disability
- an adult with a legal guardian
- an adult living in a long-term care facility (an adult family home, boarding home or nursing home)
- an adult living in their own or family's home receiving services from an agency or contracted individual provider.

What is sexual abuse?

Sexual abuse of a vulnerable adult is the infliction of non-consensual sexual contact of any kind on that person.

A vulnerable adult is someone who:

- has a physical or sensory disability or illness
- is elderly and frail
- has a learning disability
- has a mental health problem.

Abuse of adults is often a hidden, secretive matter. There are many barriers that make it difficult for vulnerable adults to report sexual assault. These can include:

- cognitive impairment
- shame and embarrassment
- dependency upon care givers, who may be the [perpetrators](#)
- severe limitations including inability to speak, e.g. due to stroke or other impairments
- fear of retaliation or losing care giver
- fear of consequences of intervention
- isolation

Child Sexual Abuse

Sexual abuse has the potential to interfere with a child's normal, healthy development, both emotionally and physically. Often, sexually victimised children experience severe emotional disturbances from their own feelings of guilt and shame, as well as the feelings which society imposes on them.

Sexual abuse of children includes:

- sexual touching of any part of the body, clothed or unclothed, including using an object
- all penetrative sex, including penetration of the mouth with an object or part of the body
- encouraging a child to engage in sexual activity, including sexual acts with someone else, or making a child strip or masturbate
- intentionally engaging in sexual activity in front of a child or not taking proper measures to prevent a child being exposed to sexual activity by others
- meeting a child following sexual 'grooming', or preparation, with the intention of abusing them
- taking, making, permitting to take, distributing, showing or advertising indecent images of children
- paying for the sexual services of a child or encouraging them into prostitution or pornography
- showing a child images of sexual activity including photographs, videos or webcams.

Effects of sexual abuse

There are multiple traumatic effects for sexually victimised children. Problems may include:

- physical injuries
- fear
- depression
- self-destructive behaviours
- low self esteem
- feelings of confusion
- sexual acting out behaviours
- nightmares
- hostility
- phobias
- anti-social behaviour
- socialisation problems.

Adults who were sexually violated as children often experience difficulties in adulthood as a consequence of the abuse. The range of abuse related difficulties in adult survivors includes:

- depression
- anxiety
- self-mutilation
- low self esteem
- eating disorders
- interpersonal difficulties
- post traumatic stress disorder
- dissociative identity disorder.

Long Term Effects

There are predictable effects to sexual abuse in the long-term. These are:

- post traumatic stress disorder
- cognitive distortions
- emotional distress
- avoidance
- impaired sense of self
- interpersonal difficulties.

Post traumatic stress disorder

Adult survivors have been found to display more symptoms of PTSD than do research subjects who were not sexually abused as children.

Cognitive distortions

Self-perceptions of helplessness and hopelessness in adulthood, impaired trust, self-blame, and low self-esteem are characteristic of the adult survivor of childhood sexual abuse.

Emotional Distress

Emotional distress manifests itself as: depression, heightened anxiety and anger.

Avoidance

Avoidance measures can include: disassociation, substance abuse, suicidal thoughts and attempts, impulsivity, self-mutilation and eating disorders.

Impaired Sense of Self

An impaired sense of self can be shown by a continuing inability to define one's boundaries or rights and can be associated with increased suggestibility, inadequate self-protectiveness, and a greater likelihood of being victimised or exploited.

Interpersonal Difficulties

Interpersonal difficulties include less interpersonal trust in close and intimate relationships; having fewer friends or experiencing greater social discomfort and social isolation, or experiencing difficulty with sexual intimacy.

Who sexually abuses children?

It is impossible to describe a typical sex abuser or paedophile. They do not look different to other people and they behave in a variety of ways. They are found in all areas of society and can come from any professional, racial or religious background.

They sometimes hold influential positions, appearing to be well-respected members of society. They may be abusing their own children as well as children within the wider community.

Those who abuse children within their own families can include fathers, live-in partners, step-fathers, boyfriends, brothers, uncles, male cousins, grandfathers and father figures. Abusers can also be a similarly wide range of female relatives, including mothers.

Contrary to the popular image, people who sexually abuse children often appear kind, concerned and caring towards children. This is part of building a close relationship with children, which allows them to abuse without being suspected or discovered.

Why do people abuse?

Some abusers learned to abuse from their parents. Their early history consisted of receiving abuse themselves and/or seeing others abused (one parent abusing the other or their sibling). As a consequence, abuse is the normal condition of life.

Source: Mental Health Net

http://mentalhelp.net/poc/view_doc.php?type=doc&id=8482&cn=2

People abuse children for a variety of reasons, including a chance to increase their sense of power and a sense of pleasure. Those who abuse can become 'hooked' on using children to achieve sexual arousal. They may seek children to sexually abuse because they have had a long history of sexual attraction to children or because they took advantage of an opportunity to abuse a child in their trust.

The earlier people who abuse children get help, the better chance they have to control their impulses.

Source: Ozark Guidance: Mental Health

http://www.ozarkguidance.org/poc/view_doc.php?type=doc&id=8482&cn=2

Financial Abuse

Financial abuse is the improper taking or misuse of the money or property of a vulnerable adult for the benefit of someone other than the vulnerable adult.

The term '**financial abuse**' describes the situation where an abuser:

- misappropriates a vulnerable person's money and/or other assets through various means (e.g. theft or fraud)
- misuses or wrongfully spends a vulnerable person's assets while having legitimate access to these
- fails to use a vulnerable person's assets to meet that person's needs.

The abuser may make excuses for their behaviour, such as 'I need this money more than they do', or 'I'll inherit this money anyway'. But they are actually taking advantage of the person. In many cases, financial abuse is often accompanied by physical or social abuse.

Who is at risk of financial abuse?

When a person loses mental capacity due to illness or injury, e.g. someone with dementia, they often become unable to manage their financial affairs. People with mental incapacity are often highly vulnerable. Without the right protection, they can be at risk of financial abuse and could face losing their home or their savings. The following conditions or factors increase an older person's risk of being victimised:

- isolation
- loneliness
- recent losses
- physical or mental disabilities
- lack of familiarity with financial matters
- having family members who are unemployed and/or have substance abuse problems.

Financial abuse can include the following:

- taking money or property
- forging an older person's signature
- getting an older person to sign a deed, will, or power of attorney through deception, coercion, or undue influence
- using the older person's property or possessions without permission
- promising lifelong care in exchange for money or property and not following through on the promise.

- Confidence crimes ('cons') use deception to gain the victims' confidence.
- Fraud is the use of deception, trickery, false pretence, or dishonest acts or statements for financial gain.
- Scams are fraudulent or deceptive acts. In the case of telemarketing scams, perpetrators call victims and use deception, scare tactics, or exaggerated claims to get them to send money. They may also make charges against victims' credit cards without authorisation.

Who are the perpetrators?

Family members: including sons, daughters, grandchildren, or spouses. They may:

- have substance abuse, gambling, or financial problems
- stand to inherit and feel justified in taking what they believe is 'almost' or 'rightfully' theirs
- fear that their older family member will get sick and use up their savings, depriving the abuser of an inheritance
- have had a negative relationship with the older person and feel a sense of 'entitlement'
- have negative feelings toward siblings or other family members whom they want to prevent from acquiring or inheriting the older person's assets.

Predatory individuals: who seek out vulnerable seniors with the intent of exploiting them. They may:

- profess to love the older person ('sweetheart scams')
- seek employment as personal care attendants, counsellors, etc. to gain access
- identify vulnerable persons by driving through neighbourhoods (to find people who are alone and isolated) or contact recently widowed people they find through newspaper death announcements
- move from community to community to avoid being apprehended (transient criminals).

Unscrupulous professionals or business persons, or persons posing as such. They may:

- overcharge for services or products
- use deceptive or unfair business practices
- use their positions of trust or respect to gain compliance.

Neglect

What is neglect?

Neglect is defined as a ‘type of maltreatment that refers to the failure to provide needed age-appropriate care’, such as shelter, food, clothing, education, supervision, medical care and other basic necessities needed for the development of physical, intellectual and emotional capacities.

Unlike physical and sexual abuse, neglect is usually typified by an ongoing pattern of inadequate care and is readily observed by individuals in close contact with the child or adult. Physicians, nurses, day care personnel, relatives and neighbours are frequently the ones to suspect and report neglected infants, toddlers and pre-school children and vulnerable adults.

Types of neglect

Physical neglect: includes the refusal of, or extreme delay in seeking, necessary health care; child abandonment; inadequate supervision; rejection of a child or vulnerable adult leading to expulsion from the home; and failing to adequately provide for the person’s safety and physical and emotional needs.

Physical neglect can severely impact a child's development by causing:

- failure to thrive
- malnutrition
- serious illnesses
- physical harm in the form of cuts, bruises and burns due to lack of supervision
- a lifetime of low self-esteem.

Educational neglect: occurs when a child is allowed to engage in chronic truancy, or is of mandatory school age but not enrolled in school or receiving needed special educational training.

Educational neglect can lead to underachievement in acquiring the necessary basic skills; truanting from school and/or continually disruptive behaviour.

Emotional neglect includes such actions as:

- chronic or extreme spousal abuse in the child’s presence
- allowing a child to use drugs or alcohol
- refusal or failure to provide needed psychological care
- constant belittling and withholding of affection.

This pattern of behaviour can lead to poor self-image, alcohol or drug abuse, destructive behaviour and even suicide. Severe neglect of infants can result in the infant failing to grow and thrive and may even lead to infant death.

Medical neglect: is the failure to provide appropriate health care for a child or adult when financially able to do so. Medical neglect can result in poor overall health and compounded medical problems.

Signs of Neglect in Children

Physical Indicators

- abandonment
- unattended medical needs
- consistent lack of supervision
- consistent hunger
- inappropriate dress
- poor hygiene
- lice; distended stomach; emaciated
- inadequate nutrition.



Behavioural Indicators

- regularly displays fatigue or listlessness (falls asleep in class)
- steals food, begs from classmates
- reports that no caretaker is at home
- frequently absent or tardy
- self destructive
- school dropout (adolescent)
- extreme loneliness and need for affection.

Signs of Neglect in Vulnerable Adults

Health effects don't always show up the same way for everyone. Vulnerable adults who experience neglect may have difficulty sleeping, lose interest in life, change their habits, such as eating, drinking or medication, or have suicidal thoughts.

What are the health effects of neglect on vulnerable adults?

Neglect can have short and long-term effects on the health and well-being of vulnerable adults. The effect depends on any emotional support received and the response of family and friends. It also depends on whether the individual feels they have some control of their situation.

Living with neglect can significantly increase the person's chances of becoming ill or dying early. The stress of living with abuse or neglect may also make other health problems worse.

Many vulnerable adults who experience neglect also face emotional and/or financial abuse. This can lead to ongoing distress in the person's life. If the abuser controls the vulnerable person's money, they may have fewer resources to take care of their own health, secure and maintain proper housing, or obtain good nutrition and participate in healthy activities.

Possible Causes of Abuse of Vulnerable Adults

Abuse and neglect are extremely complex problems. Below is simply a listing of some of the possible **contributory factors** related to neglect. It is important to also remember that these factors usually do not operate in isolation but rather interact in unique ways depending on the victim and perpetrator's situation.

Care giver stress

Caring for a vulnerable adult with a mental or physical impairment can be stressful. Individuals who do not have the requisite skills, information or resources and who are otherwise ill-prepared for the care giving role may experience extreme stress and frustration. This may lead to abuse and/or neglect of the vulnerable adult.

External stress

External stress such as financial problems, job stress, and additional family stressors have also been thought to increase the risk of abuse. This correlation has been clearly demonstrated in studies examining spousal or child abuse.

Social isolation

Abuse, whether spousal abuse, child abuse, or elder abuse occurs most often in families characterised by social isolation. Of course, this may be both an indicator of potential abuse as well as a potential contributing cause of abuse.

Intergenerational transmission of violence

Individuals who are abused as children are thought to become part of a cycle of violence. Violence is learned as a form of acceptable behaviour in childhood as a response to conflict, anger, or tension. Thus, when these feelings arise during care giving, the care giver is at risk of becoming a perpetrator of abuse or neglect.

Intra-individual dynamics or personal problems of the abuser

Some care givers may be at risk of neglecting others as a consequence of their own difficulties. For example, a care giver who suffers from such problems as alcoholism, drug addiction, and/or an emotional disorder (e.g. a personality disorder) is more likely to become an abuser than an individual who does not suffer from such problems.

Possible Causes of Child Abuse

Not all child abuse is deliberate or intended. Several factors in a person's life may combine to cause them to abuse a child:

- stress, including the stress of caring for children, or the stress of caring for a child with a disability, or difficult behaviour
- lack of nurturing qualities necessary for caring for a child
- difficulty controlling anger
- personal history of being abused
- isolation from the family or community
- physical or mental health problems, such as depression and anxiety
- alcohol or drug abuse
- personal problems such as marital conflict, unemployment, or financial difficulties.

No-one has been able to predict which of these factors will cause someone to abuse a child. A significant factor is that abuse tends to be intergenerational – those who were abused as children are more likely to repeat the act when they become parents or caretakers.

In addition, many forms of child abuse arise from ignorance, isolation, or benign neglect. Sometimes a **cultural tradition** leads to abuse. For example, such beliefs as:

- children are property
- parents have the right to control their children in any way they wish
- children need to be toughened up to face the hardships of life.

Failure to Thrive

What is Failure to Thrive?

Failure to thrive is defined as slow or arrested physical growth associated with poor developmental and emotional functioning.

Organic failure to thrive occurs when there is an underlying medical cause. Some babies fail to grow because of repeated or chronic illnesses such as diarrhoea, pneumonia, or cerebral palsy.

Non organic (also called psychosocial) failure to thrive occurs in a child who is usually younger than 2 years old and has no known medical condition that causes poor growth. It is a form of neglect in which the child's growth is inhibited in the home environment while showing a normal or above normal growth capacity when placed out of home, such as in hospital or in alternative care. It is caused both by poor nutrition accompanied by emotional deprivation.

Most diagnoses of failure to thrive are made in infants and toddlers in the first few years of life - a crucial period of physical and mental development. After birth, a child's brain grows as much in the first year as it will grow during the rest of the child's life. Poor nutrition during this period can have permanent negative effects on a child's mental development.

If the condition progresses, the undernourished child may display some of the following:

- become disinterested in his or her surroundings
- avoid eye contact
- become irritable
- not reach developmental milestones like sitting up, walking, and talking at the usual age
- mental alertness to surroundings - in extreme cases this is described as frozen watchfulness
- demonstrating aggressiveness
- immature play
- decreased inter-personal interaction
- dull, pale skin
- physically apathetic.

Who is affected by failure to thrive?

Infants born into families with psychological, social, or economic problems are more at risk of developing non organic failure to thrive.

Parental characteristics may include some of the following:

- poor planning ability
- low intellect combined with lack of knowledge, judgement and motivation
- severe depression/neurotic disorders or substance abuse
- angry, hostile mothers who feel persecuted by infants
- chaotic lives and relationships
- chronic medical problems
- substance abuse.

Social factors:

- parental isolation
- poor parental functioning
- lack of resources - for example poverty
- lack of cultural understanding of what is appropriate.



Activity 23



1. As a class, discuss your thoughts and reactions to the various types of abuse:
 - physical abuse
 - emotional abuse
 - sexual abuse
 - financial abuse
 - neglect
 - inexplicable failure to thrive.

2. In small groups of 4 or 5 research, discuss and answer the following:
 - a) Identify the signs and symptoms of each type of abuse
 - b) Identify the effects of each type of abuse.

Use the table on the next page for your answers.

Type	Signs	Symptoms
Physical		
Emotional		
Sexual		
Financial		
Neglect		
Failure to thrive		

Abuse in Care Practice

There are occasions in care practice where service users receive poor quality care and abuse at the hands of their carers.



Activity 24



Click on the **NLN web link** below:

<http://www.nln.ac.uk/page.asp?p=FEHE>

NLN Material Topics: Register (free) and log in. Then select: [Health Care, Medicine, Health And Safety](#) from the menu.

Then go to the topic **Caring Skills** and continue until **Results 56 - 60**
Select the following topics: **The Home from Heaven: The Home from Hell.**

NLN Topic: **The Home from Heaven**

In this unit you will follow Dennis and Joan as they arrive and settle in to the *'Home from Heaven'*.

NLN Topic: **The Home from Hell**

In this unit you will follow Dennis, a new resident, as he arrives and settles in to his care home. This will allow you to review and compare the standards identified within the topic: *'The Home from Heaven'*.

Glossary of Terms

Term	Meaning
Amish community	The Amish Community in Pennsylvania Dutch Country have long preferred farming as a way of life. They are very devout in their faith and believe in the literal interpretation and application of scripture as the Word of God. They have a strong sense of community spirit, and often come to the aid of those in need. http://www.800padutch.com/amish.shtml
Anti-social	Unwilling or unable to conform to normal standards of social behaviour; 'criminal behaviour or conduct that violates the rights of other individuals is antisocial'.
Arousal	Responsiveness to sensory stimulation or excitability.
Behaviourism	A psychological theory and practice which is focused on observable behaviour and the influence of conditioning and reinforcement of that behaviour.
Care plan	Individual plan of care to promote health and well being.
Catharsis	The healthful (therapeutic) release of ideas through 'talking out' conscious material accompanied by an appropriate emotional reaction. Also, the release into awareness of repressed ('forgotten') material from the unconscious.
Causal	Refers to 'cause-and-effect'.
Coercive	Urging or forcing someone into doing something.
Cognitive processes	Cognitive processes are very important for human behaviour. They are about knowledge and the way people use their knowledge. Cognitive processes include language, memory and intelligence.
Conform	Adjust or adapt to new or different conditions.
Covert	Secret or hidden; not openly practised or shown.
Defuse	Remove a threat.
Depression	A depressive disorder is characterised by extreme feelings of sadness, lack of self-worth, and dejection.
Deviant	Deviant behaviour is behaviour that differs from a norm

	or from the accepted standards of a society. Formal and informal social controls attempt to prevent and minimise deviance.
Displaced	Displaced is a term used by Freud. Displacement operates subconsciously and involves emotions, ideas or wishes being transferred from their original object to a more acceptable substitute. It is most often used to allay anxiety e.g. punching a cushion when angry at someone.
Egotism	Egotism means extreme selfishness; that is, the total disregard for the consequences of personal actions on others. It also denotes the individual's refusal to act in the best interest of their community, even when such cooperation will in the long term be to their own benefit.
Empirical	Based on experimental data, not on a theory.
Empowered	Refers to increasing the spiritual , political , social or economic strength of individuals and communities. It often involves the empowered developing confidence in their own capacities.
Environmental stimulus	An internal or external event that causes a reaction or response.
Excitation	The state of being emotionally aroused and worked up.
Goal directed	Behaviour is driven by goals.
Homogenous	The same traits or characteristics; essentially alike.
Identity	The individual characteristics by which a person is recognised or known.
Imitation	Observation of skill and attempting to repeat it. Copying (or trying to copy) the actions of someone else.
Inadequacy	Insufficiency: a lack of competence.
Individual	Separate, distinct and unique from other human beings.
Innate	A trait or characteristic that is inborn- genetically inherited. Unconditioned: not established by conditioning or learning; 'an unconditioned reflex'.

Learned helplessness	People perceive that they have no control over what happens to them. Such environments may include; repeated failures, prison, school, war, disability. Feelings of inadequacy persist. People in a state of learned helplessness view problems as personal (they are the problem), pervasive (affects all aspects of their life) and permanent (problem is unchangeable).
Libido	Term used by Freud to refer to sexual energy; the driving force in humans.
Manifest	Show by one's behaviour, attitude, or external attributes.
Mind games	Passive aggressive behaviour which is used specifically to demoralise the subject while making the aggressor look superior. The psychological field of Transactional Analysis , describes and examines mind games from a social and psychological perspective. Broadly the term can be used for any strategy or tactic where covert mental manipulation or creation of coercive pressure of another person is a goal.
Modelling	Use as a guide to behaviour.
Narcissistic	In everyday use outside the field of psychology, the word generally refers to people who just are inordinately fond of themselves.
Norm	In sociology, a norm, or social norm, refers to behaviour that is recognised as acceptable within a given culture. Norms can be formal or informal rules of behaviour.
Observation	Looking at and critically noting the details of e.g. a site, an artefact, or cultural behaviour.
Perpetrator	A person committing crimes against individuals/groups.
Physiological	Relating to science that studies the function of the body and the vital processes of living things.
Positive role model	Someone worthy of imitation. Person whose positive behaviour is copied by others.
Psychology	Related to the scientific study of the mind, mental processes and phenomena, cognitive development and behaviour.

Psychoanalytic model or theory	Psychoanalytic theory is a general term for approaches to psychoanalysis which attempt to provide a conceptual framework more or less independent of clinical practice rather than based on empirical analysis of clinical cases.
Reinforcement	Anything that occurs with a behaviour that tends to increase the likelihood that the behaviour will occur again.
Self esteem	In psychology, self-esteem or self-worth is a person's self-image at an emotional level; evading reason and logic. One can remain highly egotistical, while underneath have very low self-esteem.
Stimulus	Any stimulating information or event; acts to arouse action.
Social network	The personal or professional set of relationships between individuals. Social networks represent both a collection of ties between people and the strength of those ties. May include but is not limited to family, teachers and other school staff, friends, neighbours, community contacts, and professional support.
Social role	Mostly defined as an expected behaviour in a given individual based on their social status and social position in society e.g. expected behaviour of a friend.
Spontaneous	Happening or arising without apparent external cause e.g. 'spontaneous laughter'.
Stereotype	Popularly held belief about a type of person or a group of people which does not take into account individual differences.
Stressors	Any agent that causes stress to human beings e.g. lack of sleep, too much noise, work overload.
Sublimation	Term used by Freud and a coping mechanism. Refocusing of psychic energy away from negative outlets to more positive outlets e.g. a student who has a major exam will re-channel energy into studying rather than worrying about it.

Testosterone	Primarily a male hormone produced by the testicles which is responsible for the development and the release of sperm, male physical characteristics and sexual drive. Small amounts of testosterone are also produced in women by the ovaries and the adrenal glands.
Vicarious	Experienced second-hand; 'read about mountain climbing and felt vicarious excitement'.



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