

CONSTANTIA CARE

Staff Policy
&
Procedures

Version:
March 2018

CONSTANTIA CARE

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ACCESS TO RECORDS AND FILES POLICY

OUTCOME 21, REGULATION 20 (Records)

Policy Statement

Constantia Care Ltd. adheres fully to Outcome 21, Regulation 20 of the Care Quality Commission Guidance about compliance, Essential standards of Quality and Safety, which relates to the extent to which the rights and best interests of clients are safeguarded by the company keeping accurate and up-to-date records.

Constantia Care Ltd. also adheres fully to the *Data Protection Act 1998* which states that all records required for the protection of service users and for the effective and efficient running of Constantia Care should be maintained accurately and should be up to date, that clients should have access to records and information about them held by Constantia Care, and that all individual records and organisation records should be kept in a confidential and secure fashion. The new Social Care Record Guarantee is a part of this protection of clients.

Aim of the Policy

This policy is intended to set out the values, principles and policies underpinning Constantia Care's approach to access to records. The aim of Constantia Care is to ensure that clients can be assured that the protection of their privacy and confidentiality are given the highest consideration.

Access to Records/Files Policy

Constantia Care believes that access to information and security/privacy of data is an absolute right of every client and that clients are entitled to see a copy of all personal information held about them and be given the opportunity to correct any error or omission. Therefore, in Constantia Care:

- Clients should have access to their records and information about them held by Constantia Care, as well as opportunities to help maintain their personal records in the case of records kept in the home
- Individual records and organisation records required for the protection of clients should at all times be kept in a secure fashion and should be constructed, maintained and used in accordance with the *Data Protection Act 1998* and other statutory requirements.

Any client requiring access to their files should contact the head of organisation to make arrangements to view. Clients with sensory or other disabilities should be given appropriate help and support from an independent source as required e.g. and Advocacy Service.

The viewing of certain records may only be refused in the following circumstances as consistent with the *Data Protection Act 1998*:

- Where disclosing the personal data would reveal information which relates to and identifies another person unless that person has consented to the disclosure or it is reasonable to comply with the request without that consent
- Where permitting access to the data would be likely to cause serious harm to the physical or mental health or condition of the data subject or any other person
- Where the request for access is made by another on behalf of the data subject, access can be refused if the data subject had either provided the information in the expectation it would not be disclosed to the applicant or had indicated it should not be so disclosed, or if the data was obtained as a result of any examination or investigation to which the data subject consented on the basis that information would not be so disclosed.

Before deciding whether the above restrictions apply, the head of Constantia Care should consult the health professional responsible for the clinical care of the service user, or if there is more than one, the most suitable available health professional. If there is none then the head of organisation should consult a health professional with the necessary qualifications and experience to advise on the matters to which the information requested relates.

Clients who have a complaint about the way that Constantia Care keeps files about them, or who are refused access to files that they believe they should have access to, should be referred to the Data Protection Information Commissioner.

Training

All new staff and self-employed care assistants should be encouraged to read the policies on data protection, confidentiality, access to files and record keeping as part of their induction process. Training in the correct method for entering information in clients' records should be given to all care staff. The nominated data user/data controller for Constantia Care should be trained appropriately in the *Data Protection Act 1998*. All staff and self-employed care assistants who need to use the computer system should be thoroughly trained in its use.

This policy will be reviewed by the registered manager

Signed: *M Collier*

Date: 31/01/18

Review Date: 31/07/18

ACCIDENTS, INCIDENTS AND EMERGENCIES POLICY **OUTCOME 10, REGULATION 15 (Safety and Suitability of Premises)**

Constantia Care Ltd.

Policy Statement

Constantia Care Ltd. recognises its responsibility to ensure that all reasonable precautions are taken to provide working conditions which are safe, healthy and compliant with all statutory requirements and codes of practice.

However, Constantia Care recognises that accidents are, even in the safest of working environments, from time to time inevitable, despite the best efforts of staff, self-employed care assistants, clients, and relatives and other professionals to prevent them. Such occurrences must be handled by Constantia Care and by its staff and self-employed care assistants so as to minimise threat and injury to all, including clients, relatives and the general public.

They must also be reported and the reports acted upon by Constantia Care so that accidents can be minimised in the future and Constantia Care, staff and self-employed care assistants can learn from their experiences.

To this end Constantia Care Ltd. adheres fully to the above outcomes and regulations which relates to the degree to which staff, self-employed care assistants and clients are protected by Constantia Care's working practices, policies and procedures.

Constantia Care understands "accidents and emergencies" to cover an accident or injury to a member of staff, a self-employed care assistant or a client or relative, including health and safety accidents such as trips, falls and cuts. Fires are dealt with in a separate *Fire Policy*. Dealing with aggression and violence is dealt with in a separate policy *Dealing with Aggression and Violence*. The rendering of first aid is dealt with in a separate *First Aid Policy*.

Aim of the Policy

This policy is intended to set out the values, principles and policies underpinning Constantia Care's approach to an accident, emergency or crisis.

The goals of Constantia Care are to ensure that:

- All accidents and incidents are appropriately dealt with
- All accidents and incidents involving injury to staff or service users are reported and recorded, no matter how minor
- All reported accidents or incidents are fully investigated
- The results and recommendations from investigations are fully implemented to prevent any re-occurrence of such incidents
- Constantia Care complies fully with the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)*.

Action to be taken in the Event of an Accident or Injury

In the event of an accident, incident or emergency staff will take the following action.

- In the event of a minor injury or health related incident the First Aid Policy will be followed and first aid care rendered according to the situation and the member of staff's capabilities and training. Following such an incident an incident or accident form will be completed and the service user's GP informed.
- In the event of an injury where medical attention is considered advisable or necessary, the service user's GP or an ambulance will be called as appropriate. If there is any doubt about the need for medical attention, an ambulance will be called immediately.

If the first-aider, or care worker, decides that an ambulance is appropriate, they will follow the procedure below.

1. Call 999 and make arrangements for an ambulance to be sent immediately. It is essential that the precise location of the occurrence is given and the nearest point of access for the ambulance suggested.
2. Make arrangements for the ambulance to be met by a relative or other person as appropriate and if available.
3. Ensure that the service user is accompanied to hospital, where appropriate, by a responsible person and that they contact Constantia Care's main office soon after arrival at the hospital, to give updated information on the condition and location of the casualty.
4. Contact the main office or a line manager to report the incident and make arrangements for the appropriate forms to be completed.

Note:

If a care worker is unsure about the course of action to take, or in the event of complications (such as having to accompany the service user themselves) then they will contact their line manager or the main office for advice.

The care worker, or first aider, attending to the casualty will then ensure that the line managers/head office are notified of the accident/illness, as appropriate.

The responsible line manager will then ensure that arrangements are made for relatives or friends of the casualty to be advised fully of the situation, if necessary, and to ensure that an incident report form and any other relevant paperwork is completed as soon as possible.

In the event of an injury requiring first aid, where a fire is reported, where there is violence or aggression or where a service user goes missing, then the appropriate policy will be followed.

Accident or Incident Reporting

In Constantia Care all accidents, incidents, emergencies and "near misses" must be recorded and reported to the management using a standard incident form. Accident and incident reports will then be dealt with according to the *Accident Reporting Policy*. Employers must by law notify certain categories of accidents, specified cases of ill health and specified dangerous occurrences to the Health and Safety Executive (HSE) or the local authority (LA) to comply with the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)*. Please note: Any medication incidents are reported via the separate error record in the medication plan of care. A written record will be kept of any accident or incident, however minor, which occurs in Constantia Care.

See separate *Reporting of Accidents Policy*.

Training

The registered manager is responsible for organising and co-ordinating training. All staff receive induction training in Constantia Care's policy for dealing with accidents and emergencies. *Basic First Aid* and *Dealing with Aggressive or Potentially Violent Patients* are included in the induction training for all new staff. Training sessions are conducted at least annually and all relevant staff will attend. These sessions will cover the drill of how staff will act in an emergency situation. All employees of Constantia Care are given adequate training and information on accidents at work and how to avoid them.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 31/01/18

Review Date: 30/06/18

ACCIDENT AND INCIDENT REPORTING [RIDDOR]

Constantia Care Ltd.

Policy Statement

Constantia Care recognises its responsibility to ensure that all reasonable precautions are taken to provide working conditions that are safe, healthy and compliant with all statutory requirements and codes of practice.

Under the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 [Regulations 2014] there is a requirement to notify the Care Quality Commission when certain incidents or accidents happen by completing an online notification. In addition, Regulation 12 of this Act requires the Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance to be followed.

Constantia Care recognises that even in the safest of working environments accidents are, from time to time, inevitable. The *Health and Safety at Work Act 1974* requires employers to ensure the health, safety and welfare of all their employees as far as is reasonably practicable. As part of this commitment, employers must, by law, notify certain categories of accidents, specified cases of ill health and specified dangerous occurrences to the Health and Safety Executive (HSE) or the local authority (LA) to comply with the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013* (RIDDOR).

This is necessary so that the Health and Safety Executive HSE can determine trends and patterns in workplace accidents and put in place legislation and guidelines that will safeguard workers all over the UK. It also helps the Constantia Care to determine local patterns and causes of accidents so that it can ensure that preventative measures are in place to avoid a recurrence.

Therefore, in Constantia Care, all accidents, incidents and “near misses” must be recorded and reported to the management.

The Policy

Constantia Care ensures that:

- it complies fully with the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013* (RIDDOR)
- all accidents and incidents involving injury to staff or resident are reported and recorded in the accident book, no matter how minor
- all reported accidents or incidents are fully investigated
- the results and recommendations from investigations are fully implemented to prevent any recurrence of such incidents

An Accident Book is provided in the organisation’s main office to keep a record of all accidents which occur, whether they are notifiable or not.

1. All resident notes must be updated to include information of the accident or incident and subsequent actions required.
2. Accident/incident report forms are available from the main office. They should be completed as soon as possible and the office informed immediately.
3. All accident and incident reports are reviewed monthly and action taken where required to prevent where possible further occurrences.

Accident Reporting - RIDDOR

The following are reportable, if they arise ‘out of or in connection with a work related accident:

- the death of any worker or non-worker in a work related accident
- accidents which result in an employee or a self-employed person dying, with the exceptions of suicide
- suffering a specified* injury; being absent from work or unable to do their normal duties for more than seven days

- accidents which result in a person not at work (e.g., client or visitor) suffering an injury and being taken directly to a hospital for treatment
 - an employee or self-employed person has one of the specified occupational diseases or is exposed to carcinogens, mutagens and biological agents
 - specified dangerous occurrences, which may not result in a reportable injury, but have the potential to do significant harm
- *Specified injuries to workers**

The list of 'specified injuries' in RIDDOR 2013 replaces the previous list of 'major injuries' in RIDDOR 1995. Specified injuries are (regulation 4):

- fractures, other than to fingers, thumbs and toes
- amputations
- any injury likely to lead to permanent loss of sight or reduction in sight
- any crush injury to the head or torso causing damage to the brain or internal organs
- serious burns (including scalding) which:
 - covers more than 10% of the body
 - causes significant damage to the eyes, respiratory system or other vital organs
- any scalping requiring hospital treatment
- any loss of consciousness caused by head injury or asphyxia
- any other injury arising from working in an enclosed space which:
 - leads to hypothermia or heat-induced illness
 - requires resuscitation or admittance to hospital for more than 24 hours

Who should report?

The responsible person has the duty to notify and report.

When to report

- in the case of death as soon as possible
- over 7 days** injury must be reported within 15 days of the incident
- diseases must be reported as soon as a medical practitioner has notified you in writing of the diseases

****Over-seven-day incapacitation of a worker**

Accidents must be reported where they result in an employee or self-employed person being away from work, or unable to perform their normal work duties, for more than seven consecutive days as the result of their injury.

This seven day period does not include the day of the accident, but does include weekends and rest days. The report must be made within 15 days of the accident.

How to report

Go to www.hse.gov.uk/riddor and complete the appropriate online report form.

All fatal and major injury cases can be reported to the ICC (Incident Contact Centre) by

- phone (Mon-Fri 8.30 – 5.00) 0845 300 9923 out of hours' details for more serious reporting can be found at www.hse.gov.uk/contacts/outofhours.htm
- fax, 0845 300 9924
- or post. Incident Contact Centre, Caerphilly Business Park, CF83 3GG

Telephone notification should always be followed up with submission of form F2508. Forms should be completed, online, by the head of the organisation, their deputy or by a senior member of staff as soon as possible after the accident. Copies of the completed form should be kept.

The HSE Incident Contact Centre is able to take written forms only where it is essential, post to:

RIDDOR Reports
Redgrave Court
Merton Road
Bootle
Merseyside
L20 7HS

Record keeping

All records should include;

1. The date, time and place of the incident that occurred
2. The name, address and job of the injured or ill person
3. Details of the injury/illness and what aid was given
4. What happened to the person immediately afterwards (e.g., went back to work, went to hospital)
5. The name and signature of the first aider or person that dealt with, or was witness to, the incident.

There is a legal requirement that written records of reportable accidents and dangerous occurrences (i.e., those which must be reported to the appropriate enforcing authority) be kept for a minimum of three years.

Deaths in Health and Social Care

There is specific guidance for Health and Social Care providers issued by the HSE.
<http://www.hse.gov.uk/pubns/hsis1.pdf>

- you must report the death of any person, whether or not they are at work
- accidents which result in an employee or a self-employed person dying
- suffering a specified injury, being absent from work or unable to do their normal duties for more than seven days
- accidents which result in a person not at work (e.g. a patient, client, visitor) suffering an injury and being taken directly to a hospital for treatment, or if the accident happens at a hospital, if they suffer a specified injury
- an employee or self-employed person has one of the specified occupational diseases or is exposed to carcinogens, mutagens and biological agents
- specified dangerous occurrences, which may not result in a reportable injury, but have the potential to do significant harm

Deaths which are not reportable

- a client commits suicide, suicides are not considered 'accidents' and are not RIDDOR reportable
- a client admitted to hospital for treatment, contracts Legionnaires' disease and dies while in hospital. The death has to be caused by an accident to be reportable (Poor maintenance on a hot water system would not be considered an 'accident')

Injuries and ill health involving health and social care workers

This section covers accidents resulting in an employee or a self-employed person suffering a specified injury, or being absent from work or unable to do their normal duties for more than three days.

Specified injuries

The following are reportable specified injuries if they arise 'out of or in connection with work':

- fractures, other than to fingers, thumbs and toes
- amputations
- any injury likely to lead to permanent loss of sight or reduction in sight
- any crush injury to the head or torso causing damage to the brain or internal organs
- serious burns (including scalding) which
 - cover more than 10% of the body; or

- cause significant damage to the eyes, respiratory system or other vital organs
- any scalping requiring hospital treatment
- any loss of consciousness caused by a head injury or asphyxia
- any other injury arising from working in an enclosed space which
 - leads to hypothermia or heat-induced illness; or
 - requires resuscitation or admittance to hospital for more than 24 hours

Over-seven-day incapacitation of a worker

Accidents must be reported where they result in an employee or self-employed person being away from work, or unable to perform their normal work duties, for more than seven consecutive days as the result of their injury. The seven-day period does not include the day of the accident, but does include weekends and rest days. The report must be made within 15 days of the accident.

Over-three-day incapacitation

Accidents must be recorded but not reported where they result in a worker being incapacitated for more than three consecutive days. A record must be kept in the Accident Book.

Physical violence

A physical injury inflicted on one employee by another during a dispute about a personal matter, or an employee at work injured by a relative or friend who visits them at work about a domestic matter, is not reportable.

Other acts of non-consensual violence to a person at work that result in death, a major injury or being incapacitated for over seven days are reportable and you must keep a record of over-three-day injuries.

Diseases, infections and ill health

We must report any instance where a Registered Medical Practitioner (RMP) tells you in writing that one of your employees is suffering from a disease specified in RIDDOR.

Reportable diseases, infections and ill health include:

- carpal tunnel syndrome
- severe cramp of the hand or forearm
- occupational dermatitis
- hand-arm vibration syndrome
- occupational asthma
- tendonitis or tenosynovitis of the hand or forearm
- any occupational cancer
- any disease attributed to an occupational exposure to a biological agent

Examples of Reportable Accidents or Incidents

Reportable

- a nurse contracts active pulmonary TB after nursing a client with the condition
- a laboratory worker suffers from typhoid after working with specimens containing typhoid
- a paramedic becomes hepatitis B positive after contamination with blood from an infected client
- a care assistant is splashed in the face with bodily fluids from a client and becomes hepatitis B positive
- a surgeon suffers dermatitis associated with wearing latex gloves during surgery
- a maintenance worker contracts Legionnaires' disease after working on the hot water system
- in all of these cases it is clear that the disease is either attributable or contributed to by the work activity and an RMP has confirmed that this is the case

Not reportable

- a nurse becomes colonised with MRSA and works with residents infected with MRSA
- a cleaner catches chicken pox and residents in areas where she has worked have chicken pox
- a care home assistant is off work with influenza for two weeks, the influenza cannot be reliably attributed to their work activity, as it is common in the community

In all of these cases, either infection has not occurred at work or the disease cannot be reliably attributed to the work activity, as it might easily have occurred at home or in the community.

Sharps injuries

A sharps injury is when a needle or other sharp instrument accidentally penetrates the skin. It is sometimes called a needlestick injury.

Sharps injuries must be reported:

- When an employee is injured by a sharp known to be contaminated with a blood-borne virus (BBV), e.g. hepatitis B or C or HIV. This is reportable as a dangerous occurrence.
- When the employee receives a sharps injury and a BBV acquired by this route sero-converts. This is reportable as a disease – see 'Diseases, infections and ill health';
- If the injury itself is so severe that it must be reported.

If the sharp is not contaminated with a BBV, or the source of the sharps injury cannot be traced, it is not reportable, unless the injury itself causes an over-seven-day injury. If the employee develops a disease attributable to the injury, then it **must** be reported.

Reportable

- a cleaner suffers a needlestick injury from a needle and syringe known to contain hepatitis B positive blood (reportable as a dangerous occurrence)

Not reportable

- a community nurse suffers a needlestick injury, does not sero-convert and the source of the sharp cannot be traced
- a laboratory worker is injured by a blood specimen container, the client is not known to have any infection
- an employee is cut with a scalpel used on a client not known to be contagious, but undergoing blood checks for hepatitis A

Due to the sensitive nature of reporting diseases and infections caused by blood-borne viruses, the enforcing authority does not require you to name the injured person on the RIDDOR report.

However, if the enforcing authority decides to investigate, you may be asked to provide this information. If it is a repeat incident to the same person, you need to inform the enforcing authority.

Injuries and ill health involving people not at work

This section covers accidents which result in a person not at work suffering an injury and being taken to a hospital, or if the accident happens at a hospital, suffering a specified injury which would have required hospital treatment.

Any injury to someone not at work must be reported if it results from an accident arising out of or in connection with work being undertaken by others and it:

- results in them being taken from the premises where the accident occurred directly to a hospital for treatment*, by whatever means (for example by taxi, private car or ambulance); or
- happens at a hospital and involves a specified injury

In the past, there has been some misunderstanding as to the range of accidents that should be reported under RIDDOR when they involve members of the public who are residents, residents, residents or visitors

The following examples are to help decide about reportability.

Injuries to people not at work

Reportable

- a client is scalded by hot bath water and taken to hospital for treatment, the client was vulnerable and adequate precautions were not taken
- a client receives a fractured arm when their arm becomes trapped in a bed rail
- a visitor to the main office is struck on the head by a car park barrier and receives a specified injury that requires hospital attention
- a client requires hospital treatment after sliding through a sling after being hoisted from a chair, the wrong-sized sling was used.

Not reportable

- a client or visitor is injured by an act of physical violence from another client
- a client receives a healthcare-associated infection while receiving treatment in hospital. Hospital associated infections acquired by residents are not reportable under RIDDOR.
- a client admitted to hospital for treatment contracts Legionnaires' disease in hospital

Client falls incidents

A fall is reportable under RIDDOR when it has **arisen out of or in connection with a work activity**. This includes where equipment or the work environment (including how or where work is carried out, organised or supervised) are involved.

Reportable

- a confused client falls from a hospital window on an upper floor and is badly injured
- a client falls out of bed, is injured and taken to hospital. The assessment identified the need for bedrails but they, or other preventative measures, had not been provided
- a client trips over a loose or damaged carpet in the hallway

Not reportable

- A client falls and breaks a leg. They were identified as not requiring special supervision or falls prevention equipment. There are no slips or trips obstructions or defects in the premises or environment, nor any other contributory factors.
- A client falls out of bed and is taken to hospital. There was a detailed assessment in the care plan identifying that fall protection was not required.
- A client is found on the floor, no-one has seen it happen, and/or there are no obvious work-related contributing factors. There was a detailed assessment in the care plan, which identified that fall protection was not required.

In some circumstances, it may not be clear whether the accident that caused the injury arose out of or was connected to the work activity. Other examples are:

Example1

Reportable

A client (who is capable of understanding and following advice) falls off the toilet, having previously been advised not to get up, is injured and taken to hospital. They have been left alone for dignity reasons. Their care plan identified that the individual should have assistance or supervision.

The member of staff left the client and had not responded promptly when they called. Adequate supervision had not been provided.

Not Reportable

The member of staff returned to help them as soon as they called to say they have finished. Or if the client had got up without calling for help, it would not be reportable.

Example 2

An incontinent client slips on their own urine when returning back from the toilet and receives a major injury.

Reportable if:

- the assessment had identified the client needed help for toileting and it was not provided
- the fall took place in an area of the home where it was foreseeable that the client may slip due to a spillage and the home had failed to assess risks from floor surfaces or act on their assessment

Self-Harm

Acts of deliberate self-harm are not considered “accidents” and are not RIDDOR reportable.

Dangerous occurrences

Reportable dangerous occurrences include the following:

- the collapse, overturning or failure of load-bearing parts of lifts and lifting equipment
- the accident releases an escape of any substance which may cause a major injury or damage to health
- an explosion or fire causing suspension of normal work for over 24 hours

Reportable

A client’s hoist collapses or overturns

Not Reportable

A lifting sling fails during a lift. You don’t need to report failures of lifting accessories.

Other Regulators

Care Quality Commission (CQC) requires Notification for specific incidents or accidents for the provider to comply with Regulation 20 “Duty of Candour”.

Related Policies

Control of Substances Hazardous to Health (COSHH)

Fire Safety

Health and Safety

Moving and Handling

Notifications

Personal Safety

Restraint

Training Statement

All employees of the organisation will be given adequate training and information on accidents at work and how to avoid them. Such training should focus on specific risk areas. All new staff should be encouraged to read the policy on health and safety and on accident reporting as part of their induction process. In addition, all staff will be appropriately trained to perform their duties safely and competently and those staff that need to use specialist equipment will be fully trained and supervised while they are developing their competency

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 31/01/18

Review Date: 30/06/18

ADULT SAFEGUARDING

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ADULT SAFEGUARDING

Constantia Care Ltd

1.0 Policy Statement

With the introduction of the Care Act 2014 changes came into place, which updated adult safeguarding in England. This adult safeguarding guidance replaced “No Secrets” in its entirety.

New safeguarding duties apply to an adult who:

- Has need for care and support (whether or not the local authority is meeting any of those needs; and
- Is experiencing, or at risk of abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

The above duties have a legal effect in relation to organisation other than the local authority e.g. the NHS or Police.

1.1 Multi- Agency Safeguarding (Adults) Protocol

All local authorities have updated their multi-agency safeguarding agreement to reflect these changes.

All Local Authorities are required to produce the above Guidance. When contracted with more than one authority we ensure all protocols are listed and followed.

As Constantia Care are a national live-in-care agency we have a comprehensive list of all Multi Agency Safeguarding teams accessible to staff and carers in the agency.

2.0 Care Act 2014

The changes introduced in April 2015 are fully detailed in the Care and Support Statutory Guidance issued under the Care Act 2014 (Chapter 14) of the Act.

This replaces current guidance and covers the following:

- Adult safeguarding, what it is and why it matters
- Abuse and neglect
 - What they are and spotting the signs;
 - Reporting and responding to abuse and neglect;
- Carers and adult safeguarding;
- Adult safeguarding procedures;
- Local authority’s role and multi-agency working;
- Criminal offences and adult safeguarding;
- Safeguarding enquiries;
- Safeguarding Adult Boards; (SABs)
- Safeguarding Adults Reviews (SARS);
- Information sharing, confidentiality and record keeping;
- Roles responsibilities and training in local authorities, the NHS and other agencies
- .

The government has also re issued the Care and Support Statutory Guidance May 9th, 2016 issued under the Care Act

As an organisation, we are aware of the changes within chapter 14 relation to Local Authorities roles and responsibilities

Please note:

Where someone is 18 years old or over but whose services are arranged via children services any safeguarding issue is dealt with via the adult safeguarding arrangement within the local authority or other statutory partner such as NHS or Police.

2.1 Definition of Vulnerable Adult

The term “vulnerable adult” is in itself contentious. By labelling adults “vulnerable” there is a danger that they will be treated differently.

The label can be stigmatising and result in assumptions that an individual is less able than others to make decisions and to determinate the cause of their lives. In this way, the term can level to subtle forms of in appropriate discrimination. Throughout this policy the distinction between adult with the capacity to make decisions and adults lacking capacity is emphasised. Adults who have capacity retain the right to make their own decisions and to direct their own lives. Adults lacking capacity to make decisions, though they retain the right to be involved in decision – making as far as possible nevertheless require decisions to be made on their own behalf and the overall approach shifts to promoting their best interests. The judgement that an adult is vulnerable should not be confused with a decision about their capacity. They are distinct questions although a lack of capacity will, ordinarily, contribute to an adult’s vulnerability.

2.2 Adult Safeguarding, what it is and why it matters:

- It is a means of protecting an adult’s safety, free from abuse and neglect. It means people and organisations working together to prevent and stop such abuse and neglect, whilst making sure that the adult’s wellbeing is promoted, including, where appropriate, due regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.
- Organisations should always promote the adult’s wellbeing in their safeguarding arrangements. People have complex lives and being safe is only one of the things they want for themselves. Professionals should work with the adult to establish what being safe means to them and how that can best be achieved. Professionals should not be advocating “safety” measures which do not take account of individual wellbeing as defined in chapter 1 of the Care and Support Statutory Guidance issued by the Department of Health.

2.3 Safeguarding is not a Substitute for:

- Providers responsibilities to provide safe and high-quality care and support;
- Commissioners regularly assuring themselves of the safety and effectiveness of commissioned services;
- The Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action; and
- The core duties of the Police to prevent and detect crime and protect life and property.

2.4 The Care Act requires that each authority must:

- Make enquiries or cause others to do so, if it believes an adult is experiencing, or is at risk of abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so by whom;
- Set up a Safeguarding Adults Board (SAB);
- Arrange where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has substantial difficulty in being involved in the process and where there is no other suitable person to present and support them;
- Co-operate with each of its relevant partners to protect the adult. In their turn each relevant partner must co-operate with the local authority.

2.5 Aims of Adult Safeguarding

The Act sets out the following which apply to all local authorities and their relevant partners. Relevant partners include NHS, Police, and Ambulance Service. Regulated or unregulated providers and all parties involved in the enquiry;

- Stop abuse or neglect wherever possible
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- Safeguard adults in a way that supports them in making choices and having control about how they want to live;
- Promote an approach that concentrates on improving life for the adults concerned;
- Raise public awareness so that communities, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect;
- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and
- Address what has caused the abuse or neglect.

The Care Act sets out the steps which local authorities must implement in order to meet the legal requirements of the Act. It is imperative that all staff become familiar with these requirements. Guidance developed by our local authority partners will be included in this policy as it becomes available. All Local Authorities will review and amend the Multi-Agency Safeguarding Protocol which is available from the Local Authorities safeguarding Adult Board (SAB) website. Any changes to training are incorporated with immediate effect.

2.6 The Six Principles that underpin all Adult Safeguarding.

Empowerment – People being supported and encouraged to make their own decision and informed consent. “I am asked what I want from the safeguarding process and these directly inform what happens”

Prevention – It is better to take action before harm occurs. “I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.”

Proportionality – The least intrusive response appropriate to the risk presented
“I am sure that the professionals will work in my interest, as I see them, they will only get involved as much as needed.”

Protection – Support and representation for those in greatest need.
“I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.

Partnership – Local solutions through services working with their communities have a part to play in preventing, detecting and reporting neglect and abuse. “I know that staff treat any personal or sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.”

Accountability – Accountability and transparency in delivering safeguarding.
“I understand the role of everyone involved in my life and so do they.”

These principles apply to all sectors and settings including care and support services, further education colleges, commissioning, regulation and provision of health and care services, social work, healthcare welfare benefits housing wider local authority function and the criminal justice system. The principles should inform the ways in which professionals and other staff work with adults. They can also help SABs and other organisation more widely, by using them to examine and improve their local arrangements. In addition to these principles the Act seeks to broaden a community approach to establishing their safeguarding arrangements. It is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals. We all have different preferences, histories, circumstances and lifestyles so it is unhelpful to prescribe a process that must be followed whenever a concern is raised; and the case study below helps illustrate this.

2.7 Case study

Two brothers with mild learning disabilities lived in their family home, where they had remained following the death of their parents sometime previously. Large amounts of rubbish had accumulated both in the garden and inside the house, with cleanliness and self-neglect an issue. They had been targeted by fraudsters, resulting in criminal investigation and conviction of those responsible, but the brothers had refused services from adult social care and the case closed.

They had however, a good relationship with their social worker, and as concerns about their health and wellbeing continued, it was decided that the social worker would maintain contact, calling in every couple of weeks to see how they were and offer any help to improve the state of their house, to sell it and moved to a living environment in which practical support could be provided.

3.0 Types of Abuse and Neglect

- **Physical abuse** – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.
- **Domestic violence** – including psychological, physical, sexual, financial, emotional abuse; so, called ‘honour’ based violence.
- **Sexual abuse** – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.
- **Psychological abuse** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.
- **Financial or material abuse** – including theft, fraud, internet scamming, coercion in relation to an adult’s financial affairs or arrangements, including regarding wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
- **Modern slavery** – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.
- **Discriminatory abuse** – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.
- **Organisational abuse** – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one’s own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.
- **Neglect and acts of omission** – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.
- **Self-neglect** – this covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding.

Incidents of abuse may be one-off or multiple, and affect one person or more. Professionals and others should look beyond single incidents or individuals to identify patterns of harm, just as the Care Quality Commission, as the regulator of service quality, does when it looks at the quality of care in health and care services. Repeated instances of poor care may be an indication of more serious problems and of what we now describe as organisational abuse. To see these patterns, it is important that information is recorded and appropriately shared.

3.1 Patterns of Abuse

- Serial abusing in which the perpetrator seeks out and 'grooms' individuals. Sexual abuse sometimes falls into this pattern as do some forms of financial abuse;
- long-term abuse in the context of an ongoing family relationship such as domestic violence between spouses or generations or persistent psychological abuse; or
- Opportunistic abuse such as theft occurring because money or jewellery has been left lying around.

Domestic abuse

In 2013, the Home Office announced changes to the definition of domestic abuse:

- Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse... by someone who is or has been an intimate partner or family member regardless of gender or sexuality
- Includes: psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence; Female Genital Mutilation; forced marriage.
- Age range extended down to 16.

Many people think that domestic abuse is about intimate partners, but it is clear that other family members are included and that much safeguarding work (that meets the criteria set out in paragraph 14.2) that occurs at home is, in fact concerned with domestic abuse. This confirms that domestic abuse approaches and legislation can be considered safeguarding responses in appropriate cases.

Within the Serious Crime Act 2015 a new offence of Coercive and Controlling Behaviour intimate and familial Relationships was introduced. This offence will incur a maximum of 5 years imprisonment or a fine or both.

Financial abuse

Financial abuse is the main form of abuse identified by the Office of the Public Guardian both amongst adults and children at risk. Financial recorded abuse can occur in isolation, but as research has shown, where there are other forms of abuse, there is likely to be financial abuse occurring. Although this is not always the case, everyone should also be aware of this possibility.

Where the abuse is by someone who has the authority to manage an adult's money, the relevant body should be informed, for example, the Office of the Public Guardian for deputies and Department for Work and Pensions (DWP) in relation to appointees.

Internet Scams, Postal Scams and Doorstep Crime are targeted at adults at risk and all are forms of financial abuse.

These scams are becoming ever more sophisticated and elaborate.

- Internet scammers can build very convincing websites
- people can be referred to a website to check the caller's legitimacy, but this can be a copy of a legitimate website
- postal scams are mass produced letters which are made to look like personal or important documents
- door step criminals call unannounced at the adult's home under the guise of legitimate business and offering to fix an often non-existent problem with their property
- sometimes they pose as a police officer or someone of authority

In all cases this is financial abuse and should always be reported to the local police forces or the local Authority trading Standard Services for investigating

3.2 Who Abuses or Neglects Adults?

Anyone can carry out abuse or neglect, including:

- spouses/partners;
- other family members;
- neighbours;
- friends;
- acquaintances;
- local residents;
- people who deliberately exploit adults they perceive as vulnerable to abuse;
- paid staff or professionals; and
- volunteers and strangers.

While a lot of attention is paid, for example, to targeted fraud or internet scams perpetrated by complete strangers, it is far more likely that the person responsible for abuse is known to the adult and is in a position of trust and power.

3.3 Spotting signs of abuse and Neglect

Workers across a wide range of organisations need to be vigilant about adult safeguarding concerns in all walks of life including, amongst others in health and social care, welfare, policing, banking, fire and rescue services and trading standards; leisure services, faith groups, and housing. GPs, in particular, are often well-placed to notice changes in an adult that may indicate they are being abused or neglected.

Findings from Serious Case Reviews have sometimes stated that if professionals or other staff had acted upon their concerns or sought more information, then death or serious harm might have been prevented. The following example illustrates that someone who might not typically be thought of, in this case the neighbour, does in fact have an important role to play in identifying when an adult is at risk.

3.4 Case study

Mr A is in his 40s, and lives in a housing association flat with little family contact. His mental health is relatively stable, after a previous period of hospitalisation, and he has visits from a mental health support worker. He rarely goes out, but he lets people into his accommodation because of his loneliness. The police were alerted by Mr A's neighbours to several domestic disturbances. His accommodation had been targeted by a number of local people and he had become subjected to verbal, financial and sometime physical abuse.

Although Mr A initially insisted they were his friends, he did indicate he was frightened; he attended a case conference with representatives from adult social care, mental health services and the police, from which emerged a plan to strengthen his own self-protective ability as well as to deal with the present abuse. Mr A has made different arrangements for managing his money so that he does not accumulate large sums at home. A community-based visiting service has been engaged to keep him company through visits to his home, and with time his support worker aims to help get involved in social activities that will bring more positive contacts to allay the loneliness that Mr A sees as his main challenge.

It is important that all staff learn to ask, "Is this safe?" If it's not, then where are the risks? Can they be managed or mitigated or is an immediate response required.

Anyone can witness or become aware of information suggesting that abuse and neglect is occurring. The matter may, for example, be raised by a worried neighbour (see above case study), a concerned bank cashier, a GP, a welfare benefits officer, a housing support worker or a nurse on a ward. Primary care staff may be particularly well-placed to spot abuse and neglect, as in many cases they may be the only professionals with whom the adult has contact.

The adult may say or do things that hint that all is not well. It may come in the form of a complaint, a call for a police response, an expression of concern, or come to light during a needs assessment. Regardless of how the safeguarding concern is identified, everyone

should understand what to do, and where to go locally to get help and advice. It is vital that professionals, other staff and members of the public are vigilant on behalf of those unable to protect themselves.

This will include:

- knowing about different types of abuse and neglect and their signs;
- supporting adults to keep safe;
- knowing who to tell about suspected abuse or neglect; and
- supporting adults to think and weigh up the risks and benefits of different options when exercising choice and control.

Awareness campaigns for the general public and multi-agency training for all staff will contribute to achieving these objectives.

4.0 The Mental Capacity Act 2005

People must be assumed to have capacity to make their own decisions and be given all practicable help before anyone treats them as not being able to make their own decisions. Where an adult is found to lack capacity to make a decision then any action taken, or any decision made for, or on their behalf, must be made in their best interests.

Professionals and other staff need to understand and always work in line with the Mental Capacity Act 2005 (MCA). They should use their professional judgement and balance many competing views. They will need considerable guidance and support from their employers if they are to help adults manage risk in ways and put them in control of decision making if possible.

Regular face-to-face supervision from skilled managers is essential to enable staff to work confidently and competently in difficult and sensitive situations.

Mental capacity is frequently raised in relation to adult safeguarding. The requirement to apply the MCA in adult safeguarding enquiries challenges many professionals and requires utmost care, particularly where it appears an adult has capacity for making specific decisions that nevertheless places them at risk of being abused or neglected.

The MCA created the criminal offences of ill-treatment and wilful neglect in respect of people who lack the ability to make decisions. The offences can be committed by anyone responsible for that adult's care and support paid staff but also family carers as well as people who have the legal authority to act on that adult's behalf (i.e. persons with power of attorney or Court-appointed deputies).

These offences are punishable by fines or imprisonment. Ill-treatment covers both deliberate acts of ill-treatment and also those acts which are reckless which results in ill-treatment. Wilful neglect requires a serious departure from the required standards of treatment and usually means that a person has deliberately failed to carry out an act that they knew they were under a duty to perform.

Abuse by an attorney or deputy: If someone has concerns about the actions of an attorney acting under a registered Enduring Power of Attorney (EPA) or Lasting Power of Attorney (LPA), or a Deputy appointed by the Court of Protection, they should contact the Office of the Public Guardian (OPG). The OPG can investigate the actions of a Deputy or Attorney and can also refer concerns to other relevant agencies. When it makes a referral, the OPG will make sure that the relevant agency keeps it informed of the action it takes. The OPG can also make an application to the Court of Protection if it needs to take possible action against the attorney or deputy. Whilst the OPG primarily investigates financial abuse, it is important to note that it also has a duty to investigate concerns about the actions of an attorney acting under a health and welfare Lasting Power of Attorney or a personal welfare deputy. The OPG can investigate concerns about an attorney acting under a registered Enduring or Lasting Power of Attorney, regardless of the adult's capacity to make decisions.

5.0 Reporting and responding to Abuse and Neglect

It is important to understand the circumstances of abuse, including the wider context such as whether others may be at risk of abuse, whether there is any emerging pattern of abuse, whether others have witnessed abuse and the role of family members and paid staff or professionals.

The circumstances surrounding any actual or suspected case of abuse or neglect will inform the response. For example, it is important to recognise that abuse or neglect may be unintentional and may arise because a carer is struggling to care for another person. This makes the need to act no less important, but in such circumstances, an appropriate response could be a support package for the carer and monitoring.

However, the primary focus must still be how to safeguard the adult. In other circumstances where the safeguarding concerns arise from abuse or neglect deliberately intended to cause harm, then it would not only be necessary to immediately consider what steps are needed to protect the adult but also whether to refer the matter to the police to consider whether a criminal investigation would be required or appropriate.

The nature and timing of the intervention and who is best placed to lead will be, in part, determined by the circumstances. For example, where there is poor, neglectful care or practice, resulting in pressure sores for example, then an employer-led disciplinary response may be more appropriate; but this situation will need additional responses such as clinical intervention to improve the care given immediately and a clinical audit of practice. Commissioning or regulatory enforcement action may also be appropriate.

Early sharing of information is the key to providing an effective response where there are emerging concerns.

To ensure effective safeguarding arrangements:

- all organisations must have arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals and the SAB; this could be via an Information Sharing Agreement to formalise the arrangements; and,
- no professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If a professional has concerns about the adult's welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information with the local authority and, or, the police if they believe or suspect that a crime has been committed.

6.0 Local Authority's role in carrying out enquiries

Local authorities must make enquiries, or cause others to do so, if they reasonably suspect an adult who meets the criteria at paragraph 14.2 is, or is at risk of, being abused or neglected.

An enquiry is the action taken or instigated by the local authority in response to a concern that abuse, or neglect may be taking place. An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate, prior to initiating a formal enquiry under section 42, right through to a much more formal multi-agency plan or course of action.

Whatever the course of subsequent action, the professional concerned should record the concern, the adult's views and wishes, any immediate action that has been taken and the reasons for those actions.

The purpose of the enquiry is to decide whether or not the local authority or another organisation, or person, should do something to help and protect the adult. If the local authority decides that another organisation should make the enquiry, for example a care provider, then the local authority should be clear about timescales, the need to know the outcomes of the enquiry and what action will follow if this is not done.

What happens as a result of an enquiry should reflect the adult's wishes wherever possible, as stated by them or by their representative or advocate. If they lack capacity it should be in their best interests if they are not able to make the decision, and be proportionate to the level of concern.

The adult should always be involved from the beginning of the enquiry unless there are exceptional circumstances that would increase the risk of abuse. If the adult has substantial difficulty in being involved, and where there is no one appropriate to support them, then the local authority must arrange for an independent advocate to represent them for facilitating their involvement.

Professionals and other staff need to handle enquiries in a sensitive and skilled way to ensure distress to the adult is minimised. It is likely that many enquiries will require the input and supervision of a social worker, particularly the more complex situations and to support the adult to realise the outcomes they want and to reach a resolution or recovery.

For example, where abuse or neglect is suspected within a family or informal relationship it is likely that a social worker will be the most appropriate lead. Personal and family relationships within community settings can prove both difficult and complex to assess and intervene in.

The dynamics of personal relationships can be extremely difficult to judge and rebalance.

For example, an adult may make a choice to be in a relationship that causes them emotional distress which outweighs, for them, the unhappiness of not maintaining the relationship.

Whilst work with the adult may frequently require the input of a social worker, other aspects of enquiries may be best undertaken by others with more appropriate skills and knowledge.

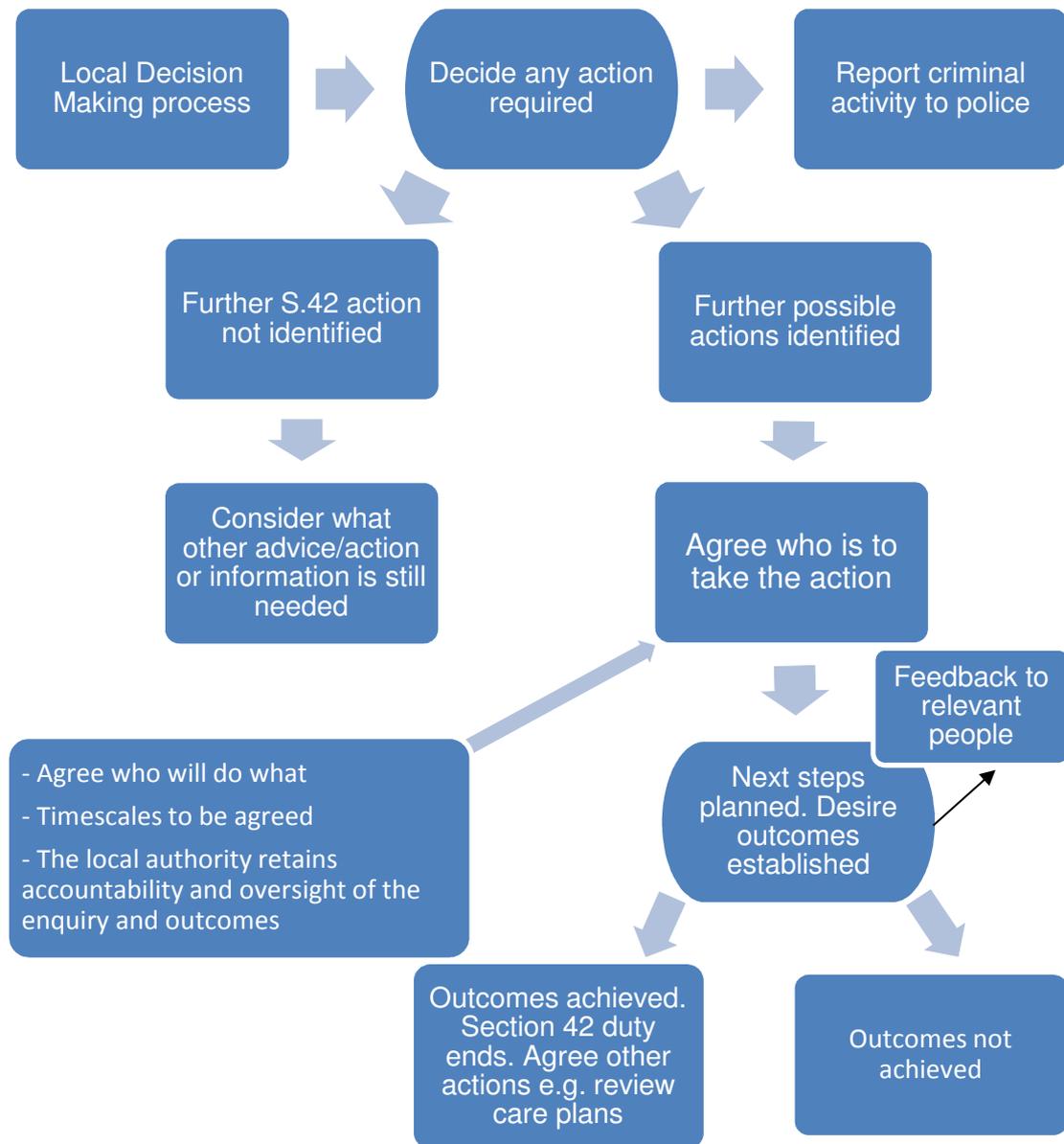
For example, health professionals should undertake enquiries and treatment plans relating to medicines management or pressure sores.

For clarity: Section 42 Enquiries are the mechanism for Safeguarding Enquiries as set out in the Care Act 2014 Chapter 14. It is a legal duty on local authorities to make enquiries or causes someone else to make enquiries.

6.1 INFORMATION GATHERING DIAGRAM



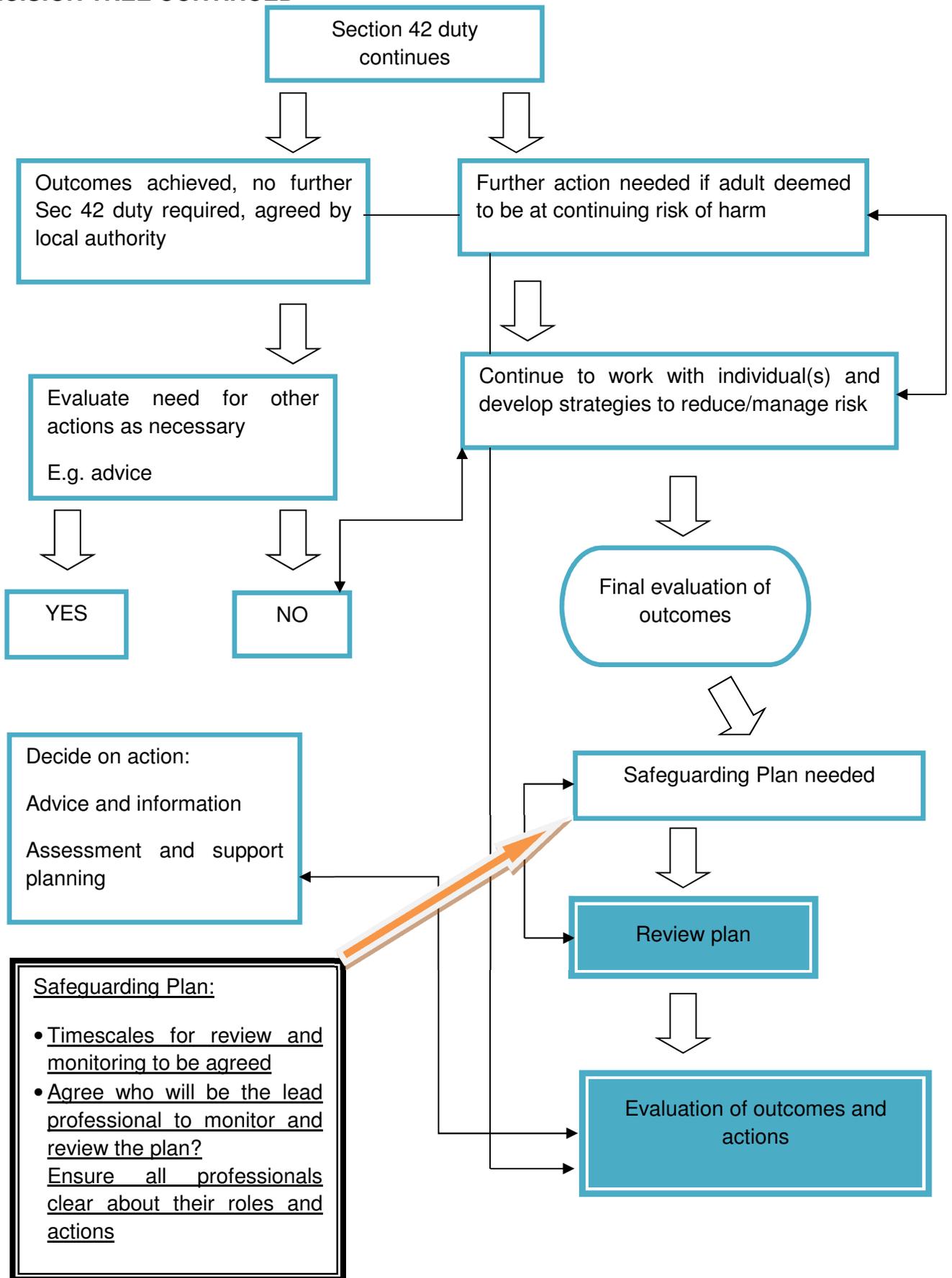
6.2 DECISION MAKING TREE



Principles

- Empowerment – Presumption of person led decisions and informed consent
- Prevention – It is better to take action before harm occurs.
- Proportionate and least intrusive response appropriate to the risk presented
- Protection – Support and representation for those in greatest need.
- Partnership – Local solutions through service working with their communities.
- Communities – have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability and transparency in delivering safeguarding
- Feeding back whenever possible

DECISION TREE CONTINUED



7.0 Procedures for responding in individual cases

7.1 When should an enquiry take place?

Local authorities must make enquiries, or cause another agency to do so, whenever abuse or neglect are suspected in relation to an adult and the local authority thinks it necessary to enable it to decide what (if any) action is needed to help and protect the adult. The scope of that enquiry, who leads it and its nature, and how long it takes, will depend on the circumstances.

It will usually start with asking the adult their view and wishes which will often determine what next steps to take. Everyone involved in an enquiry must focus on improving the adult's well-being and work together to that shared aim. At this stage, the local authority also has a duty to consider whether the adult requires an independent advocate to represent and support the adult in the enquiry. The decision-making tree at highlights appropriate pauses for reflection, consideration and professional judgment and reflects the different routes and actions that might be taken.

Objectives of an enquiry

The objectives of an enquiry into abuse or neglect are to:

- establish facts
- ascertain the adult's views and wishes
- assess the needs of the adult for protection, support and redress and how they might be met
- protect from the abuse and neglect, in accordance with the wishes of the adult
- make decisions as to what follow-up action should be taken regarding the person or organisation responsible for the abuse or neglect
- enable the adult to achieve resolution and recovery

The priority should always be to ensure the safety and well-being of the adult. The adult should experience the safeguarding process as empowering and supportive. Practitioners should wherever practicable seek the consent of the adult before taking action. However, there may be circumstances when consent cannot be obtained because the adult lacks the capacity to give it, but it is in their best interests to undertake an enquiry.

Whether or not the adult has capacity to give consent, action may need to be taken if others are or will be put at risk if nothing is done or where it is in the public interest to take action because a criminal offence has occurred. It is the responsibility of all staff and members of the public to act on any suspicion or evidence of abuse or neglect and to pass on their concerns to a responsible person or agency.

BMA Adult safeguarding toolkit:

"...where a competent adult explicitly refuses any supporting intervention, this should normally be respected. Exceptions to this may be where a criminal offence may have taken place or where there may be a significant risk of harm to a third party.

If, for example, there may be an abusive adult in a position of authority in relation to other vulnerable adults [sic], it may be appropriate to breach confidentiality and disclose information to an appropriate authority.

Where a criminal offence is suspected it may also be necessary to take legal advice. Ongoing support should also be offered. Because an adult initially refuses the offer of assistance he or she should not therefore be lost to or abandoned by relevant services. The situation should be monitored and the individual informed that she or he can take up the offer of assistance at any time."

7.2 Who can carry out an enquiry?

Although the local authority is the lead agency for making enquiries, it may require others to undertake them. The specific circumstances will often determine who the right person to begin an enquiry is. In many cases a professional who already knows the adult will be the best person. They may be a social worker, a housing support worker, a GP or other health worker such as a community nurse.

The local authority retains the responsibility for ensuring that the enquiry is referred to the right place and is acted upon. The local authority, in its lead and coordinating role, should assure itself that the enquiry satisfies its duty under section 42 to decide what action (if any) is necessary to help and protect the adult and by whom and to ensure that such action is taken when necessary.

In this role if the local authority has asked someone else to make enquiries, it is able to challenge the body making the enquiry if it considers that the process and/or outcome is unsatisfactory.

Where a crime is suspected and referred to the police, then the police must lead the criminal investigations, with the local authority's support where appropriate, for example by providing information and assistance. The local authority has an ongoing duty to promote the wellbeing of the adult in these circumstances.

7.3 Case study

Mr A is 24 and has autism and a mild learning disability. He is a very friendly and sociable young man who is prone to waving and talking to most people he comes across, seeing everyone as a potential friend. However, due to his disabilities, he struggles to read the intentions of others and is easily led astray and manipulated. He lives next door to a pub, where he knows the staff and the regulars. He also lives close to his GP, and is able to access his most frequently visited places. He does, however, like to walk into town to talk to people he meets out and about.

On such occasions he has been repeatedly tricked into stealing items from a newsagent by a group of teenagers and given large amounts of money away to strangers he strikes up conversations with.

Due to his previous experiences, Mr A was identified during a needs assessment as being at risk of abuse and neglect. A safeguarding enquiry was triggered. The council found that, although Mr A was not currently experiencing abuse or neglect, he remained highly vulnerable to abuse due to his disabilities. To assure his safety in the future, a safeguarding plan was agreed between Mr A and a social worker.

This focused on developing his social skills and understanding of relationships and boundaries and the social worker worked with Mr A to consider various support options such as having a buddy or circle of support. The social worker put Mr A in touch with an autism social group which provided sessions on skills for staying safe. As the group was based in town, Mr A's plan also included a support worker to accompany him. After the first 5 sessions Mr A was able to attend himself but continued to meet with his support worker on a monthly basis as part of the risk management strategy set out in his safeguarding plan.

7.4 What happens after an enquiry?

Once the wishes of the adult have been ascertained and an initial enquiry undertaken, discussions should be undertaken with them as to whether further enquiry is needed and what further action could be taken.

That action could take a number of courses: it could include disciplinary, complaints or criminal investigations or work by contracts managers and CQC to improve care standards. Those discussions should enable the adult to understand what their options might be and how their wishes might best be realised. Social workers must be able to set out both the civil and criminal justice approaches that are open and other approaches that might help to promote their wellbeing, such as therapeutic or family work, mediation and conflict resolution, peer or

circles of support. In complex domestic circumstances, it may take the adult some time to gain the confidence and self-esteem to protect themselves and take action and their wishes may change. The police, health service and others may need to be involved to help ensure these wishes are realised.

7.5 Safeguarding Plans

Once the facts have been established, a further discussion of the needs and wishes of the adult is likely to take place. This could be focused safeguarding planning to enable the adult to achieve resolution or recovery, or fuller assessments by health and social care agencies (e.g. a needs assessment under the Care Act). This will entail joint discussion, decision taking and planning with the adult for their future safety and well-being.

This applies if it is concluded that the allegation is true or otherwise, as many enquiries may be inconclusive.

The local authority must determine what further action is necessary. Where the local authority determines that it should itself take further action (e.g. a protection plan), then the authority would be under a duty to do so.

The MCA is clear that local authorities must presume that an adult has the capacity to make a decision until there is a reason to suspect that capacity is in some way compromised; the adult is best placed to make choices about their wellbeing which may involve taking certain risks. Of course, where the adult may lack capacity to make decisions about arrangements for enquiries or managing any abusive situation, then their capacity must always be assessed and any decision made in their best interests.

If the adult has the capacity to make decisions in this area of their life and declines assistance, this can limit the intervention that organisations can make. The focus should therefore be, on harm reduction. It should not however limit the action that may be required to protect others who are at risk of harm. The potential for 'undue influence' will need to be considered if relevant. If the adult is thought to be refusing intervention on the grounds of duress, then action must be taken.

To make sound decisions, the adult's emotional, physical, intellectual and mental capacity in relation to self-determination and consent and any intimidation, misuse of authority or undue influence will have to be assessed.

8.0 Information sharing

8.1 Record Keeping

Good record keeping is a vital component of professional practice. Whenever a complaint or allegation of abuse is made, all agencies should keep clear and accurate records and each agency should identify procedures for incorporating, on receipt of a complaint or allegation, all relevant records into a file to record all action taken.

When abuse or neglect is raised managers need to look for past incidents, concerns, risks and patterns. We know that in many situations, abuse and neglect arise from a range of incidents over a period of time. In the case of providers registered with CQC, records of these should be available to service commissioners and the CQC so they can take the necessary action.

Staff should be given clear direction as to what information should be recorded and in what format.

The following questions are a guide:

- What information do staff need to know in order to provide a high-quality response to the adult concerned?
- What information do staff need to know in order to keep adults safe under the service's duty to protect people from harm?
- What information is not necessary?
- What is the basis for any decision to share (or not) information with a third party?

Records should be kept in such a way that the information can easily be collated for local use and national data collections.

All agencies should identify arrangements, consistent with principles and rules of fairness, confidentiality and data protection for making records available to those adults affected by, and subject to, an enquiry. If the alleged abuser is using care and support themselves, then information about their involvement in an adult safeguarding enquiry, including the outcome, should be included in their case record. If it is assessed that the individual continues to pose a threat to other people, then this should be included in any information that is passed on to service providers or other people who need to know.

To carry out its functions, SABs will need access to information that a wide number of people or other organisations may hold. Some of these may be SAB members, such as the NHS and the police. Others will not be, such as private health and care providers or housing providers/housing support providers or education providers.

In the past, there have been instances where the withholding of information has prevented organisations being fully able to understand what “went wrong” and so has hindered them identifying, to the best of their ability, the lessons to be applied to prevent or reduce the risks of such cases reoccurring. If someone knows that abuse or neglect is happening they must act upon that knowledge, not wait to be asked for information.

An SAB may request a person to supply information to it or to another person.

The person who receives the request must provide the information provided to the SAB if:

- the request is made to enable or assist the SAB to do its job;
- the request is made of a person who is likely to have relevant information and then either:
 - I. the information requested relates to the person to whom the request is made and their functions or activities or;
 - II. the information requested has already been supplied to another person subject to an SAB request for information.

8.2 Confidentiality

Agencies should draw up a common agreement relating to confidentiality and setting out the principles governing the sharing of information, based on the welfare of the adult or of other potentially affected adults.

Any agreement should be consistent with the principles set out in the Caldicott Review published 2013 ensuring that:

- information will only be shared on a ‘need to know’ basis when it is in the interests of the adult;
- confidentiality must not be confused with secrecy;
- informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement; and
- it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk.

Where an adult has refused to consent to information being disclosed for these purposes, then practitioners must consider whether there is an overriding public interest that would justify information sharing (e.g. because there is a risk that others are at risk of serious harm) and wherever possible, the appropriate Caldicott Guardian should be involved.¹⁹⁹

Decisions about who needs to know and what needs to be known should be taken on a case by case basis, within agency policies and the constraints of the legal framework.

Principles of confidentiality designed to safeguard and promote the interests of an adult should not be confused with those designed to protect the management interests of an organisation. These have a legitimate role but must never be allowed to conflict with the welfare of an adult. If it appears to an employee or person in a similar role that such confidentiality rules may be operating against the interests of the adult, then a duty arises to make full disclosure in the public interest.

In certain circumstances, it will be necessary to exchange or disclose personal information which will need to be in accordance with the law on confidentiality and the Data Protection Act 1998 where this applies. The Home Office and the Office of the Information Commissioner.

8.3 Front-line Staff

Operational front-line staff are responsible for identifying and responding to allegations of abuse and substandard practice. Staff at operational level need to share a common view of what types of behaviour may be abuse or neglect and what to do as an initial response to a suspicion or allegation that it is or has occurred. This includes GPs. It is employers' and commissioners' duty to set these out clearly and reinforce regularly.

It is not for front line staff to second-guess the outcome of an enquiry in deciding whether to share their concerns. There should be effective and well-publicised ways of escalating concerns where immediate line managers do not take action in response to a concern being raised.

Concerns about abuse or neglect must be reported whatever the source of harm. It is imperative that poor or neglectful care is brought to the immediate attention of managers and responded to swiftly, including ensuring immediate safety and well-being of the adult. Where the source of abuse or neglect is a member of staff it is for the employer to take immediate action and record what they have done and why (similarly for volunteers and or students).

There should be clear arrangements in place about what each agency should contribute at this level. These will cover approaches to enquiries and subsequent courses of action. The local authority is responsible for ensuring effective co-ordination at this level.

Case study a resident at a local care home told the district nurse that staff members spoke disrespectfully to her and that there were episodes of her waiting a long time for the call bell to be answered when wanting to use the commode. The resident wished to leave the home as she was very unhappy with the treatment she was receiving, and was regularly distressed and tearful. The resident was reluctant for a formal safeguarding enquiry to take place, but did agree that the issues could be discussed with the manager. The district nurse negotiated some actions with the manager to promote good practice and address the issues that had been raised. When the district nurse reviewed the situation; the manager at the care home had dealt with the issues appropriately and devised an action plan. The resident stated that she was now happy at the care home – staff 'couldn't be more helpful' and she no longer wanted to move.

Set out below is this organisation's response to the changes explained above. It is important to emphasise the evolving nature of these changes, in particular, the relevance of local authority issued guidance and the impact on providers generally. It is therefore essential that this policy is developed, reviewed and amended as necessary during 2015 to ensure that all guidance is fully understood and embedded within this policy.

9.0 Safeguarding Adult Boards (SABs)

Local authorities have begun to implement some of the changes and Safeguarding Adult Boards (SABs) have been set up locally. Each SAB will be set up via their local authority and therefore the mechanisms may be different.

They are the strategic arm of the safeguarding team and have three core duties:

- It **must** publish a strategic plan for each financial year that sets out how it will meet its main objective and what the members will do to community involvement, and the SAB must consult with the local Health watch organisation. The plan must be evidence based and make use of all available evidence and intelligence from partners to form and develop its plan.
- It **must** publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the finding of any safeguarding Adult Reviews (SARs) and subsequent action.
- It **must** conduct any Safeguarding Action Review in accordance with Section 44 of the Act

The collaboration and cooperation of all partner agencies, including providers is core to the guidance including relevant information sharing when requested.

9.1 Safeguarding Adults Reviews (SARs)

SABs **must** arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

SABs **must** also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

The Policy

10.0 Making Enquiries

Making enquiries is the term now used as a response to any adult safeguarding concern and the following procedures are in place for all staff who need to report an adult safeguarding concern. As new guidance is issued by our local authority partners, based on the new framework for Adult Safeguarding within the Care Act 2014, becomes available the current guidance issued by this organisation has been amended to reflect the new regulatory framework which is detailed in Chapter 14 of the Care and Support Statutory Guidance October 2014.

This replaces “No secrets” 2002 which was revoked in its entirety on 1st April 2015.

10.1 Staff – How to Report a Safeguarding Concern

Any suspicion of a safeguarding situation must be reported as a matter of course, to the Registered Manager or in their absence, to the senior manager on duty at the time.

THE DESIGNATED SAFEGUARDING LEAD AT CONSTANTIA CARE is Emma Elias.

It is your duty to report any such allegation and the appropriate manager will then take advice and follow the appropriate guidance.

If the safeguarding concern involves the manager, the report should be made to the **named Manager**, who will then take advice and follow the appropriate guidance.

The requirement is to report an allegation of concern and if there is anything else required from the staff member reporting the allegation this will be requested as appropriate.

It is good practice, as soon as is possible for contemporaneous notes to be recorded for future reference.

Where required, support should be given to the staff member dependent upon the situation, their response and the urgency of the situation.

10.2 Clients – how to report a Safeguarding Concern

During the information gathering process within our quality assurance systems clients and or their representatives need to be informed and asked about any inappropriate behaviour verbal or physical that they have observed or been subject to by their carer or visitors. This needs to be handled in a sensitive manner.

As part of the information given to new clients and or their representatives our Client Guide explains and details how to report a safeguarding concern.

Information on raising a safeguarding concern can also be found at the back of the clients Care Plan in their home

Clients and or their representatives can inform any carer on duty at any time of their concerns. Carer will then report to the designated care co-ordinator.

10.3 The Role of the Manager

An immediate assessment of the alleged abuse should be undertaken by the manager in relation to the following:

- The health safety and wellbeing of the adult.
- Their needs preference and wishes concerning any action to be considered.
- Their mental capacity to understand, comprehend and make decisions regarding the actions to be considered.

From this assessment, the manager will then take further advice, or, institute steps to ensure the protection and safeguarding of the adult; as appropriate; with immediate effect. This will include notifying the local safeguarding team and police if required.

The manager, in this context, is the person to whom the concern has been reported to, whether during office hours or out of hours. They will be the Responsible Manager until they are informed otherwise. Records and notes of all actions should be taken. This includes any advice given to the Responsible Manager by any triage arrangements that are in place.

10.4 The Role of the Local Authority

All local authorities have a legal duty to make enquiries or cause another agency to do so, whenever abuse or neglect is suspected in relation to an adult. The nature, scope, how long it takes and who leads it will depend on the circumstances presented. Everyone involved in an enquiry must focus on improving the adult's wellbeing and work together to that shared aim.

The objectives of the enquiry are to:

- Establish fact;
- Ascertain the Adult's views and wishes;
- Assess the needs of the adult for protection, support and redress and how they might be met;
- Protect from abuse and neglect, in accordance with the wishes of the adult;
- Make decisions as to what follow up action should be taken regarding the person or organisation responsible for the abuse or neglect; and
- Enable the adult to achieve resolution and recovery

The priority must always be to ensure the safety and wellbeing of the adult. It is the responsibility of all staff and members of the public to act on any suspicion or evidence of concerns to a responsible person or agency.

Please note the following:

"Where a competent adult explicitly refuses any supporting intervention, this should normally be respected. Exceptions to this may be where a criminal offence may have taken place or where there may be a significant risk of harm to a third party. If for example, there may be an abuse adult in a position of authority in relation to other vulnerable adults (sic), it may be appropriate to breach confidentiality and disclose information to an appropriate authority. Where criminal offence is suspected it may also be necessary, to take further advice. Ongoing support should also be offered. Because an adult initially refuses the offer of assistance they should not therefore be lost to or abandoned by relevant services. The situation should be monitored and the individual informed that they can take up the offer of assistance at any time.

11.0 Statutory Notifications to CQC

A Statutory Notification is sent to CQC concerning any abuse or alleged abuse involving a person(s) using our service. This includes where the person(s) is either the victim(s) or the abuser(s), or both. We notify CQC about abuse or alleged abuse at the same time as alerting our local safeguarding authority for children or adults, and the police where a crime has been or may have been committed.

The person submitting the Statutory Notification must use the electronic form supplied on CQC website to notify both alleged and actual abuse and email the form to CQC at the address stated on the form. <http://www.cqc.org.uk/content/notifications>

Providers Guidance -Statutory Notifications for non-NHS trust providers

The CQC website is regularly checked to ensure the above guidance we use is up to date.

12.0 Restrictive Interventions

This policy and our organisational responses to restrictive practices reflects the guidelines in the document below.

Positive and Proactive Care: reducing the need for restrictive interventions

Prepared by the Department of Health. Published in April 2014.

This guidance is of significance for health and social care services where individuals who are known to be at risk of being exposed to restrictive interventions are cared for. Such settings may provide services to people with mental health conditions, autistic spectrum conditions, learning disability, dementia and/or personality disorder, older people and detained clients.

It is more broadly applicable across general health and social care settings where people using services may on occasion present with behaviour that challenges but which cannot reasonably be predicted and planned for on an individual basis.

13.0 Related Policies

Challenging Behaviour, Violence and Aggression

Confidentiality

Data Protection

Deprivation of Liberty Safeguards

Duty of Candour

Female Genital Mutilation

Financial Irregularities

Handling of money - clients

Handling of money – clients who lack capacity

Meeting Needs

Mental Capacity Act 2005

Notifications

Position of Trust

Radicalisation

Record Keeping

Restrain

Safeguarding children in an Adult Setting

Whistleblowing

Guidance

- Local Authority Multi-Agency Adult Safeguarding Guidance/ Protocol
- Local Safeguarding Adults Reviews / SARs
- **Older people with social care needs and multiple long-term conditions [NG 22] Published November 2015**

This guideline covers planning and delivery of social care and support for older people who have multiple long-term conditions. It promotes an integrated and person-centred approach to delivering effective health and social care services. As an organisation, we are working towards ensuring these guidelines are implemented, proportionate to our service, using the tools and resources available from NICE.

14.0 Training Statement

All staff will be made aware of the changes outlined above. This will include the Multi-Agency Safeguarding Agreement from the local authority, as amended. Adult Safeguarding training is part of Induction and staff and carers will complete annual Adult Safeguarding training along with training relevant to any of the above related policies.

This policy will be reviewed by the Register Manager.

Signed: *Morag Collier*

Date: 20/02/18

Review date: 20/08/18

ADVANCE CARE PLANNING

Constantia Care Ltd

Policy Statement

Constantia Care seeks to ensure that Advance Care Planning is a service that meets and supports the needs of its clients, their families and the wider community. Ours is an ageing society in which the dying phase is being extended and in many cases being entered into imperceptibly. Key factors such as family structures, different models of family life mean that services at the end of life are often provided by social care providers.

This policy clarifies how we will work in conjunction with multi-agency partners in order to ensure that we play our part when required to deliver quality, person-centred Advance Care Planning.

The Policy

Constantia Care with its multi-agency partners will work to ensure that the Advance Care Planning: A Guide for Health and Social Care staff: issued by NHS and University of Nottingham will be at the core of how we deliver this service.

Key principles of Advance Care Planning Process (ACP)

- The process is voluntary. No pressure should be brought to bear by the professional, the family or any organisation on the client concerned to take part in ACP
- ACP must be a person centred dialogue over a period of time
- The process of ACP is a reflection of society's desire to respect personal autonomy. The content of any discussion should be determined by the client concerned. The client may not wish to confront future issues; this should be respected
- All health and social care staff should be open to any discussion which may be instigated by an client and know how to respond to their questions
- Health and social care staff should instigate ACP only if in the context of professional judgement that leads them to believe it is likely to benefit the care of the client. The discussion should be introduced sensitively
- Carers will require the appropriate training to enable them to communicate effectively and to understand the legal and ethical issues involved
- Carers need to be aware when they have reached the limits of their knowledge and competence and know when and from whom to seek advice.
- Discussion should focus on the views of the client, although they may wish to invite their carer or another close family member or friend to participate. Some families may have discussed the issues and would welcome an approach to share this discussion
- Confidentiality should be respected in line with current good practice and professional guidance
- Health and social care staff should be aware of and give a realistic account of the support, services and choices available in the particular circumstances. This should entail referral to an appropriate colleague or agency when necessary
- The professional must have adequate knowledge of the benefits, harms and risks associated with treatment to enable the client to make an informed decision
- Choice in terms of place of care will influence treatment options, as certain treatments may not be available at home, e.g. chemotherapy or intravenous therapy. Clients may need to be admitted to hospital for symptom management, or may need to be admitted to a hospice or hospital, because support is not available at home
- ACP requires that the client has the capacity to understand, discuss options available and agree what is then planned. Agreement should be documented
- Should a Client wish to make a decision to refuse treatment (advance decision) they should be guided by a professional with appropriate knowledge and this should be documented to the requirements of the MCA 2005

Advance care planning (ACP)

- Advance care planning (ACP) is a voluntary process of discussion about future care between a client and their care providers. If the client wishes, their family and friends may be included. It is recommended that with the client's agreement this discussion is documented, regularly reviewed, and communicated to key persons involved in their care¹.

An ACP discussion includes:

- The client's concerns and wishes,
- Their important values or personal goals for care,
- Their understanding about their illness and prognosis,
- Their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these.

If an client wishes, ACP may be an integral part of the care and communication process and of their regular care plan review. The difference between ACP and care planning more generally is that the process of ACP will usually take place in the context of an anticipated deterioration in the client's condition in the future, with attendant loss of capacity to make decisions and/or ability to communicate wishes to others.

- A record of advance care planning discussions is documented in the Care Plan. Interviews and recording of discussions, are achieved by using an open question style of dialogue
- For clients with capacity it is their current wishes about their care which needs to be considered. Under the MCA of 2005, clients can continue to anticipate future decision making about their care or treatment should they lack capacity. In this context, the outcome of ACP may be the completion of a statement of wishes and preferences or if referring to refusal of specific treatment may lead onto an advance decision to refuse treatment (Chapter 9 MCA 2005 Code of Practice). This is not mandatory or automatic and will depend on the person's wishes. Alternatively, an client may decide to appoint a person to represent them by choosing a person (an 'attorney') to take decisions on their behalf if they subsequently lose capacity (Chapter 5 MCA 2005 Code of Practice). A statement of wishes and preferences is not legally binding. However, it does have legal standing and must be taken into account when making a judgement in a person's best interests. Careful account needs to be taken of the relevance of statements of wishes and preferences when making best interest decisions (Chapter 5 MCA 2005 Code of Practice).

If an advance decision to refuse treatment has been made it is a legally binding document if that advance decision can be shown to be valid and applicable to the current circumstances.

If it relates to life sustaining treatment it must be a written document which is signed and witnessed. In all cases, an client's contemporaneous capacity must be assessed on a decision-by decision basis. An client may retain the ability to make a simple decision but not more complex decisions (Chapter 4 MCA 2005 Code of Practice).

- ACP may be instigated by either the client or a care provider at any time not necessarily in the context of illness progression but may be at one of the following key points in the client's life:
 - Life changing event, e.g. the death of spouse or close friend or relative
 - Following a new diagnosis of life limiting condition e.g. cancer or motor neurone disease
 - Significant shift in treatment focus e.g. chronic renal failure where options for treatment require review
 - Assessment of the client's needs
 - Multiple hospital admissions

- Sometimes people will want to write down or tell others their wishes and preferences for future treatment and care, or explain their feelings or values that govern how they make decisions. Statements of wishes and preferences or documented conversations the person has had with their family or other carers may be recorded in the person's notes.

A statement of wishes and preferences can be of various types, for example:

A requesting statement reflecting an client's aspirations and preferences. To help health and social care professionals identify how the person would like to be treated without binding them to that course of action if it conflicts with professional judgment.

A statement of the general beliefs and aspects of life which an client values.

This might provide a biographical portrait of the client that subsequently aids deciding his/her best interests.

Statements of wishes and preferences can include personal preferences, such as where one would wish to live, having a shower rather than a bath, or wanting to sleep with the light on. Sometimes people may wish to express their values e.g. that the welfare of their spouse or children is taken into account when decisions are made about their place of care. Sometimes people may have views about treatments they do not wish to receive but do not want to formalise these views as a specific advance decision to refuse treatment. These views should be considered when acting in a person's best interests but will not be legally binding. A statement of wishes and preferences cannot be made in relation to any act which is illegal e.g. assisted suicide.

Best interest decision

Under the MCA, anybody making a decision about the care or treatment of an client, who has been assessed as lacking the capacity to make that decision for himself, will be required to take any statement of wishes and preferences into account when assessing that person's best interests. Part of assessing best interests should include making reasonable efforts to find out what a person's wishes, preferences, values and beliefs might be. This is likely to involve contacting the person's family or other care providers. They may be able to advise whether any statements of wishes or preferences exists or for help in determining that person's wishes.

This will not always be possible, e.g. if an client is admitted as an emergency, is unconscious and requires rapid treatment.

A person assessing a client's best interests must:-

- Not make any judgement using the professional's view of the client's quality of life
- Consider all relevant circumstances and options without discrimination
- Not be motivated by a desire to bring about an client's death
- Consult with family partner or representative as to whether the client previously had expressed any opinions or wishes about their future care e.g. ACP
- Consult with the clinical team caring for the client
- Consider any beliefs or values likely to influence the client if they had capacity
- Consider any other factors the client would consider if they were able to do so
- Consider the client's feelings

Advance Decision

During the course of ACP discussions it may become apparent that the person wishes to make an advance decision to refuse treatment. The making of an advance decision should be made under the guidance of someone who understands the complexities of the process. The professional involved in the discussion should be willing and able to discuss what is involved in the making of an advance decision or be able to give direction as to the appropriate action to be taken (refer to the MCA 2005 Code of Practice Chapter 9).

The MCA 2005 provides the statutory framework to enable adults with capacity to document clear instructions about refusal of specific medical procedures should they lack capacity in the future.

An advance decision to refuse treatment:

- Can be made by someone over the age of 18 who has mental capacity
- Is a decision relating to refusal of specific treatment and may be in specific circumstances
- Can be written or verbal
- If an advance decision includes refusal of life sustaining treatment, it must be in writing, signed and witnessed and include the statement 'even if life is at risk'
- Will only come into effect if the client loses capacity
- Only comes into effect if the treatment and circumstances are those specifically identified in the advance decision
- Is legally binding if valid and applicable to the circumstances.

Part of the Advance Care Planning is recording any Lasting Power of Attorney. Under the MCA 2005, the holder or holders of a personal welfare LPA may be appointed by the client to make all or specific health and welfare decisions on their behalf, should they lose capacity, as if he/they were the person receiving care. In particular, the client must specify whether the appointed holder of the LPA has the authority to make decisions on life sustaining treatment.

Any decisions taken by the appointed person must be made in the client's best interests. Part 1, Section 4, MCA gives a checklist to define 'best interests'.

Constantia Care recognises that Advance Care Planning does not stop at the point of death, and that often for the carer and family further support is needed especially in the wake of a death. It is crucial that discussions take place with the carer and the family so that agreement can be reached about the level and need of support required. This will inevitably vary according to the family's structure and inter-dependency. A carer's support plan should detail these requirements and this can include emotional and practical bereavement support.

Related Policies

Advocacy

Co-operating with other Providers

Deprivation of Liberty Safeguards

DNACPR

Equality and Diversity

Meeting Needs

Mental Capacity Act 2005

Training Statement

All staff will undertake appropriate training.

This policy will be reviewed by the Register Manager.

Signed: *Morag Collier*

Date: 20.02.18

Review date: 20/08/18

ADVOCACY

Constantia Care Ltd.

Policy Statement

Constantia Care believes that clients should be enabled to express their views as clearly and candidly as they wish. Recognising that some clients may not be able to communicate easily, this organisation encourages representatives to speak on their behalf where this is appropriate.

This organisation believes that representation of this sort may be required:

- In the course of the initial needs assessment
- During any subsequent assessment of needs
- In the drawing-up or review of the service user plan of care
- In the process of assisting a service user to participate in the day-to-day delivery of their service
- In making risk assessments relating to a service user's activities
- When helping a service user to represent their views to an outside organisation
- When a service user wishes to express a concern or complaint
- In instances where a service user may have been subject to abuse
- When a service user wishes to submit their views on the organisation as part of our quality assurance programme
- In helping a service user to have an input to the drawing up or review of our policies and procedures
- In situations where the service user must take important decisions, e.g. about having surgery, but might lack the mental capacity to take the necessary decision on their own.

The Care Act 2014

On the 1st. of April 2015 independent advocacy becomes part of the above Act. This places a duty on local authorities to arrange an independent advocate for all adults as part of their own assessment and care planning process. This applies to both clients and their carers. There is also a separate duty to arrange an independent advocate for adults who are subject to a safeguarding enquiry or Safeguarding Adults Review (SAR). Subject to Parliamentary process this is expected to come into force in April 2016.

Care and Support Statutory Guidance issued under the Care Act 2014 is available from Department of Health. Advocacy is chapter 7.

The Policy

The aim of this policy is to help the service user through the use of advocacy to express their views both to the organisation and to other bodies and to feel that their views are understood and respected.

Defining Advocacy

The Advocacy Charter

Constantia Care accepts the following definition of advocacy adopted by the organisation Action for Advocacy following consultation with a wide range of advocacy bodies in the social care field in 2002. Further work in updating the principles and the Code of Practice were revised in 2014 by Empowerment Matters CIC and the National Development Team for Inclusion (NDTi) which reflect changes in legislation and well as developments in Advocacy practice

“Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain the service they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice.”

The Qualities of Advocacy

Constantia Care subscribes to the Advocacy Charter promoted by Action for Advocacy, which lists ten essential qualities:

- **Independence:** Advocates should be independent from statutory and other service-providing agencies.
- **Empowerment:** People using advocacy should be able to participate in the running of the scheme.
- **Accountability:** Every advocacy scheme should monitor and evaluate its work effectively.
- **Support for advocates:** Advocates must be appropriately prepared, trained and supported.
- **Complaints:** Advocacy schemes must have policies for dealing with complaints.
- **Clarity of purpose:** Advocacy schemes must have clear objectives and must make these known.
- **Person Centred Approach:** Advocates must be non-judgmental and respectful of clients' needs, views and experiences.
- **Equal opportunities:** Advocacy schemes must have and observe a written equal opportunities policy.
- **Accessibility:** Advocacy must be provided free of charge and in ways that make it widely accessible.
- **Confidentiality:** Advocacy schemes must have a policy on confidentiality, which includes the circumstances under which confidentiality might be breached.
- **Safeguarding** Clear policies and procedures will be in place to ensure safeguarding issues are identified and acted upon. Advocates will be supported to understand the different forms of abuse and neglect, issues relating to confidentiality and what to do if they suspect a service user is at risk

Our Clients' Access to Advocacy

Constantia Care will seek to make advocacy available to any service user who needs help in presenting their views by:

- Publicising information on local advocacy schemes
- Involving advocates, where appropriate, in the preparation and review of individual care plans
- Using advocates to promote service user participation in the running of the organisation
- Helping clients to find and participate in advocacy schemes
- Seeking peer support for individual clients from people who share their disability, heritage or aspirations
- Promoting a culture which enables clients to call on advocates to express their concerns and provide feedback on the way the organisation is run
- Respecting the role of advocates in situations in which clients wish to complain about services
- Co-operating with any Independent Mental Capacity Advocate (IMCA) appointed to assist a service user under the *Mental Capacity Act 2005*.

Advocates Appointed under the *Mental Capacity Act 2005* (IMCA)

Constantia Care recognises the role under the *Mental Capacity Act 2005* of the Independent Mental Capacity Advocate (IMCA), who can be formally appointed to support someone who lacks capacity, for example, a service user with advanced dementia or a severe learning difficulty. The IMCA's task is to make representations about the person's wishes, feelings, beliefs and values, to bring to the attention of decision makers all relevant factors, and to challenge decisions if necessary. An example of a key decision would be if the carers of a service user decided he/she should move to a care home without attempting to involve the person in the decision.

Constantia Care will encourage the appointment of an IMCA where a service user, who has been assessed as lacking mental capacity, needs to take a key decision that affects or possibly compromises the service delivery that has been agreed upon with the organisation.

Constantia Care then undertakes to co-operate with the advocate to arrive at a decision that clearly represents the service user's best interests. The organisation will at all times follow the principles and practices laid down by the *Mental Capacity Act 2005* as described in its code of practice.

Related Policies

Adult and Safeguarding
Assessment of Need and Eligibility
Deprivation of Liberty Safeguards
Dignity and Respect
Equality and Diversity
Mental Capacity Act 2005

Training Statement

All staff will be encouraged to read this policy and will be provided with training on the use of advocacy at all suitable stages of their employment with the organisation.

This policy will be reviewed by the Registered Manager

Signed: *Morag Collier*

Date: 31/01/18

Review Date: 31/06/18

ALCOHOL AND DRUGS

Constantia Care Ltd.

Policy Statement

All employers have a general duty to ensure the health, safety and welfare of their employees. If an employer knowingly allowed an employee or self-employed care assistant under the influence of alcohol or drugs to continue working and this placed the employee, self-employed care assistant or others at risk, the employer could be liable to charges.

Employees and self-employed care assistants are also required to take reasonable care of themselves and others who could be affected by what they do. They could be liable to charge if their alcohol consumption or drug taking put safety at risk.

The law on alcohol and drugs at work

Health and Safety at Work Act 1974

Misuse of Drugs Act 1971

Makes it an offence to possess, supply or offer to supply or produce controlled drugs without authorisation. It is also an offence for the occupier of premises to permit knowingly the production or supply of any controlled drugs or allow the smoking of cannabis or opium on those premises.

Under common law it is an offence to “aid and abet” the commission of an offence under the *Misuse of Drugs Act*.

Constantia Care enforces a strict no alcohol or drugs on duty regime. Both alcohol consumption and illegal drug taking impair judgement, reaction time and the employee’s or self-employed care assistants ability to carry out their duties, thereby placing themselves and the client at considerable risk.

The Policy

If an employee or self-employed care assistant is accused of illegal drug taking or alcohol consumption whilst on duty they will face an immediate suspension from their duties whilst an investigation is conducted. A full disciplinary investigation will be undertaken. If the accusation is proven to be true then the employee or self-employed care assistant concerned could be dismissed.

Clients

If employees or self-employed care assistants are ever asked to purchase alcohol by a client they can only do so where it is recorded as part of the care plan. Illegal drugs can never be purchased for a client, and a disciplinary investigation will be undertaken in such circumstances.

Staff or Self-employed Care Assistants

The effect on staff or self-employed care assistants of alcohol or drugs is detrimental not only to their health and well-being but represents a risk both to themselves and clients.

The potential effects of alcohol or drugs are numerous, including:

- Absenteeism, unauthorised absence, lateness, etc.
- Higher accident levels, including at work, whilst driving, and whilst performing tasks.
- Impaired work performance, difficulty in concentrating, tasks taking more time, increased mistakes, heightened distraction.

If the performance or attendance of an employee or self-employed care assistant at work is affected by alcohol or drug misuse outside of working hours, they may be subject to disciplinary action and, dependent on circumstances, this could result in their dismissal. These circumstances will be dealt with via the disciplinary procedures.

Wherever possible this organisation will signpost employees and self-employed care assistants with an identified alcohol or drug problem towards the appropriate help and support so that they recognise the dangers of alcohol, drug and other substance misuse, whilst encouraging them to seek help for themselves.

Where any misuse of alcohol or drugs is reported via the whistle blowing procedures then the whistle blowing policy must be followed.

Related Policies

Code of Conduct for Workers
Monitoring and Accountability
Supervision

Training Statement

Managers will be educated to recognise the signs of alcohol or drug consumption in staff and supported to act quickly in a situation of drug or alcohol abuse so as to protect and safeguard the client and others.

This policy will be reviewed by the Registered Manager

Signed: *Morag Collier*

Date: 30/01/18

Date of review: 30/06/18

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APPRAISAL POLICY

OUTCOME 14, REGULATION 23 (Supporting Workers)

Constantia Care Ltd.

Policy Statement

Constantia Care Ltd. recognises appraisal to be a method by which a manager or supervisor can objectively and fairly measure or evaluate the performance of a particular staff member by holding a formal annual appraisal meeting which involves a review of past and current performance and the setting of objectives and goals for the following year. The organisation also recognises that such appraisal sessions are a good time to discuss the overall development and career aspirations of a member of staff and to put in place a training plan which seeks to support their work and help them to realise their potential.

Constantia Care Ltd. fully supports the above Outcome and Regulatory requirements contained within the Health and Social Care Act 2008(Regulated Activities) Regulations 2010 and the Care Quality Commission Guidance on Compliance.

Appraisal Procedure

In Constantia Care:

1. Every member of staff member will have a personnel file which will include an appraisal, a personal development plan and a training record
2. Every member of staff will have an annual appraisal meeting with the registered manager.
3. During each appraisal session:
 - a. The previous appraisal and personal development plan should be reviewed (if available)
 - b. Performance over the previous year should be reviewed and measured against the previous year's objectives or goals
 - c. Objectives or goals for the following year should be agreed and any areas within which the member of staff is expected to or wishes to develop should be noted
 - d. Requirements for training or development should be discussed and agreed and a personal development plan created covering the year ahead
4. A written record of the appraisal should be made with a copy of the appraisal and personal development plan placed on the personnel file of each care or support worker and another copy held by the worker themselves
5. A six month review should be held for each member of staff member to check that all is going to plan and to make any necessary readjustments to the plan
6. All managers should be trained in providing appraisal and performance review before they are asked to conduct an appraisal. They should also be familiar with the requirements specified under Outcome 14, Regulation 23

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 31/01/18

Review Date: 31/06/18

ASSESSMENT OF NEED AND ELIGIBILITY

Constantia Care Ltd.

Policy Statement

With the introduction of the Care Act 2014 comes a big change in the assessment of needs and new eligibility criteria the intention of which is to provide a national framework throughout England, where all clients will have the same eligible needs criteria, enabling them to access care no matter where they live.

Care Act 2014

The importance of the assessment process cannot be overstated within the care and support system. Person – centred throughout, the process must support the person to have choice and control and involve them at all levels, from discussions to decision.

This approach which local authorities have implemented from April 2015 impacts on our current L.A funded clients and on new L.A funded clients as our Local Authority Commission partners start to implement these government changes.

Different types of assessment models will be undertaken but must always be appropriate and proportionate to the situation. Assessment may be face to face , a supported self-assessment using the same tools as the face to face, an online or telephone assessment, a joint assessment, where relevant agencies work together to avoid multiple assessments and a combined assessment where an adult with a carer are completed together. Some of these assessment models are being used already by local authorities.

The purpose of the assessment is:

- To identify the persons needs
- To assess how they impact on their wellbeing
- To identify the outcomes that the person wants to achieve in their day to day life

Local authorities will use the assessment to support the determination of whether needs are eligible for funded care and support by the local authority or a provider such as us, who are contracted to deliver services on behalf of the local authority.

Eligibility

The national eligibility criteria sets a minimum threshold for adult care and support needs. In considering whether an adult with care and support needs has eligible needs local authorities must consider whether:

- The adult's needs arise from, or are related to, a physical or mental impairment or illness
- As a result of the adult's needs the adult is unable to achieve two or more of the specified outcomes (see outcomes below)
- As a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing.

Outcomes

The Eligibility Regulations set out a range of outcomes. Local authorities must consider more of these outcomes when making the eligibility determination:

- Managing and maintaining nutrition.
- Maintaining personal hygiene.
- Managing toilet needs.
- Being appropriate clothed.

- Being able to make use of the home safely.
- Maintaining a habitable home environment.
- Developing and maintaining family or other personal relationships.
- Accessing and engaging in work, training, education or volunteering.
- Making use of any necessary facilities or services in the local community including public transport and recreational facilities or services.
- Carrying out any caring responsibilities the adult has for a child.

As a consequence there is, or there is likely to be, a significant impact on the adult's wellbeing. This is the third condition that must be met and that local authorities must consider. Wellbeing is core to the eligibility criteria.

Definition of Wellbeing:

- Personal dignity
- Physical and mental health and emotional wellbeing
- Protection from abuse and neglect
- Control by the individual over day-to-day life (including over care and support and the way it is provided.)
- Participation in work, education, training or recreation
- Social and economic wellbeing
- Domestic, family and personal
- Suitability of living accommodation
- The individual's contribution to society

The full guidance on Assessment and Eligibility is in the Care and Support Statutory Guidance updated on May 9th 2016 issued under the Care Act 2014 - Chapter 6.

The Policy

In setting out policy, the organisation is aware that the changes for local authority funded clients will be phased in and will bring challenges to us as a provider. We have set out below how we will manage these changes and we are committed to working collaboratively with our health and local authority partners in order to facilitate and contribute positively as they are implemented.

Principles of Care Needs Assessment

Needs assessments are only carried out by competent members of staff who have been appropriately trained and who are specifically authorised for this task. Throughout the care needs assessment process, the staff member carrying out the assessment should communicate with and actively involve the prospective client and their representative. It is particularly important to find out the client's wishes and feelings, and to take them into account; to provide the client with full information and suitable choices; and to enable and encourage clients to make decisions about their own care. We will comply with any special local arrangement for self-assessment by clients

Sources of Information

The general expectation is that the client will give us the necessary information, but where this is not possible the client's carer, relative or representative becomes the most-likely source. In such cases the client should, if at all possible, be present while information is gathered and recorded; as an indication that they agree that we should have access to the information, and that the information provided to us is true. The staff member carrying out the assessment needs to interview the client (and carer) either pre admission, or in the setting in which the service will be delivered. A specific appointment should be offered with a named staff member. The staff member should aim to create a warm and relaxed atmosphere for the interview, should give the prospective client the opportunity to demonstrate his or her abilities, as well as discussing his or her needs. They should use the time to observe the client. Within a domiciliary setting it should be remembered that the client's home becomes

the staff member's workplace, so a full environmental risk assessment should be completed, as well as discussing what we have to offer.

Information should be recorded at the time of the interview, or as soon as possible afterwards, on the Care Needs Assessment Form. The staff member should be quite open about recording the information and should show the prospective client the form if requested.

Information Gathering

A full and comprehensive Care Needs Assessment or pre-admission form should be completed with the client, their relatives or representatives involved where requested. Staff need to ensure that consent is able to be given and where there are capacity issues advice should be sought.

Physical and Mental Health and Abilities

We record information about the client's health and abilities. It is the task of the staff member carrying out the needs assessment to decide which items are relevant for the service that this organisation is being asked to provide. The form lists a range of possible items for consideration. Although we need as full a picture as possible of the needs of the client, we do not wish to intrude on the client's privacy any more than is necessary, so staff members must use their judgement as to which items on the form have to be completed.

Care should be taken not to place too great a stress on disabilities. The staff member should emphasise from the outset that a worker will work with the client (and with the carer if applicable) and try to support the client's independence as far as possible. If there are health issues on which further medical or nursing details are required, the staff member should ask the client or carer to obtain and pass to us the necessary reports.

Any written documentation about the client's care needs should be appended to the form.

Services Requested

This information is recorded on the form, detailing the services that this organisation is being requested to supply. At this point a manager must take the formal decision that we are in a position to provide the requested services, given the details of the care needs assessment or pre-admission form.

Passing Information to the Allocated Worker

When the manager has decided that we will supply services, identified workers should be allocated to the case. We believe that the matching of the worker to the client is of paramount importance and so due consideration is given to the worker's availability. When all of the required elements have been agreed the client will be informed of the staff team who will undertake the service. The worker will be introduced personally to the client on the commencement of the service. The allocated worker(s) are responsible for reading and understanding the care plan.

Referrals from Social Services Departments

In cases where a potential client is referred by a social services department, the manager must obtain a summary of the needs assessment that the department has undertaken. A care needs assessment form will be completed using some of the details provided by the social services departments own care plan or care diary. The summary of the social services needs assessment should be filed with the organisation's own form. We will comply with any special local arrangements for self-assessment by clients.

Emergency Service Provision

If the organisation has been requested to provide services at short notice or in a crisis, there may not be an opportunity to carry out a full assessment before starting to provide a service. A telephone discussion, to ascertain as much information as is possible before the commencement of the service, will be recorded and used as the care needs assessment for the first 72 hours of any immediate response on emergency service provision. The organisation has a form specifically to record the needs of an immediate response situation.

When emergency services are provided, the manager must complete the basic information required and allocate the case to a worker who is competent to undertake an initial contact assessment. In these circumstances only experienced managers of the service will make the decision to respond. Within three working days, the manager will arrange for a full assessment to be carried out, and the form to be completed with all relevant details for providing services over a longer term.

Where the immediate response is of a short-term basis only, the immediate response form will be used in conjunction with any other details supplied by social services or health to assist in the service delivery. If the service is provided at the request of a social services department, the manager must ensure that the department completes an assessment within two working days and passes the information to us as described above.

Changes in a Client's Care Needs

It is the responsibility of any worker providing service to report to their manager any significant changes in a client's needs and circumstances. The manager is responsible for considering whether any change in the service is required as a result of the change in the client's needs. If so, the manager should initiate a discussion with the client or the client's carer or representative, if appropriate and with the relevant social services department, if necessary.

If the changes to the care plan are of a type not exceeding 2 hours more or less than the agreed care plan this will be deemed to be a temporary change. If the change is to be a permanent one a review will be instigated that will include a variation to the fees and charges.

Reviews of Care Needs

A minimum standard of an annual review is the mechanism for the organisation to ensure that the needs of the client are relevant. We will, however, retain the flexibility to initiate a review whenever we feel it is in the client's best interests.

Whether or not any specific changes to a client's needs and circumstances have been reported, the manager should review the appropriateness of the service provided within six weeks, and at least annually thereafter.

Throughout the whole assessment process great importance should be attached to the client's own views of their needs and wishes, and clients should be given every encouragement to express themselves. In the local authority areas where systems of self-assessment are in place, managers should seek advice from their social services department about the precise implications for their procedures.

At the initial assessment of needs visit a discussion will take place regarding the frequency of reviews. Where social services are involved with the client they retain responsibility for the setting up of reviews, however it should be noted that this organisation reserves the right to initiate a review where there are concerns regarding the care or services provided.

NICE Guidelines

Older people with social care needs and multiple long-term conditions [NG 22] Published November 2015

This guideline covers planning and delivery of social care and support for older people who have multiple long-term conditions. It promotes an integrated and person-centred approach to delivering effective health and social care services. As an organisation we are working towards ensuring these guidelines are implemented, proportionate to our service, using the tools and resources available from NICE.

Related Policies

Autonomy and Independence
Care and Support Planning
Dignity and Respect
Meeting Needs
Mental Capacity Act 2005
Client's Contract

This policy will be reviewed by the Registered Manager

Signed: *Morag Collier*

Date: 31/01/18

Review Date: 31/06/18

ASSISTIVE TECHNOLOGY

Constantia Care Ltd.

Policy Statement

Assistive technology is a generic term, covering a multitude of devices or systems which assists individuals with certain tasks. Generally, this technology is grouped according to its purpose. "Supportive technologies" help the individual with tasks, this includes things such as walking aids, walking frames, bath aids etc.

"Preventative technologies" manage risk and raise claims such as numeric entry pad keys; automatic lighting etc. "Telecare" is used to describe sensors or detectors such as flood, gas, falls etc. that send a signal via a base unit connected to a telephone line (tele) to a carer, community alarm or monitoring service which can call for assistance (care) when it is needed.

Examples of assistive technology are numerous but can include:

- Electronic location devices, using GPS technology that can locate people who have become lost or disorientated.
- Temperature, smoke and carbon monoxide detectors which can be standalone devices, or, can be linked to a number of other devices which enables gas or electricity supplies to be cut off automatically, or power operated windows to be opened.
- Memo minders can help people who have difficulty in remembering to carry out tasks.
- Medication dispensers can help people who have difficulty in remembering to take their medication.

This list is not exhaustive, but serves to demonstrate the possibilities now available through assistive technology, which, like all technology, is improving all the time in its range and use of products.

The policy

Care Needs Assessment

It is important that from the outset, any use of assistive technology is discussed with the client, their family or representative and consent for such use is clearly recorded as part of the assessment process and incorporated into their care plan. As a forward looking company, we are always happy to explore any avenue which enhances and maintains the independence of our clients and contributes to their well-being. It is important that assistive technology is personalised to the needs of the service-user and the overall best value contribution, from the business in any investment of time and resources which keeps costs to a minimum for our clients

Ethical considerations

Like many new ideas, assistive technology has the potential to benefit people, but it can also be misused or have unintended effects. It can offer greater independence and free up carers time, but there are some aspects that can compromise people's privacy, autonomy and well-being. Particular attention should be paid to the care planning process including assessment, installation, consent and training in its use so that the beneficial effects of the technology are realised.

Future Developments

There is no doubt that assistive technology is an evolving element of health and social care, but as in most things, the benefits need to be evaluated as the technology develops. It is important to remember that the technology is part of a range of remedies which, if used and utilised appropriately, can benefit individuals and businesses to enhance lives and contribute to lower costs of service delivery, over time.

Training Statement

Any assistive technology service which is introduced will be in place after staff, and where appropriate, clients are fully conversant with its use and updated where and when required.

Related Policies

Data Protection

Consent

Record Keeping

This policy will be reviewed by the Registered Manager

Signature: *Morag Collier*

Date: 30/01/18

Date of Review: 30/06/17

AUDIT

Constantia Care Ltd

Policy Statement

Constantia Care has in place a range of Policies and Procedures which are annually reviewed and updated. These provide the core operational standards set by the business, and reflect the regulatory requirements set by the Care Quality Commission in New Fundamental Standards Regulations 2014, The audit processes set out below ensure that day to day service delivery provision meets the required standards and provides a tool which can identify any shortfalls in the assessment and monitoring of the quality of our service provision.

The Policy

It sets out how a robust self-aware improvement system for the business which introduces a critical analysis framework of continuous improvement and learning will engage staff, service users and multi-agency partners in the process. It will link into the Business Plan which will ensure audit findings are actioned and Implemented on a regular basis.

Audit Roles

Only those job holders listed below will undertake the audit function.

Process

The audit function has to be a planned and systematic process of evaluating and validating the monitoring mechanisms set out in the company policies and procedures. It ensures that the monitoring role within the business is in place, timely, fit for purpose, proportionate to the service and enables the implementation of any actions required from the cycle of improvement.

Therefore, although two different functions, they are inextricably linked and one often follows the other.

“**Monitor**” means to check, observe, identified tasks or performance

“**Audit**” means to evaluate, examine, critically analyse, conformance to set standards by reviewing the objective evidence from statements, records, files and any formal monitoring systems in place.

In Health and Social Care the standards are those set by the Care Quality Commission in the Health and Social Care Act (Regulated Activities) Regulations 2014. These Standards apply to all Registered Providers of Health and Social Care.

All providers need to evidence their compliance. Audits are a way of identifying, within a range of indicators, whether the business is meeting its regulatory requirements.

It also provides a mechanism for good practice to be shared whilst dealing with any practice which does not meet the expected standard of regulatory requirements.

Audit Structure

For ease of use the audit is set up to follow the Regulations from the Care Quality Commission.

Different Regulations require different frequency of audit therefore each audit record needs to have the code identified.

Audit Frequency Coding.

A = Annually

M = Monthly

Q – Quarterly

R = Randomly

W = Weekly

Our audit frequency codes reflect the activity of Constantia Care and are proportionate to our service delivery.

Each and every audit record must be completed, signed and dated by the designated post holder who is named below, within the frequency coding timescales. Where this is not possible, a written record should be available detailing why the timescale lapsed.

Weekly audits are controlled by the administrator.

Weekly audits are controlled by Erin Callaghan

Monthly audits are controlled by Morag Collier.

Constantia Care Ltd is audited by Care Management & Brokerage on an Annual Basis – Contact: Carol Thompson 01462 411802

Data Interrogation

The audit itself is the start of the process but to complete the cycle from the data of the audit the record must be scrutinised, findings reported and actions implemented to remedy any identified non-conformance with the standards.

The senior management team will have responsibility for the scrutinising of all such data, including the written report and lead the implementation of any action planning and delivery.

Related Policies

Good Governance

Quality Insurance

Staff Training

All staff involved in the audit functions will have received training and guidance in the function and purpose of the audit conformance.

This policy will be reviewed by the registered manager annually

Signature: *Morag Collier*

Date: 30/01/18

Date of review: 30/06/18

AUTONOMY AND INDEPENDENCE POLICY

OUTCOME 1, REGULATION 17 (Respecting and Involving People who use Services)

Policy Statement

In May 2008, Ivan Lewis, the Minister for Care, announced the introduction of seven Core Principles to Support Self Care with the objective of helping health and social care staff to support people who wish to remain independent. The Core Principles, which were developed by Skills for Care and Skills for Health, are as follows.

- Ensure that individuals are able to make informed choices to manage their own care needs.
- Communicate effectively to enable individuals to assess their needs, and develop and gain confidence in self care.
- Support and enable individuals to access appropriate information to manage their self care needs.
- Support and enable individuals to develop skills in self care.
- Support and enable individuals to use technology to support self care.
- Advise individuals how to access support networks and participate in the planning, development and evaluation of services.
- Support and enable risk management and risk taking to maximise independence and choice.

Constantia Care Ltd. seeks to ensure that these principles are appropriately reflected in their policies and practice in promoting autonomy and independence.

This document outlines the policy of Constantia Care Ltd. in relation to promoting its clients' autonomy and independence.

Aim of the Policy

Constantia Care Ltd. seeks positively to promote the autonomy and independence of our clients. We recognise that the capacity for independent action of our clients has often been undermined by illness, disability and failing mental capacity and that insensitive action by workers can reinforce dependence. We therefore strive to help clients make their own decisions and to support them in controlling their own lives. We aim always to balance the protection of clients from unnecessary risks with the promotion of independence and choice, in accordance with Department of Health guidance *Independence, Choice and Risk: a guide to best practice in supported decision making*.

Care Needs Assessment

We recognise that the tone of the relationship between Constantia Care Ltd. and a client is often set by the initial contact and that the care needs assessment or pre admission assessment which must be undertaken before we start to provide a service can in itself be a process which endangers a potential client's sense of being in control. We do everything we can to empower our clients from the very outset of our dealing with them.

Information

We recognise the important role which can be played by knowledge of what is going on in making people feel independent. We therefore provide good, thorough and up-to-date information about our service and other facilities at the beginning and throughout our contact with a client. We would provide information in formats and languages which make it accessible to the individuals to whom it is addressed.

Choice

We know that choice has become important for clients and we attempt to advance this principle throughout our operations. We ensure that every client who receives our service has positively opted to use our organisation. We try to provide clients with the chance to exercise choice about the workers with whom they interact and will change the worker in instances when the client requests it. We are particularly sensitive to matching workers and clients where issues of gender, culture or ethnicity play a role.

Care and Support Workers

The workers providing care and support on a day-to-day basis aim to carry out their tasks in co-operation with clients not in ways which destroy the possibility for the client to exercise their own discretion, initiative and control. We realise that this principle is particularly difficult to uphold where clients have disabilities or severe mental incapacities.

We value risks as playing an essential part in a fulfilling lifestyle. Carers support clients in taking reasonable risks, without obviously endangering their health or safety, and subject to a thorough risk assessment recorded in the Client Plan.

We know how disempowering it can be for clients not to understand fully what is going on. Workers wherever possible communicate with clients in their first or preferred language.

Personal Finances

Where requested, we provide support to clients in controlling their own financial affairs, always respecting the privacy and confidentiality of documents to which we have access.

Personal Files

We provide facilities for clients to see their personal files in accordance with the *Data Protection Act 1998* and inform them of the access to files which may be required by inspectors.

Limitations to a Client's Chosen Lifestyle or Human Rights

We try to respect the lifestyles clients have chosen for themselves but exceptionally may be obliged to intervene to prevent a client from harming themselves or becoming a danger to someone else. On these rare occasions, our workers will act with respect for human rights, within our responsibilities in law and Constantia Care policy on restraint, and in the best interests of the client and others closely involved.

Clients who lack Mental Capacity

We continue to respect the rights of clients who have been assessed as lacking capacity to make certain decisions or who are thought to lack that capacity by considering their best interests at all times. We do this by ensuring that we implement fully the code of practice for the *Mental Capacity Act 2005*. In relation to maintaining clients' autonomy and independence, this entails involving them as fully as possible in every decision concerning their care and the services this organisation provides. (See also the policy on working with clients who might lack mental capacity)

Dealing with Clients' Relatives and Carers

We try to relate to clients' relatives and carers where this is appropriate, treating them as partners in providing care. But we are concerned that these relationships should not undermine the autonomy of clients themselves, so we insist on having the client's permission before dealing with anyone on their behalf or releasing confidential information to others. (See also the policy on relatives, friends and staff).

Advocacy

We provide information when requested about the availability of independent advocates and self-advocacy schemes, and are quite willing if required to communicate with clients' advocates. (See advocacy policy).

Review of this Policy

This policy will be reviewed by the registered manager

Morag Collier

Signed: *Morag Collier*

Date 30/01/18

Review Date 30/06/18

BRIBERY AND CORRUPTION

Constantia Care Ltd.

Policy Statement

The *Bribery Act 2010* came into force on 1st July 2011. The Act is concerned only with Bribery within the context of commercial corporate governance. This organisation sets out below its understanding of the scope of the Act and its response in terms of management responsibilities and reporting duties.

The Policy

Through this policy Registered Managers and the senior management team will be aware of their role in mitigating any corporate risk to the company by failing to adhere to the guidance below.

Definition(s) of Bribery

“Giving someone a financial or other advantage to encourage that person to perform their functions or activities improperly or to reward that person for having already done so.”

“A form of corruption, an act of implying money or gift given that alters the behaviour of the recipient.”

“The offering, giving, receiving or soliciting of any item of value to influence the action of an official or other person in charge of a public or legal duty”

The “bribe” is the gift bestowed to influence the recipients conduct. It may be any money, goods, property, preferment, privilege, emolument, object of value, advantage or merely a promise or undertaking to induce or influence the action, vote or influence of a person in an official or public capacity.

Principles

- Proportionate Procedures
- Top-level Commitment
- Risk Assessment
- Due Diligence
- Communication (Including Training)
- Monitoring and Review

1 Proportionate Procedures

The actions undertaken must be proportionate to the size, scope and aligned to the commercial activity of the business, e.g. foreign contractual arrangements where it could be that bribery is known to be commonplace. Such foreign contracts would greatly increase the risk of the company to exposure of the *Bribery Act 2010*.

2 Top-level Commitment

This organisation is fully committed to a zero-tolerance response to bribery in any form. The Board of Directors and the Senior Management Team, including all Registered Managers, have responsibility to ensure that a culture of integrity is fostered in order to make bribery unacceptable. A firm anti-bribery stance is expected from management including adherence to the formal statement on anti-bribery culture.

3 Risk Assessment

Any anti-bribery risk assessment should take account of the following factors, categorised as internal or external:

External

Country Risk
Sectional Risk
Transaction Risk
Business Opportunity Risk
Business Partnership Risk

Internal

Employee Training
Bonus Culture
Absence of Audit/ Financial Controls
Management/Leadership

4 Due Diligence

This is a well-established element within the corporate governance overview of the senior management team. It is particularly relevant where third party intermediaries are used, e.g. where local law or convention dictates the use of local agents.

5 Communication (Including Training)

Internal and external communication may vary in tone and context dependent upon the relationships and the bribery risks involved. Internal communications should convey a “tone from the top” regarding financial control, hospitality, promotional expenditure, charitable or political donations, and penalties for breach of rules.

An important aspect is the establishment of a secure confidential and accessible means for internal or external to raise concerns about bribery on the part of the associated parties. All staff and self-employed care assistants must be made aware of the above via training, and it should be incorporated into the whistleblowing policy.

6 Monitoring and Review

The importance of a good monitoring and review system within the organisation is vital. These already exist, but the new Act may change the reporting of such audits or reviews.

The Future

Senior managers will undertake a risk assessment, and procedures, including a formal statement, will then be agreed and communicated to all staff and self-employed care assistants.

The legislation is new and complex. The Serious Fraud Office (SFO) will be responsible for any criminal investigations, and like all new legislation, the press reporting and interpretation of what the Act could mean has focussed on hospitality and dining. The SFO and the Ministry of Justice are remaining unclear on this part of the Act.

The director of the SFO, Richard Alderman, gave the following speech in April 2011:

Let me start by talking about hospitality. I have to say that I found some of the coverage over the last few months about this issue to be difficult to understand. The notion that the SFO would be interested in the extra bottle of wine or the opportunity to watch a match at Twickenham seemed to me to be greatly exaggerated. It was significant though that these views were genuinely held. Clearly there was much misapprehension about the effect of the Act and what the SFO might do in implementing it. By and large I think this issue has now died down as a result of the sensible guidance that has been given.

Normal corporate hospitality is a part of business and is a part of building up relationships that are needed in order to make business work. This is not a problem. Buying meals and putting foreign public officials up for reasonable accommodation is not a problem. Nor is flying a group of foreign public officials across the world to see one of your sites so that they can get the best possible view of what you are doing and whether they should offer you a contract. Normal business. This is to be encouraged. Companies in my view are generally comfortable with this because after all they need to justify this in terms of shareholder funds. They know as well that the all expenses

paid holiday at the company's private island for a foreign public official and their family with lots of expenses for one month is totally unacceptable. In my view, therefore, we seemed to have reached a balance.

This sets the "proportionate" response in context. As a care sector provider there will be very little identified risks, except perhaps in the contractual relationship between our local authority or NHS partners. Our Gifts and Legacies Policy should be robust enough but will be reviewed as part of our assessment of risk principle & actions.

PricewaterhouseCoopers (PwC) have issued this guidance:

Acceptable:

- Calendars
- Mouse mats
- Drink mats
- Company logo branded low-cost merchandise (umbrellas, sports bag, pens, stress balls etc.)
- Invite to modest Christmas party or lunch.
- Reasonable social

Related Policies

Duty of Candour

Financial Irregularities

Financial Procedures

Premises and Resources

This policy will be reviewed and updated by the registered

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

BULLYING AND HARASSMENT

Constantia Care Ltd.

Policy Statement

Constantia Care believes in a zero tolerance attitude toward bullying and harassment in the work place. This in practice requires that all staff and self-employed care assistants are treated with dignity and respect whilst undertaking their duties in a working environment in which the dignity of all employees/self-employed care assistant is respected and where employees/self-employed care assistant feel able and encouraged to reach their full potential and effectiveness.

Harassment as defined in the Equality Act 2010 is:

Unwanted conduct related to relevant protected characteristic, which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual.

Bullying may be characterised as

Offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient.

The Policy

The recipient's view is crucial because what one person may find acceptable another may not. Any form of harassment or inappropriate behaviour which causes offence, whether intentional or not, will be treated very seriously and where appropriate will lead to disciplinary action, which could include dismissal, being taken.

Examples of unacceptable behaviour:

- Spreading malicious rumours or insulting someone.
- Offensive language, swearing.
- Copying memos that are critical about someone, to those who do not need to know.
- Ridiculing or demeaning someone – setting them up to fall or fail.
- Exclusion or victimisation.
- Unfair treatment.
- Overbearing supervision.
- Sexual harassment – unwelcome remarks such as jokes, innuendos, touching, standing too close, display of offensive materials.
- Racial harassment.
- Religious discrimination.
- Disability discrimination.
- Age discrimination.

Harassment does not mean:

- Mutually acceptable friendship or flirtation
- Enjoying a joke at work providing that it is not at someone else's expense
- Enjoying a joke at work if no-one shows they are offended
- Normal operational management of staff in the conduct of their duties

Keeping perspective:

If you are in an environment and are uncomfortable about jokes or banter in the environment, it is your responsibility to raise concerns early so they can be dealt with.

Our responsibilities and actions as a Company

- We promote an environment where no-one is harassed or victimised.
- All management employees are aware of this policy and aim to ensure that all Workers are treated fairly and that no-one is harassed or victimised.
- To be observant and alert to the kind of behaviour which might indicate a problem, i.e. where one employee is always critical of another or where an employee is left out of social interaction.
- To deal with any form of harassment or intimidation at an early stage, this may be initially informally as the accused may not be aware their behaviour is causing offence. If this approach is not successful then written statements will be taken from the complainant and the accused and an investigation will be undertaken seeking advice from senior management or outside agencies as deemed necessary. Where possible, steps will be taken to ensure the two parties are not placed in a situation where the matter can be aggravated. If the outcome of the investigation shows that there is a reasonable belief of bullying and harassment it is within the realm of the employer to take disciplinary action against that employee.
- To offer support for the victims of harassment or bullying.

Responsibilities of the Employee

- All employees must comply with this policy.
- Employees must be aware that it is their personal responsibility not to harass, bully or intimidate another employee.
- If an employee becomes aware that a colleague is experiencing harassment or bullying it is part of their duty of care not to allow it to continue by reporting all incidents to a manager

How to report an allegation of bullying and harassment

Very often people are not aware that their behaviour is unwelcome or misunderstood and an informal discussion can sometimes help to solve the problem. However, if you feel you are being bullied or harassed, we realise that the situation may be sensitive and may make you feel vulnerable or in fear of reprisal and therefore, may make it difficult for you to make an allegation.

Subsequently, we suggest you consider discussing matters informally with your manager, in confidence, who will then be able to support you when pursuing the matter. If you feel able to do so, you should then raise the matter informally with the perpetrator, with your manager to support you.

If this does not solve the problem, or if the matter is more serious, (or if you do not feel able to do so,) you should report the matter to the manager as a formal written grievance

Grievance

We endeavour to manage grievances in a timely and confidential manner via an investigation to establish full details of what happened. Your name and the name of the alleged harasser will not be divulged other than on a "need to know" basis to those individuals involved in the investigation. At the outset, someone with no prior involvement in the complaint will be appointed. The investigation will be impartial and objective, and will be carried out sensitively and with due respect for the rights of all parties concerned.

Consideration will be given to whether the alleged harasser or bully should be redeployed temporarily, or suspended on contractual pay or whether reporting lines or other managerial arrangements should be altered pending the outcome of the investigation.

As part of the investigation, the person will meet with you to hear your account of the events leading to your grievance. You have the right to be accompanied by a colleague of your choice.

The investigating officer will also meet with the alleged harasser or bully who may also be accompanied by a colleague. It may also be necessary to interview witnesses to any of the incidents mentioned in your grievance. Where it is necessary to interview witnesses, the importance of confidentiality will be emphasised to them.

At the conclusion of the investigation, the outcome of the findings will be notified to both you and the alleged harasser usually within two weeks of your complaint first being reported.

If the conclusion is that harassment or bullying has occurred, prompt action will be taken to stop the harassment or bullying immediately and prevent its recurrence.

The findings will be dealt with under the disciplinary procedure. Consideration will be given to whether the harasser or bully should be dismissed and, if not, whether he or she should remain in his or her current post or be transferred. Even where a grievance is not upheld, (for example, where evidence is inconclusive), consideration will be given to how the on-going working relationship between you and the alleged harasser or bully should be managed. This may involve, for example, arranging some form of mediation or counselling or a change in the duties or reporting lines of either party.

Should the investigation show that there may be a case to answer the organisations disciplinary procedure will be invoked against the alleged perpetrator.

Confidentiality

At all times throughout the process and after, all parties involved, including the alleged perpetrator, the victim, the manager, and any witnesses will need to give due consideration to confidentiality. As such, all parties will be reminded that they should not breach confidentiality and should not discuss the matter with anyone outside of the procedure.

Details of the investigation and any subsequent disciplinary procedure which may take place will be kept on the employees personnel file.

Untrue claims

Whilst we will support all parties during and after a thorough and objective investigation into the allegation as appropriate, if through the course of the investigation and subsequent disciplinary meetings evidence demonstrates that the allegation has been made maliciously, or for personal gain, then the individual making the complaint will be subject to Disciplinary proceedings as outlined in the organisation's Disciplinary Policy.

Appeals

If you are not satisfied with the outcome of the investigation, you have the right to appeal the decision within 7 calendar days of being notified of the outcome. You should submit your full written grounds of appeal to another manager, Morag Collier. The person hearing your appeal will meet with you to discuss your appeal. You may be accompanied by a colleague or Trade Union Official. You will normally be notified of the outcome of the appeal within fourteen days of this meeting. This is the final stage of the formal procedure.

Further Guidance and advice is available from ACAS
<https://www.gov.uk/workplace-bullying-and-harassment>

Related Policies

Code of Conduct for Workers
Disciplinary
Equality and Diversity
Grievance

Training Statement

As part of their induction programme all staff are made aware of the organisation's zero tolerance attitude and are encouraged to report any such behaviour whether witnessed or suffered.

This policy will be reviewed and updated by the Registered Manager

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/01/18

BUSINESS CONTINGENCY AND EMERGENCY PLANNING

Constantia Care Ltd.

Policy Statement

Constantia Care is aware of its responsibilities in respect to delivery of its commissioned services. This policy sets out the contingency arrangements which can be implemented when an unplanned critical or emergency event or *force majeure* situation arises.

The Policy

This policy aims to enable service delivery to take place even in unplanned situations. Working with multi-agency partners, this organisation would seek to ensure the following measures were in place to minimise any disruption to planned services and to co-operate in any way possible to assist in any *force majeure* situation which may arise.

Procedures

The following sets out how we at this organisation would seek to minimise the impact of unplanned situations.

Utilities Failure

From time to time a utilities failure occurs that impacts upon the service user's home. We would be able to access camping gas and water to enable the service user to be cared for in terms of personal care, warmth and nutritional needs. We would keep in contact with the family (where applicable), the utility agency (to ensure we could respond appropriately) and, where a large section of the community was affected, the relevant statutory agencies (e.g. police, social services) and the emergency civil planning department of the council where necessary.

Adverse Weather/Winter Planning

In situations such as these it would mean rescheduling of visits. Families and social services would be contacted, informed and an explanation given of why the changes had been implemented.

To minimise travel, care workers would be scheduled to start as close to home as possible and some could be scheduled to walk where flooding or snow and ice were present.

The employment of locally-based staff would assist in this situation.

The involvement of family and neighbours would be considered for service users whose needs could be met by this assistance. All service users would be contacted and given information and advice pertinent to the service user, e.g. the times of visits and who would be making them.

A statutory notification must be sent to CQC if the adverse weather was likely to last more than 24 hours.

Pandemic Management

A pandemic is recognised as one of the highest risks faced by the Health and Social Care sector. Public Health England now has responsibility to protect the public's health from such an outbreak and to provide guidance to organisations where the impact of such a pandemic could be catastrophic. They regularly publish Preparedness Strategies, Response plans etc in the event of such a situation.

The five phases of detection, assessment, treatment, escalation and recovery are monitored, appropriate data collected, the route of the pandemic tracked and advice and guidance issued, as appropriate.

Staffing is the biggest issue for continuity of service to be ongoing and when necessary, statutory notifications should be completed in order to assist with the planning required for cover.

All Local Authorities have an Emergency Civil Plan (ECP) which is activated when certain criteria are met. A multi-agency approach is in place via the health authority and Public Health England and the organisation will follow all available advice and guidance in managing any pandemic or similar situation.

Staff will be advised as to their actions via the office.

Force majeure Situations

Where a *force majeure* was in place, e.g. major flooding, fuel shortages, road closures, winter conditions, we would take advice and co-operate in any way possible with the Civil Emergency Team and the statutory agencies involved.

This could include:

- Emergency centres being utilised
- Evacuation procedures
- Staff secondment to assist
- Assisting other providers with visits
-

We have good local knowledge and our relationship with our multi-agency partners would enable us to deliver the service except where advice was given to the contrary. We are aware of winter plans from our local authority and the NHS, and would seek appropriate advice immediately in order to manage the situation effectively.

A statutory notification must be sent to CQC if any of the above situations were likely to last more than 24 hours.

Related Policies

Co-operating with Other Providers
Continuity of Care and Support Workers
Duty of Candour
Notifications

Training Statement

Managers will be kept up to date with relevant local plans, as appropriate, at least annually, in order to respond in an effective and efficient manner.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

CARE AND SUPPORT PLANNING

Constantia Care Ltd.

Policy Statement

We are acutely aware of the importance of care and support planning and of the impact it can have when it is not undertaken in a planned and systematic way. The individual, their needs and preferences must be at the core of the process.

Information giving and sharing, with the individuals needs preferences and choices being heard and listened to and their role influencing and controlling the shaping of their care and support plan is fundamental in ensuring person centred care.

Care Act 2014

It is often said that a services led approach to delivering services is the Achilles heel of adult care. In trying to move things forward the Care Act sets meeting needs at the centre of care and support planning and moves away from the previous terminology of “providing services”. This is to enable a much broader diversity and variety of approach in how needs can be met

This will require providers such as us to reassess our current services, whilst keeping an open and honest dialogue with clients and commissioners to diversify the services available.

As a provider, this means the utilisation of the voluntary sector, community groups and development of individual service funds, where appropriate. A collaborative engagement process will need to be developed and local authority guidance will be issued in order to facilitate the development stages of the relationship with other services.

Local Authority Funded Person(s)

Care and support funded by the local authority will reflect the Care Act 2014 requirements and these changes have been implemented since April 2015 and will continue through to April 2017.

These include changes to the following:

- Personal budgets
- Direct Payments
- Individual service fund (ISF)
- Purchase of regulated and unregulated services
- Mixed funding arrangements
- Flexible choices of care and support
- “Prescribed providers” do not fit with the governments vision of personalised care and should be avoided
- No constraint on how needs are met as long as this is reasonable
- Steps should be taken to avoid decisions on the assumption that the views of the professional are more valid than those of the person
- Persons lacking capacity are equal within the Care Act 2014 but the principles and requirements of the Mental Capacity Act 2005 (MCA) must be adhered to if the person lack capacity

All this good practice will be embedded for all of our users, including self-funders. As the Care Act 2014 begins to shape local authority practice, so too will it shape ours as providers. The important of good information advice and guidance cannot be underestimated and local authorities, under this Act have a duty to provide such a service.

The Policy

The Care Act 2014 has huge implication both for local authorities and providers of services over the coming months and we, as provider, are well placed to meet the challenge ahead. We set out below a set of principles which applies to all our care and support planning process from April 2015.

Principles

- Information advice and guidance will be available to all prospective users of services in order that an informed decision on our ability to meet the assessed need can be determined.
- The user, their family, representative or “relevant person” will be involved from the start, during the assessment and care and support planning process to ensure their needs, choices and preferences are reflected in the care plan agreement
- Consent will be discussed, formally recorded and agreed within the care plan.
- The Mental Capacity Act 2005 (MCA) Code of Practice will be followed where someone lacks capacity or where there is fluctuating needs identified and decision recorded in the care plan.
- Choice and control will be retained by the client including their ability to take or make unwise decisions where they have capacity.
- Self-supported care and support planning will be encouraged and available to all users.
- Individual services funds (ISF) will be developed in agreement with users and will be offered where requested.

These principles will be further developed as the Care Act 2014 is implemented throughout 2015.

Assessment of Care Needs

NICE have published a quality Standard QS123 “Home care for older people” June 2016 Before we enter into an agreement to provide a service, we ensure that a thorough assessment of a prospective client’s needs has been undertaken. For people referred to [this organisation] by a social services department, this assessment will have been carried out as part of the care management process; we will be provided with at least a summary of it. For people who approach the organisation directly, we are responsible for carrying out a full assessment of care needs under our procedures for care needs assessment. All action considered for the client plan must be soundly based on material in the care needs assessment.

Needs assessments are only carried out by competent members of staff, who have been appropriately trained and who are specifically authorised for this task. Throughout the care needs assessment process, the staff member carrying out the assessment should communicate with and actively involve the prospective client and their representative. It is particularly important to find out the client’s wishes and feelings, and to take them into account; to provide the client with full information and suitable choices; and to enable and encourage clients to make decisions about their own care. We will comply with any special local arrangement for self-assessment by clients.

Sources of Information

The general expectation is that the client will give us the necessary information, but where this is not possible the client’s carer, relative or representative or the relevant person is the most-likely source. In such cases the client should, if at all possible, be present while information is gathered and recorded; as an indication that they agree that we should have access to the information, and that the information provided to us is true. The staff member carrying out the assessment needs to interview the client (and carer) either pre admission, or in the setting in which the service will be delivered. A specific appointment should be offered with a named staff member. The staff member should aim to create a warm and relaxed atmosphere for the interview, should give the prospective client the opportunity to demonstrate his or her abilities, as well as discussing his or her needs. They should use the time to observe the client. Within a domiciliary setting it should be remembered that the

client's home becomes the staff member's workplace, so a full environmental risk assessment should be completed, as well as discussing what this organisation has to offer. Information should be recorded at the time of the interview, or as soon as possible afterwards, on the Care Needs Assessment Form. The staff member should be quite open about recording the information and should show the prospective client the form if requested.

Information Gathering

A full and comprehensive Assessment of Need should be completed with the client, their relatives or representatives where requested. Staff need to ensure that consent is able to be given and where there are capacity issues advice should be sought.

Physical and Mental Health and Abilities

We record information about the client's health and abilities. It is the task of the staff member carrying out the needs assessment to decide which items are relevant for the service that this organisation is being asked to provide. The form lists a range of possible items for consideration. Although we need as full a picture as possible of the needs of the client, we do not wish to intrude on the client's privacy any more than is necessary, so staff members must use their judgement as to which items on the form have to be completed.

Care should be taken not to place too great a stress on disabilities. The staff member should emphasise from the outset that a worker will work with the client (and with the carer if applicable) and try to support the client's independence as far as possible. If there are health issues on which further medical or nursing details are required, the staff member should ask the client or carer to obtain and pass to us the necessary reports.

Any written documentation about the client's care needs should be appended to the form.

Services Requested

This information is recorded on the form, detailing the services that this organisation is being requested to supply. At this point a manager must take the formal decision that we are in a position to provide the requested services, given the details of the care needs assessment.

Passing Information to the Allocated Worker

When the manager has decided that this organisation will supply services, identified workers should be allocated to the case. We believe that the matching of the worker to the client is of paramount importance and so due consideration is given to the worker's availability. When all of the required elements have been agreed the client will be informed of the staff team who will undertake the service. The worker will be introduced personally to the client on the commencement of the service. The allocated worker(s) are responsible for reading and understanding the care plan.

Referrals from Social Services Departments

In cases where a potential client is referred by a social services department, the manager must obtain a summary of the needs assessment that the department has undertaken. A care needs assessment form will be completed using some of the details provided by the social services departments own care plan or care diary. The summary of the social services needs assessment should be filed with the organisation's own form. We will comply with any special local arrangements for self-assessment by clients.

Emergency Service Provision

If this organisation has been requested to provide services at short notice or in a crisis, there may not be an opportunity to carry out a full assessment before starting to provide a service. A telephone discussion, to ascertain as much information as is possible before the commencement of the service, will be recorded and used as the care needs assessment for the first 72 hours of any immediate response on emergency service provision. This organisation has a form specifically to record the needs of an immediate response situation. When emergency services are provided, the manager must complete the basic information on page one of the form and allocate the case to a worker who is competent to undertake an

initial contact assessment. In these circumstances only experienced managers of the service will make the decision to respond.

Within three working days, the manager will arrange for a full assessment to be carried out, and the form to be completed with all relevant details for providing services over a longer term. Where the immediate response is of a short-term basis only, the immediate response form will be used in conjunction with any other details supplied by social services or health to assist in the service delivery. If the service is provided at the request of a social services department, the manager must ensure that the department completes an assessment within two working days and passes the information to us as described above.

Care plan

Constantia Cares process of planning client care is based upon the following principles:

- *Planning care is user-centred.* A plan of care will never be made without the active participation of the person to whom they relate, or, where necessary, this person's representative;
- *Planning care involves others who are relevant to the client.* Many clients want their carers or relatives to be involved in planning their care. We will ensure this happens, provided that it does not prejudice the principle that the client must always remain central;
- *Planning care often needs to be multidisciplinary.* Most clients have needs that span social care and health. We will ensure that the views and contributions of all relevant agencies and professions are collated into a single plan;
- *The plan of care has to be based on evidence.* The plan of care for each client will be based on a formal assessment of their care needs;
- *The plan of care sets objectives.* As a plan of care is intended to bring about some sort of desired change, we work with the client to set objectives and to give thought as to how those aims are to be achieved;
- *The care planned must be realistic.* The plans of care we prepare are not merely expressions of aspirations; instead, they are based on realistic judgements about what can be achieved, including honest estimates of the resources involved.
- *Plans have to be reviewed.* A plan of care is not a static document; plans must be capable of being adapted if new evidence becomes available or if circumstances change. Every plan will be regularly reviewed and revised over time.
- *Plans have to be acted on.* The planning of care is not a mere paper exercise. We are sincerely committed to putting every plan of care into action, and therefore set out defined responsibilities and a clear process for monitoring progress.

Those Involved in Planning

The following people are involved in planning the care:

- *The client.* The client is always central. We emphatically do not plan *for* people; we plan *with* them. If a client is not able to participate meaningfully for them, we will always seek an appropriate representative or advocate who can faithfully put forward what they believe the client would have contributed.
- *Relatives, friends and carers.* Subject to the client's agreement, we would wish to involve other people in the client's circle who are likely to be involved in implementing the agreed client plan. We recognise that carers and others sometimes have needs and interests of their own; we will take these into account but will insist always that the needs and preferences of the client remain pre-eminent.
- *Staff of this organisation.* In planning and reviewing the care we provide, we try to involve all of the people who know the client well. This is likely to mean the staff who carried out the care needs assessment, or who dealt with the social services referral; the care staff who are providing the day-to-day service; and the person who supervises the workers.
- *Other agencies and professionals.* As health and social care needs and services are closely related, it is likely that our clients will have been in touch with other agencies. Where appropriate, and with the client's agreement, we will involve representatives of these bodies in planning care to ensure that the services we provide are as well co-ordinated as possible.

Creating the Plan

Before we start to provide a service or, in urgent cases, as soon as possible afterwards we will convene a meeting of all of the appropriate people to draw up the plan to our regular format. A central task is to identify the objectives of the care we will be providing and then to outline appropriate strategies to meet those objectives. Those involved in the process need to be realistic about what can be achieved, what resources are needed and available, who will undertake the agreed tasks, and the timescale(s). In all of these discussions, the user's views will be central.

Risks

Any plan is likely to include some risks for the client. This does not mean that no action should be taken, however, since reasonable and responsible risks are inherent to quality of life. For any situation that entails risk which is identified during the creation of the plan, a formal risk assessment will be undertaken. This will list and weigh up the positive benefits against the possible adverse effects of the proposed action; the precautions that should be taken; and the arrangements for reconsidering the matter, when appropriate. These factors and the measured conclusion of the risk assessment will be recorded as part of the care plan.

Implementing the Plan

All of those who participate in the creation of the plan must accept responsibility for contributing to its implementation. We believe a plan is for action, and our staff will be supervised and monitored against the plan's objectives and time scales.

Reviews of Care Needs

A minimum standard of an annual review is the mechanism for this organisation. To ensure that the needs of the client are relevant; we will, however, retain the flexibility to initiate a review whenever we feel it is in the client's best interests.

Whether or not any specific changes to a client's needs and circumstances have been reported, the manager should review the appropriateness of the service provided within six weeks of our starting to provide services, and at least annually thereafter. Throughout the whole assessment process great importance should be attached to the client's own views of their needs and wishes, and clients should be given every encouragement to express themselves. In the local authority areas where systems of self-assessment are in place, managers should seek advice from their social services department about the precise implications for their procedures. At the initial assessment of needs visit a discussion will take place regarding the frequency of reviews. Where social services are involved with the client they retain responsibility for the setting up of reviews, however it should be noted that this organisation reserves the right to initiate a review where there are concerns regarding the care or services provided.

Changes in a Client's Care Needs

It is the responsibility of any worker providing service to report to their manager any significant changes in a client's needs and circumstances. The manager is responsible for considering whether any change in the service is required as a result of the change in the client's needs. If so, the manager should initiate a discussion with the client or the client's carer or representative, if appropriate and with the relevant social services department, if necessary. If the changes to the care plan are of a type not exceeding 2 hours more or less than the agreed care plan this will be deemed to be a temporary change. If the change is to be a permanent one a review will be instigated that will include a variation to the fees and charges.

Records

The initial decisions about the client plan, the risk assessments and any other significant issues will be recorded and should be signed by all parties. Copies of the plan, both in its initial form and as subsequently reviewed, will be held by the client, except where there are clear and recorded reasons against this. The plan is in a format intended to be accessible to clients and others. If appropriate, arrangements will be made to translate the plan into a language the client can readily understand.

Working with clients with fluctuating needs

Principles

- We will take decisions on behalf of a client only if there is evidence that they cannot take the decision (at the time it needs to be made) because of mental incapacity. We will co-operate with relatives and others involved with the client in decision making on behalf of a person on the same basis;
- We will not take or collude in taking decisions for a client where, from its point of view, there is insufficient justification and it does not appear to be in that person's best interests;
- Staff in this organisation will only take a decision for one of its clients after it has exhausted every means of enabling the person to take it of their own accord. It will also demonstrate its actions in taking the decision are reasonable and in the person's best interests; Where staff has information that suggests the person might be unable to take some decisions at sometimes it will carry out, or contribute to, an assessment of that person's mental capacity. It recognises that the assessment procedure should follow the two-step assessment process recommended in the *Mental Capacity Act's* Code of Practice;
- This organisation ensures that it complies with all aspects of the law in the cases of clients who are subject to guardianship proceedings or who need legal protection on account of their lack of mental capacity. Included in this are clients who have assigned powers of attorney or who are subject to Court of Protection proceedings;
- Staff in this organisation familiarises themselves with and acts upon any advance directives or advance decisions that its clients have chosen to make in contingency situations where they might lose the ability to take a decision.

Assessment of Mental Capacity

- Staff ensures that a person's needs assessment and client plan of care contain all the information needed that relates to a person's decision-taking capacity, as well as the decisions over which they might need help with, on account of their possible lack of capacity;
- The information included indicates: a) which decisions the person is able to take at all/most times; b) those that the person has difficulty in taking; and c) those that the person is unable to take;
- In respect of each area of decision taking, where there are difficulties or an inability to take decisions the client plan of care records the actions to be taken for the person that are deemed in their best interests;
- The individual is always as fully involved as possible. Decisions are only taken on the basis of the best information available and with the agreement of those concerned in the person's care and future. All decisions taken for that person are fully recorded and made subject to regular review;
- Clients who lack mental capacity are only subject to restraint, in any form, when not doing so would result in injury or harm to them or to other people. All incidents where restraint has been used are recorded and reported.

Staff Involvement

- This organisation requires its care (and nursing) staff to implement the agreements and decisions that are identified in an individual's plan of care;
- This organisation also expect its staff to involve clients in all day-to-day decisions that need to be taken by seeking their consent and checking that the actions to be taken are consistent with their plan of care, if the individual client lacks capacity at the time. Where the client needs to take a decision that lies outside of their ability at the time, staff must do everything to help the person decide for herself or himself;
- This organisation expects its staff to avoid taking decisions on behalf of a client unless it can be shown that it is necessary and that the client at the time is unable to take that decision her or himself. Any such incident must be fully recorded;
- This organisation expects its staff to take decisions for clients lacking capacity only when they are reasonably believed to be necessary and in the person's best interests. When in doubt that they can act in this way they must seek advice from their line manager.

Choice has become increasingly important for clients and this organisation will attempt to advance this principle throughout our operations; we will ensure that every client who receives our service has consented. We will work to provide clients with the opportunities to exercise choice about the workers with whom they interact, and will when possible change the worker in instances when the client requests it. We are particularly sensitive to matching workers and clients where issues of gender, culture or ethnicity play a role.

Related Policies

Assessment of Need and Eligibility
Advanced Care Planning
Consent
Dignity and Respect
Deprivation of Liberty Safeguards
Meeting Needs
Mental Capacity Act 2005

Guidance

NICE Quality Standard QS123 "Home care for older people" June 2016

NICE Guidelines Older people with social care needs and multiple long-term conditions [NG 22] Published November 2015

This guideline covers planning and delivery of social care and support for older people who have multiple long-term conditions. It promotes an integrated and person-centred approach to delivering effective health and social care services.

As an organisation, we are working towards ensuring these guidelines are implemented, proportionate to our service, using the tools and resources available from NICE [

NICE quality standard [QS13]: End of life care for adults (Published August 2011). Updated March 2017

NICE Clinical guideline [CG42] Pub. November 2006 updated: September 2016
Dementia: supporting people with dementia and their carers in health and social care

NICE quality standard [QS1]: Dementia quality standard (Published June 2010).

NICE quality standard [QS30] Dementia Independence and Wellbeing April 2013

Training statement

All staff involved in the Care and Support Planning process will undertake Care Act 2014 training via the Care and Support statutory guidance with particular and emphasis on the chapter 10-13, accompanied by local authority guidance as it becomes available along with record keeping training.

The Registered Manager will review this policy.

Signed: Morag Collier

Date: 30/01/18

Review Date: 30/06/16

CHALLENGING BEHAVIOUR, VIOLENCE AND AGGRESSION

Constantia Care Ltd

Policy Statement

From time to time, clients present challenging behaviour, violent or aggressive tendencies which need to be fully documented in the assessment of need and the care plan. For the purposes of this particular policy, challenging behaviours includes self harm, self neglect, self abuse or harm to others. If challenging behaviour, violent or aggressive tendencies are present then a full and robust risk assessment must be undertaken in order to protect not just the client, but the carer. This needs to include the use of any restraint techniques where appropriate.

The Policy

This document outlines the policy of this organisation in relation to dealing with challenging behaviour, violence and aggression among clients.

Principles

- Constantia Care seeks to demonstrate respect for the lifestyles and human rights of its clients.
- We recognise, nevertheless that exceptional circumstances may arise when our workers might be called upon to place limitations on a client's behaviour, either for their interest or for the protection of others.
- We will attempt to anticipate these possibilities and to follow precise procedures designed to ensure that the limitation to a client's lifestyle or human rights is kept to a minimum.

Care Plan

In all instances where our carer's are likely to encounter challenging behaviour, violence or aggression to an extent that might limit a client's lifestyle or human rights, we will seek, when the client Care Plan is drawn up or revised, to discuss the facts with all concerned and record the decision and the proposed action in detail.

We will seek to understand the reasons for the possible action, and to initiate action which will tackle the problem more positively.

Risk Assessment

In the course of considering the client plan we will carry out and fully record a risk assessment in order to make a sober calculation of the possible danger which is faced, and the balance of benefits and disadvantages of the proposed course of action.

Client's Consent

We will make every effort to involve the client at risk of limitation to their lifestyle or human rights in the discussion about possible physical intervention, and to obtain their agreement that such an intervention might be necessary.

For clients who are permanently unable to understand the situation or to give informed consent, we will seek agreement from someone close to them and knowledgeable about the situation that can genuinely represent their interests.

The Use of Restraint

The circumstances in which we regard as justified an intervention by a worker of this organisation which would have the effect of limiting a client's lifestyle or human rights are:

- To prevent self-harm or self-neglect by the client
- To prevent abuse or harm to others.

We class intervention as the use of chemical, physical or mechanical methods of restraint. The intervention used must be the least that is able to contain the risk, last for as short a time as possible, be administered only by appropriately trained and competent staff and neither intervention, nor the threat of intervention, should ever be used as a form of punishment.

Reporting

Any instance of the use of any intervention methods should immediately be recorded. The Carer involved should report what happened to their co-ordinator as soon as possible and the manager should review the position and initiate any possible action to avert a recurrence.

Inappropriate Use of Intervention by Others

We regard the use of medication simply as a means of chemical intervention to be unethical. Because our carers work permanently in a client's home, on occasions they observe the services provided by other professionals and the care given by relatives and friends. If we learn of situations where we believe physical intervention is being used inappropriately by others, we will bring the matter to the attention of the appropriate authorities.

Related Policies

Assessment of Need and Eligibility

Adult Safeguarding

Care and Support Planning

Consent

Dignity and Respect

Mental Capacity Act 2005

Restraint

Guidance

NICE Quality Statement, QS154 published June 2017 - Violent and aggressive behaviours in people with mental health problems

Training Statement

All staff and self-employed care assistants will have training in prevention of & dealing with people with challenging behaviour. They will also be supported in understanding the meaning of physical intervention and their responsibilities.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 16/03/16

Review Date: 30/06/16
30/09/16
10/12/16
28/03/17
23/06/17
20/02/18

CLIENT'S HOME SECURITY

Constantia Care Ltd

Policy Statement

Constantia Care believes that carers should ensure the security and safety of Clients and their homes at all times when providing a personal service.

The Policy

The aim of Constantia Care is to ensure that clients are protected and are safe and secure in their home.

Carers should ensure the security and safety of the home and the client at all times when providing a personal service.

- During the initial assessment, when care is planned, the security of the home should be discussed and an agreement reached about how the carer will affect entrance to the client's home; this should be entered in the Care Plan.
- Carers should always:
 - a) Carry their identification badge and show it to the client on entry.
 - b) Encourage clients to adopt safe home security practices wherever possible, including using door safety chains, even when they know that the worker will be at the door and requesting identification.
- Carers should never:
 - a) Agree to leave a key outside a house, in a safe place or on string by the letterbox.
 - b) Attempt to effect forced entry to the home.
- If it is decided that the carer should hold a copy of the client's key, then the permission of the client or their relatives should be made in writing and a suitable entry made to the Care Plan. Key holding should never be embarked upon without the express permission of the client and their co-ordinator and without an entry being made into the Care Plan.
- Carers who hold keys for clients should
 - a) Label the key with a code, never with the name and address of the client (in case the key becomes lost).
 - b) Be very careful to keep the key in a safe place at all times.
 - c) Inform their co-ordinator immediately in cases of the loss or theft of keys.
- When key safes and key cards are used. Key code numbers are recorded in the clients Care Plan.
- Security of key code numbers is paramount; if a carer forgets a key code number they must call their co-ordinator who will call the carer back to confirm their identity before giving the number over the phone.
- Carers should never:
 - a) Leave key safe open when leaving the client,
 - b) Attempt to effect forced entry to the home.

Entering a Client's Home — Protocol

When entering a client's home, carers should

- Knock or ring the doorbell or call out before entry, even if they hold a key and can let themselves in.
- Always show their identification badge on entry.
- Offer to check that windows and doors are secure before leaving a premises.
- Always check that the door is secure as they leave.

Identity Card Policy

Identity cards are provided for all carers entering the home of clients.

These cards should display:

- A photograph of the member of the carer.
- The name of the person and employing organisation in large print.
- The contact number of the organisation.
- The date of issue and an expiry date, which should not exceed 36 months from the date of issue.

and should also be

- Available in large print for people with visual disabilities.
- Laminated.
- Renewed and replaced within at least 36 months from the date of issue.
- Returned to the organisation when employment ceases.

Emergency Procedure

The following procedure should be followed in cases where a carer first attends a client's home and cannot gain access or receive an answer from the client.

The carer should

- Check in their diary that they have the right day/time/address.
- Knock several times and try to raise the client by calling through the letterbox.
- If there is still no answer then they should try phoning the client or their relatives, or get the agency to call the client or their relatives.
- If the problem is not resolved by phone, then the situation should be reported to their co-ordinator who will continue to attempt to contact the client and/or their relatives.
- If there is cause for concern as to the client's wellbeing then the carer should report this to their co-ordinator and the police should be contacted, either by the office or by the carer themselves.
- On no account should the carer attempt to affect forced entry to the home; in the event of an emergency, the carer should always contact the police or an ambulance and wait for them.

Related Policies

Adult Safeguarding

Assessment of Needs and Eligibility

Care and Support Planning

Code of Conduct for Workers

Cyber Security

Data Protection

Monitoring and Accountability

Record Keeping

Client Records (HOME)

Training

All staff and carers will read this policy and be trained in home security procedures. Security training will be included in the induction process for all new staff and training on security will be conducted at least annually.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 20/02/18

Review Date: 20/08/18

CLIENT'S RECORDS (HOME)

Constantia Care Ltd

Policy Statement

Constantia Care believes that all records required for the protection of clients and for the effective and efficient running of the organisation, should be maintained accurately and be kept up to date; that clients should have access to their records and information about them; and that all individual records and organisation records should be kept in a confidential and secure fashion. The organisation also adheres fully to the *Data Protection Act 1998*.

The Policy

This policy is intended to set out the values, principles and policies underpinning this organisation's approach to record keeping, data protection and access to records.

Record-keeping

- With the clients consent, carers should complete the Daily Observations daily; including the services provided and any significant occurrences.
- Where appropriate, records should include:
 - Assistance with medication including any changes or additions; plus the MAR chart initialled immediately after medication is given.
 - Financial transactions undertaken on behalf of the client.
 - Details of any changes in the client's or carer's circumstances, health, physical condition or care needs.
 - Any accident, however minor, to the client and/or yourself.
 - Any other untoward incidents.
 - Any other information that would assist the next health or social care worker to ensure consistency in the provision of care.
 - Health professional, relative, friend and agency visits.
- All records required for the protection of clients and for the effective and efficient running of the organisation should be maintained in an up-to-date and accurate fashion by all staff.
- Clients have access to their records and information about them held by the organisation; they should also be given opportunities to help maintain their own personal records.
- Individual records and organisation records should be kept in a secure fashion; should be up to date and in good order; and should be constructed, maintained and used in accordance with the *Data Protection Act 1998* and other statutory requirements.
- Records should be kept in the home until the service is concluded, after which time they should be transferred, with the permission of the service user, to the provider company or other suitable body (e.g. local authority or health trust, or other purchaser of the service for safe keeping).

In this organisation carers should

- Fill in all care records and clients notes in the presence of and with the co-operation of the client concerned, wherever practical or reasonable
- Ensure that all care records and notes, including clients care plans, are signed and dated
- Ensure that all files or written information of a confidential nature are stored in a secure manner, wherever possible.

Access to Records Policy

The organisation believes that access to information, alongside the security and privacy of data, is an absolute right of every client and they are entitled to see a copy of all personal information held about them, and to correct any error or omission therein.

Related Policies

Access to records
Adult Safeguarding
Care and Support Planning
Confidentiality
Cyber Security
Data Protection
Record Keeping

Training Statement

All new staff and carers are encouraged to read the policies on data protection and on confidentiality as part of their induction process. Training in the correct method for entering information in clients' records is given to all carers. The nominated data user/data controller for the organisation will be trained appropriately in the requirements of the *Data Protection Act 1998*.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 20/02/18

Review Date: 20/08/18

Clinical Governance Statement

Constantia Care Ltd.

Constantia Care embraces the concept that 'clinical governance' is a framework which helps all clinicians – including nurses to continuously improve quality and safeguard standards of care by creating an environment in which excellence in clinical care will flourish.

Clinical governance aims to integrate all the activities that impact on client care into one strategy.

This involves

- improving the quality of information,
- promoting collaboration, team working and partnerships
- reducing variations in practice and implementing evidence based practice

Constantia Care recognises that 'Clinical governance' is an umbrella term for everything that helps maintain and improve high standards of client care. It covers a whole range of quality improvement activities that many nurses are already undertaking for example clinical audit and practice development. It also provides a framework to draw these activities together in a more co-ordinated way

The sections of this framework therefore are set out under the following key headings, which have been adopted from the Department of Health (DH) reporting framework for clinical governance (DH, 2003):

- risk management
- supporting nurses in the work place
- quality improvement in action
- placing clients experience at the heart of health care

Risk management is about minimising risks to clients by:

- identifying what can and does go wrong during care
- understanding the factors that influence this
- learning lessons from any adverse events
- ensuring action is taken to prevent recurrence
- putting systems in place to reduce risks
- ensuring information works for you recognising the importance of the flow of information in safeguarding clients

Supporting Nurses in the workplace

Staffing and staff management is vital to our ability to provide high-quality care. We need to have highly skilled staff, working in an efficient team and in a well-supported environment. Education, training and continuing professional development

It is vital that nursing staff caring for clients have the knowledge and skills they need to do a good job. It is for that reason that they are given opportunities to update their skills to keep up with the latest developments as well as learn new skills and work effectively with other visiting health professionals.

Quality improvement in action

- Evidence-based care and effectiveness
- Care for clients based on good quality evidence from research.
- The National Institute for Health and Clinical Excellence (NICE) is responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.
- Effective monitoring and auditing processes

Clinical audit

Clinical audit is a way that healthcare professionals can measure the quality of the care they offer. It allows them to compare their performance against a standard to see how they are doing and identify opportunities for improvement. Changes can then be made, followed by further audits to see if these changes have been successful. As an organisation we may be called upon from time to time to participate in national audits

Placing clients experience at the heart of health care

As an organisation we want to offer the highest quality care and recognise the importance of working with clients and carers. This includes gaining a better understanding of the priorities and concerns of those who use our services by involving them in our work, including our policy and planning.

We gain the views of clients and carers is through our meetings and feedback We also monitor the views of patients through complaints and compliments Staffing and staff management

Staffing and staff management is vital to our ability to provide high-quality care. We need to have highly skilled staff, working in an efficient team and in a well-supported environment.

This statement will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

CODE OF CONDUCT FOR WORKERS

Constantia Care Ltd

Policy Statement

Constantia Care believes that all clients, staff and self-employed care assistants have a right to:

- Privacy
- Dignity
- Freedom of choice
- Control over what happens in their own home
- Independence
- Fulfilment
- Integrity

All Care and Support staff/ self-employed care assistants will be issued with a copy of the "Skills for Care Code of Conduct".

All registrants with the Health and Social Care Professions Council (HSCP) will be issued with a copy of the "Standards of conduct, performance and ethics"

All nurses and midwives registered with the Nurses and Midwifery Council (NMC) will be issued with The Code.

All workers must treat clients in such a way that respects these rights. This Code of Conduct sets down the expected standards of behaviour in general and in particular, to ensure that workers work with clients in such a way as to maintain these rights.

All of the above codes should be used as a cross-referencing guide for this policy.

The Policy

Behaviour

- Workers and self-employed care assistants will not smoke in a client's home.
- Workers and self-employed care assistants will not consume alcohol whilst on duty, nor be under the influence of alcohol when reporting for duty.
- Workers and self-employed care assistants will not take any other person into a client's home without written authorisation from the office manager or their representative.
- Workers and self-employed care assistants will not remain in a client's home without the client or their representative being present, unless specific permission in writing is given by the client or their representative to the local office.

Identity Cards

- Workers and self-employed care assistants will carry their identity card to all clients' assignments, and show it upon entry or when requested to do so by the client, their representative, or any other person in authority.
- Failure to carry their identity card may result in the worker or self-employed care assistant not being admitted to a client's home and subsequent disciplinary action may be taken.

Dress and Infection Control

- Workers and self-employed care assistants will ensure that their personal hygiene is satisfactory, before entering a client's home.
- Workers and self-employed care assistants will be smart in appearance and dress appropriately for the tasks they are to carry out.
- Disposable latex gloves and disposable aprons will be used for all personal care work.

Confidentiality

- Workers and self-employed care assistants must observe at all times, whether during or after termination of any assignment, the strictest confidence in all dealings with the client and this organisation in accordance with the company's confidentiality policy.

Equal Opportunities

- All workers will be treated equally and fairly, regardless of their race, nationality, ethnic or natural origin, religion, marital status, sexuality or disability;
- All clients will be treated in the above manner by workers.

Time Keeping

- Workers and self-employed care assistants will visit clients at the times specified on their rota, and stay with the client for the entire duration allocated, and failure to do so could lead to disciplinary action.

Gifts and Gratuities

- Workers and self-employed care assistants must not accept gifts, tips or gratuities from clients without prior written approval from this organisation

Wills

- A worker or self-employed care assistant will decline to be a signatory to, or beneficiary or executor of a client's will.

Purchases and Sales

- Workers and self-employed care assistants, or their friends, relatives or acquaintances will not, under any circumstances, offer either to purchase or sell any item—irrespective of size or value—from a client, including via catalogue shopping and similar means of purchase.
- When shopping for clients, workers and self-employed care assistants will not claim these purchases on their own bonus or loyalty cards.
- Workers and self-employed care assistants or their friends, relatives or acquaintances will not borrow money from, nor lend money to, clients.

Use of client's property

- Workers and self-employed care assistants or their friends, relatives or acquaintances will not use or borrow any household or garden equipment, car or any other property of the client, for their own, their family's or friends' benefit, either in the client's home or outside it. This also includes the use of any electronic media including computers.

Medication

- Workers and self-employed care assistants will not, under any circumstances, purchase, collect or assist in giving any proprietary or prescribed medication, except in accordance with this organisation's Medication Policy.

Appointee and Financial matters

- Workers and self-employed care assistants will not act as appointees, or in any other official capacity, either for, or on behalf of, the client without prior written approval from this organisation.
- Workers and self-employed care assistants will not undertake any financial transactions either for, or on behalf of, a client, except those set down in the clients care or support plan.

Personal Relationships

- Workers and self-employed care assistants will at all times maintain a proper, professional relationship with the client, avoiding emotional and physical familiarity.
- Workers and self-employed care assistants that find themselves becoming personally involved with a client must notify the office manager immediately so that appropriate action can be taken after discussion with the client, their representatives and the worker or self-employed care assistant.

Behaviour whilst Off Duty

- Workers and self-employed care assistants must be mindful not to breach confidentiality or professional boundaries whilst off duty.
- Issues regarding work must not be discussed or disclosed to any third party whilst off duty.
- Workers and self-employed care assistants must not visit a client whilst off duty, unless written permission has been given by this organisation
- Workers and self-employed care assistants must be mindful not to talk about clients or their colleagues whilst socialising, especially in public places where their conversation might be overheard.
- Workers and self-employed care assistants must ensure that all paperwork relating to their work is stored safely and out of sight, even at home.
- Report any breaches of this policy immediately.

Related Policies

Alcohols and Drugs

Bullying and Harassment

Dress Code

Monitoring and Accountability

Social Media and Networking

Training Statement

All workers and self-employed care assistants will receive an induction into the service, which includes an employee handbook and appropriate policies and procedures identifying the above. These areas will also be covered in staff supervision sessions as required.

The Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England will be issued and explained to staff at induction. Following the guidance set out in this Code of Conduct will give our health and care staff the reassurance that they are providing safe and compassionate care of a high standard, and the confidence to challenge others who are not. This Code will also tell the public and people who use health and care services exactly what they should expect from our health or care staff.

This policy will be reviewed by the Registered Manager.

Signed: Morag Collier

Date: 30/01/18

Review Date: 30/06/18

COLLECTION OF PRESCRIPTIONS

Constantia Care Ltd.

Policy Statement

With respect to the collection of prescriptions for a client, this organisation adheres to the *Medicines Act 1968*, the *Misuse of Drugs Act 1971*, the *Misuse of Drugs (Safe Custody) Regulations 1973* and the Nursing and Midwifery Council Guidelines for the Administration of Medicines.

Constantia Care believes that every client has the right to manage and administer their own medication if they wish to, and that this is an important part of maintaining their independence, dignity and autonomy.

This not only applies to the keeping and administration of medicines, but also to their collection and dealing with prescriptions

The Policy

- When the client cannot collect their own medication or it cannot be delivered by the pharmacy the carers needs to take on this task for the client
- Carers from Constantia Care will provide support to enable safe self-administration and collection of prescriptions or medication when required.
- To ensure the safety of both clients and carer, any request for care involving medication including the collection of prescriptions by carers should be discussed with the line managers before being implemented, to ensure that the role being requested is appropriate and can be performed safely and competently by staff. No member of staff should proceed with care involving medication including the collection of prescriptions, unless they have the agreement of a line supervisor or manager and a risk assessment has been carried out and fully documented in the Care Plan.
- When collecting prescriptions, staff should follow these guidelines:
 - Wherever the possibility of an arrangement exists for the GP practice to automatically inform a pharmacist of a prescription and for that prescription to be delivered to a client by the pharmacist, then this arrangement should be supported by staff in preference to actually collecting the prescription themselves.

Where no such arrangement exists, carers should:

- Ensure that both the GP surgery and the pharmacy are informed of who will be collecting the prescription and that, in the case of repeat prescriptions, the appropriate forms have been completed and handed to the surgery
- Collect the prescription from the GP surgery, following whatever prescription system is in place at the surgery and giving the surgery sufficient warning as is required in the case of repeat prescriptions
- Take the prescription immediately to the pharmacy and follow whatever system is in place at the pharmacy
- Where necessary, produce proof of identity
- Transport the medication immediately to the client's home
- Show the medication to the client or a relative and go through the prescription to ensure that it is correct
- Place the medication in a safe place as agreed with the client, relative or other staff.

Where a member of staff has any queries about the prescription or collection of a prescription they should, with the client's permission, discuss the matter with the GP or pharmacist involved or with their line manager and inform the manager.

Related Policies

Autonomy and Independent
Care and Support Plan
Medication
Meeting Needs

Training Statement

All staff will be offered Induction training covering basic information about common medicines, prescribing practice and how to recognise and deal with medication problems. Nursing staff will be expected to keep themselves up to date as specified in the Nursing and Midwifery Council guidelines for the administration of medicines. Additional training will be by staff annually or as required undertaken.

Staff in this organisation should never undertake any duties or roles that they have not been trained to do, or for which they do not feel competent.

This policy will be reviewed by the Registered Manager.

Signed: Morag Collier

Date: 30/01/18

Review Date: 30/06/18

COMPLAINTS POLICY

OUTCOME 17, REGULATION 19 (Complaints)

Constantia Care Ltd.

Policy Statement

Constantia Care Ltd's policy is intended to comply with the above Outcome and Regulation contained within the Care Quality Commission Essential Standards of Quality and Safety Guidance.

Constantia Care Ltd. accepts the rights of clients to make complaints and to register comments and concerns about the services received (please see separate Comments and Compliments policy). It further accepts that they should find it easy to do so. It welcomes complaints and looks upon them as opportunities to learn, adapt, improve and provide better services.

This policy is intended to ensure that complaints are dealt with properly and that all complaints or comments by clients and their relatives, carers and advocates are taken seriously.

The policy is not designed to apportion blame, to consider the possibility of negligence or to provide compensation. It is not part of Constantia Care's disciplinary policy.

Constantia Care believes that failure to listen to or acknowledge complaints leads to an aggravation of problems, client dissatisfaction and possible litigation. Constantia Care supports the idea that most complaints, if dealt with early, openly and honestly, can be sorted at a local level between just the complainant and Constantia Care.

Constantia Care acts on the basis that, wherever possible, complaints are best dealt with on a local level between the complainant and Constantia Care's management.

Aim of the Complaints Procedure

Constantia Care aims to ensure that its complaints procedure is properly and effectively implemented and that clients feel confident that their complaints and worries are listened to and acted upon promptly and fairly.

Specifically it aims to ensure that:

1. Clients, carers, users and their representatives are aware of how to complain and that Constantia Care provides easy to use opportunities for them to register their complaints
2. A named person will be responsible for the administration of the procedure
3. Every written complaint is acknowledged within 5 working days
4. All complaints are investigated within 14 days of being made
5. All complaints are responded to in writing within 28 days of being made
6. Complaints are dealt with promptly, fairly and sensitively, with due regard to the upset and worry that they can cause to both clients and staff.

Responsibilities

The registered manager is responsible for following through complaints for Constantia Care.

The Care Quality Commission contact details are:

Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Complaints Procedure

Verbal complaints

1. Constantia Care accepts that all verbal complaints, no matter how seemingly unimportant, must be taken seriously.
2. Front-line care staff who receive a verbal complaint are expected to seek to solve the problem immediately.
3. If they cannot solve the problem immediately, they should offer to get their line manager to deal with the problem.
4. Staff are expected to remain polite, courteous, sympathetic and professional to the complainant. They are taught that there is nothing to be gained by adopting a defensive or aggressive attitude.
5. At all times in responding to the complaint, staff are encouraged to remain calm and respectful.
6. Staff should not accept blame, make excuses or blame other staff.
7. If the complaint is being made on behalf of the client by an advocate, it must first be verified that the person has permission to speak for the client, especially if confidential information is involved. (It is very easy to assume that the advocate has the right or power to act for the client when they may not). If in doubt it should be assumed that the client's explicit permission is needed prior to discussing the complaint with the advocate.
8. After talking the problem through, the manager or member of staff dealing with the complaint will suggest a course of action to resolve the complaint. If this course of action is acceptable then the member of staff should clarify the agreement with the complainant and agree a way in which the results of the complaint will be communicated to the complainant (ie through another meeting or by letter).
9. If the suggested plan of action is not acceptable to the complainant, then the member of staff or manager will ask the complainant to put their complaint in writing to the registered manager. The complainant should be given a copy of Constantia Care's complaints procedure if they do not already have one.
10. Details of all verbal and written complaints must be recorded in the Complaints Book, the client's file and in the home records.

Serious or written complaints

1. Preliminary steps:
 - a. When we receive a written complaint it is passed to the named complaints manager who records it in the Complaint Book and sends an acknowledgment letter within 5 working days to the complainant
 - b. The manager also includes a leaflet detailing Constantia Care's procedure for the complainant. (The complaints manager is the named person who deals with the complaint through the process)
 - c. If necessary, further details are obtained from the complainant; if the complaint is not made by the client but on the client's behalf, then consent of the client, preferably in writing, must be obtained from the complainant
 - d. If the complaint raises potentially serious matters, advice could be sought from a legal advisor. If legal action is taken at this stage, any investigation by Constantia Care under the complaints procedure immediately ceases
2. Investigation of the complaint by Constantia Care:
 - a. Immediately on receipt of the complaint, the complaints manager will start an investigation and within 14 days should be in a position to provide a full explanation to the complainant, either in writing or by arranging a meeting with the individuals concerned
 - b. If the issues are too complex to complete the investigation within 28 days, the complainant will be informed of any delays.
 - c. Where the complaint cannot be resolved between the parties, an arbitration service will be used. This service and its findings will be final to both parties. The cost of this will be borne by Constantia Care.

3. Meeting:
 - a. If a meeting is arranged, the complainant will be advised that they may if they wish bring a friend or relative or a representative such as an advocate
 - b. At the meeting a detailed explanation of the results of the investigation will be given and also an apology if it is deemed appropriate (apologising for what has happened need not be an admission of liability)
 - c. Such a meeting gives Constantia Care management the opportunity to show the complainant that the matter has been taken seriously and has been thoroughly investigated.

4. Follow-up action:
 - a. After the meeting, or if the complainant does not want a meeting, a written account of the investigation will be sent to the complainant. This includes details of how to approach the Care Quality Commission if the complainant is not satisfied with the outcome
 - b. The outcomes of the investigation and the meeting are recorded in the Complaint Book and any shortcomings in company procedures will be identified and acted upon
 - c. Constantia Care management formally reviews all complaints at least every six months as part of its quality monitoring and improvement procedures to identify the lessons learned.

Vexatious Complainers

This company takes seriously any comments or complaints regarding its service. However, there are clients who can be treated as vexatious complainers due to the inability of Constantia Care to meet the outcomes of the complaints, which are never resolved. Vexatious complainers need to be dealt with by the arbitration service in order that the time factor required to investigate repeatedly becomes less of a burden on Constantia Care, its staff and other clients.

Local Government Ombudsman (LGO)

Since October 2010 the Local Government Ombudsman can consider complaints from people who arrange or fund their own adult social care. This is in addition to complaints about care arranged and funded by local authorities, which the LGO has dealt with for more than 35 years.

The LGO's new role includes those who "self-fund" from their own resources or have a personalised budget. It will ensure that everyone has access to the same independent Ombudsman service regardless of how the care service is funded. In most cases they will only consider a complaint once the care provider has been given reasonable opportunity to deal with the situation. It is a free service. Their job is to investigate complaints in a fair and independent way. They do not take sides and they do not champion complaints.

They are independent of politicians, local authorities, government department, advocacy and campaigning groups, the care industry, and the Care Quality Commission. They are not a regulator and do not inspect care providers.

The short film linked below provides an overview of the new adult social care service. It explains our new role and how the service will benefit both clients and care providers. You can also download a free copy of the film and a copy of the manuscript.

<http://www.lgo.org.uk/adult-social-care/>

They are fully independent of the Care Quality Commission (CQC). They deal with individual injustices that people have suffered and CQC will refer all such complaints to them. CQC deals with complaints about registered services as a whole and does not consider individual matters. They can share information with CQC but only when they feel it is appropriate. CQC will redirect individual complaints to them, and they will inform CQC about outcomes that point at regulatory failures.

Relevant Contacts

County Council
Contracts Monitoring Unit

Social Services Local Office

County Police HQ

The Parliamentary and Health Service Ombudsman
Millbank Tower
Millbank
London
SW1P 4QP
Tel. 0345 015 4033

The Local Government Ombudsman
10th Floor,
Millbank Tower,
Millbank,
London
SW1P 4QP
Advice Line Tel: 0300 061 0614

*Out of Hours Service (Social Services)

*This service is available when social services offices are closed

To Raise Concerns Contact:

The Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA
Tel. 03000 616161

They will take details of concerns and respond appropriately and proportionately to the information divulged.

Training

The registered manager is responsible for organising and co-ordinating training on the complaints procedure.

All staff receive training in dealing with and responding to verbal and written complaints. The complaints policy and procedures are included in new staff members' induction training. In order to learn from mistakes, staff group meetings and supervisions are used to discuss formal complaint issues, in order that all staff can share and learn from the experiences.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review date: 30/06/18

COMPLIANCE PRINCIPLES

Constantia Care Ltd.

Policy Statement

Constantia Care is aware of the governance requirements that are in Regulation 17 New Fundamental Standard Regulations that are basis required by the company in order to gain, maintain and improve the required regulatory conformance. The company is aware of the importance of its staff and their contribution in terms of their own conduct, regardless of their role. In order to meet the regulatory requirements and the compliance framework, staff understands the context of compliance, its legislative and regulatory framework and their role and contribution to that framework

Compliance Statement

As Constantia Care we are committed to fulfilling its obligations to provide safe and effective care in accordance with the Health & Social Care Act 2008, the Fundamental Standards 2014 and the 5 key domains of: is the service Safe, Effective, Caring, Responsive and Well led?

We will ensure our service is **Safe** by ensuring our systems and processes are continually monitored and evaluated to promote a culture of continuous improvement. Our management team will follow safer recruitment principles to ensure we employ the very best people who possess the skills, experience and competence necessary to deliver safe and person centred care. People will be kept safe because staff will be trained to the highest standards and will be managed and supported to deliver safe care through robust safeguarding and whistle blowing procedures. We will provide a safe and comfortable environment for people to live, supported by stringent health and safety and environmental management.

We will ensure our service is **Effective** because people will be in control of their care and support. We are a listening organisation, so care and support plans will be tailored to the needs and aspirations of each individual by working to realistic and attainable outcomes. We will continuously check that outcomes are being met through our quality monitoring systems and will use the evidence gathered to ensure our service is fit for purpose and meeting people's needs.

Our staff are selected and trained to the highest standards to ensure they possess all the personal and professional qualities needed to deliver a service that is **Caring**. To ensure these standards are maintained our staff are encouraged to embark on a career based on the principles of continuous professional development and sharing best practice. We will provide an environment where staff and customers feel cared for and where this is not the case swift corrective action is taken.

Our infrastructure is well established and through robust management systems, care-planning tools, professional well-trained staff and effective operating procedures the service is **Responsive** to peoples changing needs. We constantly engage, observe and listen to ensure that the service constantly evolves with the people that use it. We ensure that our customers have a platform to raise any issues with us without fear of recrimination or bias and will always act swiftly to rectify any problems.

Our management team is committed to maintaining the highest level of corporate governance. We will always operate in an open and transparent manner and will ensure we support our managers and staff to deliver the very best standards of care possible. We will never compromise on quality and encourage a culture of learning and self-improvement to ensure that our service is outstanding and our organisation is **Well Led**

The Policy

This policy sets out for all staff the procedures that are in place to ensure compliance with all required legislation, regulations and good practice. This policy needs to be read in conjunction with other relevant policies.

Regulation of Adult Health and Social Care

For staff at all levels within the organisation it is important to understand the regulations that are worked to on a day-to-day basis and that those regulations underpin the daily good practice. It is the daily practice and interaction with Clients that evidences compliance with such regulations. Government legislation and the regulatory framework is the structure upon which all service delivery is benchmarked.

Set out below is a non-exhaustive list of the main relevant regulators, demonstrating the complex and varied types of regulation currently in force.

Please note: Local Authority or NHS contracts which are in place for clients each of which have a Service Specification which should be viewed as a regulatory framework for the business to meet and be monitored as to performance in meeting those contractual obligations.

- Health and Safety Executive (HSE)

National regulator for health and safety in the workplace. Works in partnership with co-regulators in local authorities to inspect, investigate and when necessary take enforcement action.

On 1st April 2015 a Memorandum of Understanding (MoU) was introduced. The MoU reflects the changes in enforcement powers granted to the CQC by the Regulated Activities Regulations 2014. It replaces the 2012 liaison agreement between CQC and the HSE that applied to Healthcare only.

The purpose of the MoU is to help ensure that there is effective, co-ordinated comprehensive regulation for patients, clients, workers and members of the public. The MoU outlines the respective responsibilities of CQC, HSE and LA when dealing with health and safety incidents in the health and adult care sectors. The MoU is one of the measures taken by government to close the “regulatory gap” identified by the Francis report into failings at Mid Staffordshire NHS Foundation Trust.

HSE homepage: www.hse.gov.uk

- Care Quality Commission (CQC)

National regulator of health and social care. Includes care provided by the NHS, local authorities, independent providers and voluntary or charitable organisations in registered settings. They register and license care services and inspects and take enforcement action where necessary.

CQC homepage: www.cqc.org.uk

- Monitor

National regulator for the health sector. Protects and promotes the interests of people who use health services. Licenses providers of health, regulates prices, enables integrated care and supports service continuity.

Monitor homepage: www.monitor-nhsft.gov.uk

- Medicines and Health Care Product Regulatory Agency (MHRA)

Government agency responsible for ensuring that medicines and medical devices work and are acceptably safe. It is an executive agency in the Department of Health. It regulates medicines, medical devices and equipment within the NHS or used in healthcare settings. It looks after blood and blood products. It issues Medical Devices alerts.

MHRA homepage: <http://www.mhra.gov.uk>

- Quality Monitoring and Audits

In order to foster an ethos of continuous improvement in this organisation's compliance plan, monitoring and auditing take place regularly; this organisation monitors performance and audits conformance. Both monitoring and auditing are set within the compliance regulatory framework and provide evidence to inspectors and other regulators or quality assessors, e.g. ISO9001 of our ability to meet compliance.

- Professional Bodies

These are the regulatory bodies whose aim is to ensure that proper standards are maintained by health and social care professionals in their day-to-day work, and to act when they are not. In order to practice in the UK, professionals are required to register with the relevant body. All bodies fulfil similar functions for different professions across the UK. This organisation has robust recruitment and selection policies and procedures that comply with Regulation 21 of the *Health and Social Care Act 2008*; as part of this the organisation ensures that, where appropriate to the post, a check of the registers takes place and that all staff are up to date with the requirements of such registers, e.g. the Nursing and Midwifery Council for the registration of nurses. The recruitment of non-care staff also follows the required robust procedures.

Constantia Care also recognises its responsibility under compliance to inform the regulator when the person running the provision, or a health and social care worker, is no longer fit for work for the purpose of carrying out or working in a regulated activity. This includes, where necessary, reporting to the DBS referral.

- Code of Conduct

The Code of Conduct issued by Skills for Health and Skills for Care, for health and social care workers. This organisation promotes this Code of Conduct at recruitment and throughout the career of the staff member.

Relevant links: <http://www.skillsforcare.org.uk/www.skillsforhealth.org.uk>

- Health and Care Professions Council (HCPC)

The HCPC regulates health care professionals. This organisation, as part of its safeguarding procedures, checks any private health care professional it contracts against their register, and encourages its clients to do so if employing them independently. HCPC homepage: www.hcpc.org.uk.

Related Policies

All Organisation Policies

Training Statement

All staff are made aware of this policy during induction and are updated if the policy is reviewed and amended. Any regulatory framework training changes are implemented with immediate effect. All staff are given the relevant Codes of Conduct as they are issued.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/17

Date of Review: 30/06/18

COMPLIMENTS (LISTENING AND LEARNING) POLICY **OUTCOME 16, REGULATION 10 (QUALITY)**

Policy Statement

Constantia Care Ltd wants to make it as easy as possible for you to let us know your views and thoughts. Through listening and learning we will improve the quality of the services we provide and encourage good practice by our staff.

Aim of the Policy

Constantia Care wants to make sure that everyone can contact and communicate with us. Please let us know if you would like help in making your views known

Please Let us know if:

- You have a suggestion on how we might improve services
- You would like to compliment us on a job well done
- We have fallen short of your expectations
-

Comments

We always encourage open communication about your satisfaction or dissatisfaction with the service we provide. Constantia Care want you to know that you can always tell us about your experiences of the service you receive and we welcome suggestions from you on how we can improve things.

It is always encouraging when you feel motivated enough to compliment us or a member of staff for something you feel they have done well, "over and above the call of duty" etc. Naturally, Constantia Care want to ensure others know you have passed on a compliment because they too feel encouraged and this filters down to the standard of care we provide.

We are happy to receive any compliment in whatever manner you see fit. If it is possible that you can let the Registered Manager know of your compliment this helps us ensure that others may be encouraged to let us know. It is important that staff have positive feedback which helps to balance any negative views of their performance.

Everyone needs to know how well they do, as well as areas where improvements are required.

Registered Manager: Morag Collier
Contact Address: Constantia Care Ltd
North London Business Park, Building 3
Oakleigh Road South
Barnet
London N11 1NP

Of course, if you are pleased, a letter to the Regional Director of our Inspectorate is very welcome.

The details for such a letter are:

The Care Quality Commission
Citygate, Gallowgate
Newcastle upon Tyne NE1 4PA
Telephone: 03000 616161
Fax: 03000 616171

Good news is always encouraging, if you could send us a copy of that letter, we can use it to encourage others too by passing the information on.

You will receive a written response within 15* working days.

*However, in exceptional circumstances where this is not possible, we will explain why and new timescales will be given.

Wherever possible we would hope that you can come and tell us when you are unhappy about something, or have a suggestion for an improvement to the service we provide, it may only seem like a “small thing” but if it matters to you then it matters to us, and we would like to do all we can to make you feel as comfortable as possible.

All comments are taken seriously so that we can resolve any niggles. Where you feel this has not happened, we encourage you to utilise our separate complaints procedure.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

CONFIDENTIALITY

Constantia Care Ltd

Policy Statement

The policy outlined below adheres fully to the principles within the Data Protection Act 1998, the Freedom of Information Act 2000 and the Confidential Memorandum in place for local authority information purposes. All data held, stored or handled by this Constantia Care complies with the current legislation and guidance.

This document outlines the Constantia Care policy in relation to the handling of confidential information we need to hold about clients.

Definitions:

Confidential – means private, personal, intended to be kept secret

Private – belonging to or for the use of one particular person or group of people

It is important to make the above distinctions in order to fully understand our obligations in respect of confidentiality.

General

- The work of this organisation inevitably involves the need to know a good deal about our services users. We cannot provide good care without access to this information.
- Much of this information is highly personal and sensitive. We recognise that our clients have a right to privacy and dignity, and that this extends to our handling information about them in ways which cause as little as possible intrusion on those rights.
- We want our clients to feel at ease with the staff who help to care for them. An important element in that relationship is the capacity of a client to be able to share information with staff, confident that it will be used with appropriate respect and only in relation to the care provided.
- As providing care is a complex process, it is not possible to guarantee to a client that information they give about themselves will be handled only by the staff to whom it was first passed; however, we can ensure that information is seen only by staff on the basis of their need to know.
- We sometimes have to share information with colleagues in other agencies, but we only do so on the basis of their need to know and as far as possible only with the permission of the person concerned.
- We will only break the rule of confidentiality in very extreme circumstances which justify our taking that action for the greater good of a client or, exceptionally, others.

Our Legal Obligations

The **Data Protection Act 1998** lays various legal obligations on this organisation and similar organisations concerning the handling of the information we hold on individuals. Information must, for example, be obtained fairly and lawfully; be held for specified purposes; be adequate, relevant and not excessive for the purpose for which it was gathered; be accurate and up to date; and not be held for longer than is necessary. We observe all of these requirements.

Please Note

Guidance on confidentiality and how it can be maintained in respect of client information is now assisted by a wealth of information. Reference should be made to the following:

- Department of Health 2003 Confidentiality NHS Code of Practice
- National Institute for Health and Social Care Excellence
- Information Commissioner Codes of Practice
- Local Authority Confidentiality Agreements *
- Code of Practice on confidential information published by the Health and Social Care Information Centre December 2014
- Records Management Code of Practice for Health and Social Care 2016 **

* These are usually found within the Local Authority Contract or Service Specification Documents issued to you as a provider of services. These will often have a set of procedures which are in addition to any other guidance.

** This Code of Practice is for providers working under contract to the NHS

The Caldicott Principles - Revised September 2013

Principle 1. Justify the purpose(s) for using confidential information

Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

Principle 2. Don't use personal confidential data unless it is absolutely necessary

Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

Principle 3. Use the minimum necessary personal confidential data

Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

Principle 4. Access to personal confidential data should be on a strict need-to-know basis

Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

Principle 5. Everyone with access to personal confidential data should be aware of their responsibilities

Action should be taken to ensure that those handling personal confidential data - both clinical and non-clinical staff - are made fully aware of their responsibilities and obligations to respect patient confidentiality.

Principle 6. Comply with the law

Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

Principle 7. The duty to share information can be as important as the duty to protect patient confidentiality

Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

Information and Care Needs Assessment

Every user of the services of this organisation must have their care needs thoroughly assessed before services are provided. This necessarily entails the staff who carry out an assessment, or handle assessment material sent to us from other agencies, learning a considerable amount about an individual. It is the duty of such staff to retain record and pass to the allocated care workers only the information that is relevant to the person's future care. A similar obligation applies to staff involved in a review or reassessment of care needs or in making any changes in the service provided.

Handling of Information by Carers

The carers assisting a client have access both to the information passed to them when they start to work with that client and to knowledge which accumulates in the course of providing care.

They have a duty of confidentiality:

- To treat all personal information with respect and in the best interests of the client to whom it relates.
- To share with their co-ordinator, when appropriate, information given to them in confidence.
- To share confidential information, when appropriate, with colleagues with whom they are sharing the task of providing care.
- To pass and receive confidential information to and from colleagues on occasions when they have to be replaced because of sickness, holidays or other reasons, in a responsible and respectful manner.
- To pass confidential information to other social and healthcare agencies only with the agreement of the client, with the permission of their manager, or in emergencies (when it is clear that it is in the interests of the client or is urgently required for the protection of the client or another person)
- To refer to confidential information in training or group supervision sessions with respect and caution and preferably in ways which conceal the identity of the client to which it relates.
- To never gossip about a client or to pass information to any other individual other than for professional reasons.

Managerial and Administrative Responsibilities

Confidential information must occasionally be seen by staff other than the carer providing direct care. It is therefore the responsibility of managers to ensure that information is stored and handled in ways that limit access to those who have a need to know, and to provide the following arrangements in particular:

- To provide lockable filing cabinets to hold clients' records and ensure that records are kept secure at all times.
- To arrange for information held on computers to be accessed only by appropriate personnel.
- To locate office machinery and provide appropriate shielding so that screens displaying personal data are hidden from general view.

Exceptional Breaches of Confidentiality

There are rare occasions in which it is necessary for a carer acting in good faith to breach confidentiality in an emergency situation - for example, to protect the client or another person from grave danger - without obtaining the permission of the person to whom it applies. In such circumstances, the carer should use their best judgement, should consult the client's representative - a manager or a colleague if possible - and should inform their co-ordinator of what has happened as soon afterwards as possible.

Related Policies

Co-operating with other Providers

Consent

Cyber Security

Data Protection

Good Governance

Record Keeping

Services Users Records (HOME)

Training Statement

Staff Briefing, Training and Discipline

It is a responsibility of management to ensure that all relevant staff and carers are briefed on this organisational policy and procedures on confidentiality, are trained in the implications of this issue, and have opportunities to explore any problems they encounter and be supported through appropriate supervision. Inappropriate breach of the rules of confidentiality will be treated as a disciplinary matter.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 31/12/15

Review Date: 16/03/16
30/06/16
30/09/16
10/12/16
28/03/17
23/06/17
20/02/18

CONSENT

Constantia Care Ltd

Policy Statement

Constantia Care needs to ensure that suitable arrangements are in place for obtaining and acting in accordance with the consent of clients in relation to the care, treatment and support they receive.

The Policy

The aim of this policy is to provide an overview and understanding of consent, the process of gaining consent and, in relation to the *Mental Capacity Act 2005*, the importance of capacity in relation to agreed consent. All staff within Constantia Care will be kept updated of any changes via legislation or guidance.

What is Informed Consent?

“The process of agreeing to care, treatment or support based on access to all relevant and easily digestible information regarding their care, treatment or support needs”.

The above definition is straightforward and sets out the importance of the information which clients should receive before consent is agreed, in order to ensure that the consent is valid.

For truly informed consent, the client must understand the following;

- The purpose of the care, treatment or support
- Who is involved in the delivery of the service
- The practicalities and processes involved
- The benefits and risks
- Data Protection and storage
- The purpose of the consent form
- How information will be provided and updated
- The notice periods which apply
- Contact details should they have any further questions
- Full details of fees and the process of collection

In addition, a care plan should be prepared which uses language appropriate to the client and avoids the use of technical language or jargon.

It is also important to remember that written information is only one method of sharing, and the use of diagrams, pictures, tables and flow charts could make a contribution to understanding the information. There may be circumstances where video pens, podcasts, recordings or other means of sharing information may be more appropriate.

All of the above contribute to an informed consent decision.

Ongoing Consent as a Process

Informed consent is an ongoing process and consequently providers must ensure that clients:

- Continue to understand what they are consenting to
- Are provided with any new information which could influence their decision to consent
- Continue to consent to care, treatment and support in an informed environment.

Reviewing Informed Consent

Reviewing informed consent is often done informally, but on occasions it will be appropriate for formal consent to be obtained and recorded, e.g. where there is a significant change to the care plan

The Legal and Ethical Framework

“The aim of the *Mental Capacity Act 2005* is to balance the importance of care, treatment and support of people who lack capacity with a need to protect their interests and respect their current and previously expressed wishes and feelings”

The ethical principle relating to informed consent is the belief that everyone should be treated with respect, and that their diverse needs when gaining informed consent must take into account factors such as:

- Ethnicity
- Gender
- Disability
- Religious beliefs
- Culture
- Language
- Level of understanding

Sensitivity and care must be taken when going through the process of gaining informed consent. When the client has made the decision relating to their care, treatment or support this organisation will respect that autonomous decision even if they disagree with it.

This respect for autonomous and informed decision making also requires that clients are never coerced into informed consent decisions. It is important to remember that clients are potentially vulnerable to such coercion by nature of their relationship with this organisation

UK case law on consent has established 3 requirements that need to be satisfied before a client can give informed consent:

- Consent should be given by someone with the mental capacity to do so
- Sufficient information should be given to the client
- Consent must be freely given

If any of these requirements are lacking then the consent is invalid.

Informed Consent in Special Circumstances

The principles and processes in obtaining informed consent are the same, but there are circumstances where it is not possible to gain consent via the usual practices:

Delayed Consent

This usually applies in emergency situations, for instance:

- At the road side in the event of an accident
- At a cardiac arrest
- During the early stages of a person’s admission to an Accident and Emergency department.

In these circumstances a “Best Interest” decision will be taken by the emergency team involved.

Implied Informed Consent

This may arise when express written and/or verbal consent is not given, e.g. when a client is asked to transfer from chair to bed; implied consent is assumed by their participation in the manoeuvre.

The Process of Gaining Informed Consent

Below are the factors to be considered when going through the process of obtaining informed consent.

The Discussion

It is important to make clients, their family or representative as comfortable as possible at the assessment of needs stage in order that they are able to concentrate and feel confident enough to ask questions. The location should be private and free of any interruptions, where possible. Where necessary, repeat, explain and re-enforce the information given. Always ask questions to check their understanding of the information.

It is also important to think about the timing and context of the discussion, e.g. clients who have just been given news of a life-threatening illness are unlikely to be able to make informed decisions regarding, care, treatment or support whilst struggling to come to terms with their situation. Such issues will need to be considered at different intervals.

Acknowledging Diversity

It is important to acknowledge diversity alongside other factors when gaining informed consent. Asking questions can help to understand client's needs and how these can best be met.

Re-enforcing the discussion

It is not enough to give clients a verbal explanation of their care, treatment or support; their understanding of the, frequently complex and detailed, information which they have been given must also be ensured. To this end, it may be necessary to prepare information material in different formats and languages, where appropriate.

Consent Form

The signing of such a form has become standard practice in confirming that the client has freely given their informed consent to care, treatment or support they receive. Clients should not be asked to sign the consent form until they have been given adequate information and time to consider their decision. It is important to explain verbally all aspects of their care, treatment or support and check their understanding.

During the assessment of needs process it is important to engage with the clients, their families or representatives in a meaningful and professional manner in order to make the process work

Clients

The "Statement of Government policy on Adult Safeguarding", issued by the Department of Health, introduces 6 principles of safeguarding adults.

The principle of empowerment is based on a presumption of person-led decision making and informed consent. This new principle should be prioritised in working with adults. This includes safeguarding, but must also be seen as the individual being able to take person led decisions, and that their views and wishes are to be listened to and respected. Where lack of capacity is an issue the *Mental Capacity Act 2005* Code of Practice must be observed.

Assessing a client's capacity to give informed consent autonomously is an essential part of the informed consent process. This can prove challenging, however, so it is important to involve multi-agency partners and others who know the client in making such decisions. It is important to remember that the *Mental Capacity Act 2005* begins with the presumption of competence, and that capacity can fluctuate and be affected according to the manner in which information is conveyed.

The provision of accurate and meaningful information is at the very heart of acquiring informed consent.

Below are factors to consider when working with clients or groups who may be considered vulnerable.

Recognising Special Needs

Clients can have a range of special needs which should to be taken into account, but which are not always obvious: some clients may conceal them; some clients with reading or writing difficulties may conceal their limitations due to embarrassment (e.g. "I've forgotten my glasses, I will read it later") while others may have visual or hearing impairment, illness or emotional difficulties.

It is vital therefore to explore the client's abilities sensitively. The ability to process information can slow with age so older people should be given plenty of time and opportunity to ask questions, and to think about whether they desire the care, treatment and support. It is important, however, that older people are encouraged to participate fully in the consent process.

Capacity to Decide

Clients can only give consent if they are capable of choosing between alternative courses of action. This means they must be able to understand the information given to them. Where a client lacks capacity a best-interest decision involving those who know the client should be instigated using the *Mental Capacity Act 2005* Code of Practice and the local Mental Capacity team guidance.

Clients with Learning Disabilities

Clients with learning disabilities must be accorded the same respect as anyone else. Some may not be able to exercise fully their right to self-determination, but nonetheless should be offered choices within their capabilities.

Care should be taken in evaluating each individual's comprehension; use plain language, supported if necessary by using other materials such as pictures. Dependent upon the needs of the client, it may be necessary to present the information in different formats or over a longer duration.

Every effort should be made to seek informed consent. It may be necessary to involve a range of multi-agency partners who are knowledgeable about the client's situation and can contribute to an assessment of their best interests.

Conclusion

The key principles in obtaining informed consent are to put the client's needs first. To participate effectively in informed consent processes all staff and carers should have the knowledge, expertise and competencies to give sufficient information in an appropriate format and be able to answer any questions raised by the client, their family or representative.

It is vital that the relevant staff be able to assess a client's capacity to give informed consent. If staff and carers are open, honest and ensure the client understands and then truly informed consent will be obtained.

Related Policies

- Accessible Information and Communication
- Adult Safeguarding
- Assessment of Need and Eligibility
- Care and Support Planning
- Cyber Security
- Data Protection
- Deprivation of Liberty Safeguards
- Mental Capacity Act 2005
- Record Keeping

Training Statement

All staff and self-employed care assistants undertaking assessment of needs and care planning duties will be updated yearly on the *Mental Capacity Act 2005* and relevant guidance including guidance from local mental capacity teams. All staff and self-employed care assistants as part of their Induction undertake *Mental Capacity Act 2005* awareness training, and this will be updated bi-annually.

The Registered Manager is responsible for the regular updating of the policy.

Signature: *Morag Collier*

Date: 30/09/16

Date of review: 10/12/16
28/03/17
23/06/17
20/02/18

CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH (COSHH) POLICY OUTCOME 3 REGULATION 13 (Safety and suitability of premises)

Policy Statement

This policy is one of several related to Health and Safety and subject to the Health and Safety Executive Guidance and Codes of Practice.

Aim of Policy

Staff need to be aware of and understand their roll in Constantia Care Ltd adherence to Safety at Work Act 1974 and all other subsequent legislation including those covered by the European Community Directives. This policy specifically relates to the requirements of the Control of Substances Hazardous to Health Regulations (COSHH) 2002 and to the REACH regulations, where appropriate.

Hazardous Substances

There are many hazardous substances which are considered as hazardous to health. The COSHH Regulations apply to substances which are identified as Toxic, Corrosive or Irritant. These can include cleaning materials, pesticides, acids, disinfectants, bleach and naturally occurring substances such as blood and bacteria.

Constantia Care Ltd provide and require all staff to wear protective clothing i.e. disposable gloves and aprons and where required protective eye goggles when working with hazardous substances as directed by the Safety Data leaflet.

Signage.

All toxins, corrosives and irritants are identified when they are considered “dangerous to supply” by a label with a specific symbol.

International symbols have replaced the old European symbols and staff need to be aware of changes.

Constantia Care Ltd would display these signs in the Clients Home, if they agree!

Any product deemed to be “dangerous to supply” must be supplied with a Safety Data Sheet.

Please Note:

Medicines, cosmetics and pesticides are covered by different legislation and do not have a Safety Data Sheet.

Employers Responsibilities

To comply with the Health and Safety Executive’s (HSE) steps for all employers to protect their employees from Hazardous Substances, Constantia Care

- Identifies the hazardous substances that are used in the work place and the risks the substances pose to workers health.
- Will put into place and regularly review any precautions required before any work starts with hazardous substances.
- Will prevent people being exposed to hazardous substances, but where this is not reasonably practicable will control the exposure.
- Will make sure that control measures are used and properly maintained and that safety procedure is followed and reviewed regularly.
- Will if necessary monitor staff exposure to hazardous substances.
- Requires all accidents, incidents and emergencies associated with COSHH to be reported and recorded according to Constantia Care’s policy.
- Will ensure that all employees are properly informed, updated, trained and supervised as appropriate.

A COSHH file is in place in each workplace; if the Client agrees.

The file lists all the hazardous substances used in the workplace.

It details

- Where they are kept
- How they are labelled
- Their effects
- The maximum amount of time it is safe to be exposed to them
- How to deal with any emergency involving them.

Misuse or harmful practice.

If workers are concerned about:

- A substance being used in the workplace which is not in the COSHH File
- Incorrect containers or labels being used
- A container of one substance being used to store another substance.
- Labels being removed or changed.
-

It must be reported to their line manager or supervisor immediately.

Disposal of hazardous materials

- Body Fluids – Blood, urine, vomit, sputum and faeces
- Disposable gloves and aprons must be worn
- Where possible the waste should be cleared and flushed down a sluice or toilet.
- The affected area to be cleaned with a disinfectant
- Cloths used for cleaning must be disposed of along with the disposable apron and gloves.
- Hands must be thoroughly washed.
- Any waste must be transferred in a sealed bag to the appropriate waste bin or container.
- All waste disposal bags must be correctly sealed as other people will have to deal with the waste after it has been placed in the bags or container

Needles, syringes, cannulas (Sharps).

Disposable gloves must be worn

A yellow sharps box will be provided by a Health Professional. Never put sharps in anything other than this or in an emergency, a hard plastic box. This must be sealed and collected for incineration.

Disposal of all other types of waste will be included in the staff training

Training.

All staff must be appropriately trained and regularly updated as required by legislation. All staff will be issued with clear instructions and guidance on how to deal with spillages and reporting and recording of such accidents, incidents or emergency situations,

This policy will be reviewed by the Registered Manager

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/6/18

CO-OPERATING WITH OTHER PROVIDERS

Constantia Care Ltd

Policy Statement

Constantia Care is committed to a service that prioritises the client. As a private provider there are some business activities which, from a commercial perspective, cannot be shared. In the interests of openness and clarity we detail our co-operation mode *di emploi* and when we would share and exchange information.

The Policy

The aim of this policy is to ensure that where there is more than one provider of care and support, all multi-agency partners are aware of our commitment to our clients and to assist where possible in a smooth transfer of information between multi-agency partners and other providers.

Arrangements

From time to time situations occur where it is important to share information in order to play our part in making a valid contribution to a seamless service for the client.

In order that care planning information is shared in relation to the admission, transfer or discharge of clients, and to facilitate any emergency procedure co-ordination with the minimum of distress and anxiety, we will co-operate fully with our multi-agency partners in the exchange of information.

Where multi-agency working is involved we will ascertain the lead responsible for the co-ordination of the care. We are aware of our Civil Emergency Team in our local authority, and have emergency and contingency plans in place.

We are aware of the *Data Protection Act 1998* and our confidentiality policies and procedures include sharing on a "need to know" basis. The shared information will be appropriate, measured, transferred securely, up to date and relevant.

Information is reviewed and updated using the review system.

If information relates to a safeguarding allegation, or disclosure is in the public interest, senior management advice is sought before any information is released to ensure the release is in accordance with relevant legislation and guidance.

Information sharing

We will ensure that any exchange of information will adhere to the Data Protection requirements and will include the following as a minimum:

- Name
- Gender
- Date of birth
- Address
- Unique Identification Number or Reference Number
- Emergency contact details
- Any person who acts as representative, advocate, who holds an LPA or equivalent with contact details where available
- Records of care, treatment and support provided up to the date of transfer
- Assessed needs
- Known preferences and any relevant diverse needs
- Previous medical history that is relevant to the clients present needs and any relevant GP contact details
- Any infection that needs to be managed
- Any medicines they need to take
- Any allergies they have
- Reason for transferring to the new service
- Any advanced decision and any assessed risk of suicide or homicide or harm to self and others.

The above information should ensure that there are no interruptions to the continuity of care, treatment and support for the client.

Emergency Admission to Hospital Procedure

- When a carer makes a decision that the health of the client has deteriorated, or when the client has had an accident, they must ring the office or the on-call supervisor. The office or on-call supervisor will make the decision to call the GP or paramedics.
- If a decision is made by a GP or the paramedic team that the client needs emergency hospital admission the carer must re contact the office immediately and accompany the client to hospital.
- The office will contact the next of kin to either accompany the client or meet them at hospital.
- The member of staff will be required to give relevant verbal information to the paramedic team in relation to the history of events, known allergies, medical conditions and medication. All of this information needs to be kept up-to-date in the Hospital Plan by the carer.
- Any Care Quality Commission (CQC) notifications should be completed by the manager and sent online to CQC.
- If relevant any RIDDOR notifications must be made
- If relevant any accident forms should be completed and signed.
- Before the client returns home this organisation will ensure that it can continue to meet the needs of the client through liaising with the hospital and family and carrying out a revised needs assessment.

Related Policies

Confidentiality

Consent

Cyber Security

Data Protection

Medication

Notifications

Guidance

NICE Guidelines NG 22 Published November 2015 - Older people with social care needs and multiple long-term conditions

NICE guidelines NG27 Published date: December 2015

Transition between inpatient hospital settings and community or care home settings for adults with social care needs.

This guideline focuses on what should happen in hospital, from admission onwards and throughout someone's stay, so that their discharge isn't rushed or unplanned. The guideline, developed by the NICE Collaborating Centre for Social Care - a partnership led by SCIE, ensures people with social care needs get the support they need to leave hospital and prevent delayed discharge from care. SCIE is keen to encourage good collaboration between health and social care. People's experience of transition between hospital and home is a key indicator on how well integration is working.

NICE Quality Standard QS 136 published December 2016 - Transition between inpatient hospital settings and community or care home settings for adults with social care needs

NICE Quality Standard QS159 published September 2017 – Transition between inpatient mental health settings and community or care home settings.

NICE guidelines NG43 Published date: February 2016 -Transition from children to adults' services for young people using health or social care services

NICE Guideline NG67 Published March 2017. Managing Medicines for adults receiving social care in the community

Training Statement

Staff and Carers are familiar with the arrangement needed to ensure any transitional arrangement between services, know where and how to access support and advice, and are aware of the type and content of information to be shared.

This policy is reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 20/02/18

Review Date: 20/08/18

Corporate Social Responsibility Policy

Outcome 16 Regulation 10

(Assessing and monitoring the quality of service provision)

Policy Statement

Constantia Care Ltd is committed to good practice and ethical behaviour, and we recognise that we have responsibilities to all stakeholders. We regularly review our employee, ethical and environmental policies and improve them where appropriate.

Corporate Social Responsibility for Constantia Care is about how we align our activities with the expectations of our stakeholders in relation to our economic, social and environmental impacts. Our stakeholders include local authorities and private service users, as well as our employees, suppliers, communities and society as a whole.

The Corporate Social Responsibility policy covers our existing operation.

The Directors receives regular updates on Corporate Social Responsibility policies and reviews recommended changes.

Aim of policy

Business Ethics

Constantia Care works to ensure standards are met, and where possible, exceeds all relevant legal requirements.

Constantia Care endeavours to behave with honesty, integrity and acts fairly and ethically in its relationships and dealings with its suppliers, customers and other stakeholders and extends its own values to relationships with these parties, working only with companies that uphold high standards of ethical conduct and fair practices.

Our employee handbook details its approach to these matters and a comprehensive section on whistle blowing encourages employees to report any concerns and provides means for them to do so with anonymity. This is reinforced in the organisations Whistle blowing policy

Summary of key policies.

Equal opportunities policy

Constantia Care is committed to achieving equal opportunities for all its employment policies, procedures and practices.

The organisation respects employee human rights and dignity and recognises the advantages of a diverse workforce. Constantia Care does not tolerate any harassment of, or discrimination against, employees or potential employees, irrespective of their race, creed, colour, sexual orientation, nationality, ethnic origin, religion, disability, age, gender or marital status.

Employment of people with disabilities

Constantia Care makes every effort to ensure that disabled employees are treated fairly and without prejudice.

Job applicants with disabilities have an equal opportunity to be selected for employment, and disabled employees have an equal opportunity to be selected for promotion and receive training to aid their career development. However Constantia Care is aware of its responsibility in working in a Regulated Activity to ensure that employees are fit both physically and mentally to do the work required. (As on page 36 of Essential Standards of Quality and Safety, Guidance issued by CQC)

Family friendly employment policies

The Maternity and Paternity policies of Constantia Care meet the statutory minimum standards in relation to leave.

Flexible approaches to returning to work after maternity leave, including part-time and non-standard hours of work, are adopted where viable. We also offer care/ support staff the opportunity of selecting their working hours, and patterns of work to fit in with existing domestic arrangements.

Employee training and development

Constantia Care considers continuous learning to be one of its core organisational values and training is a key constituent of the employee supervision and appraisal processes.

This organisation has a dedicated in house training manager who, together with the manager, is responsible for sourcing appropriate employee training.

Constantia Care aims to provide a safe and rewarding career pathway for all its employees.

Employee communication and involvement

Management acknowledges the importance of internal communication.

Managers and their employees are kept informed of general business issues and other matters of interest. This is by regular staff meetings, memos and newsletters which are used both to communicate organisational matters to employees and to elicit questions, feedback and requests.

Procurement

People are the organisations largest expense and the procurement of other supplies such as stationery and medical supplies is a smaller proportion of outgoings.

However, we aim to use local companies for supplies wherever possible and have a company policy of recycling printer cartridges, paper, cardboard and other supplies as appropriate.

Health and Safety

Given the nature of our services, Health and Safety is a priority within the organisations work spaces. Risk assessments are undertaken at all service user's homes, and every service user also is subject to a manual handling risk assessment.

The organisation's Health and Safety Policies and Procedures are issued to all employees at the start of their employment, and induction training for all staff, reinforces specific health & safety training.

Environment

Constantia Care offices occupy a leased part of larger buildings and therefore the organisation has no control of overall building emissions, energy usage or waste.

However, the organisation seeks to reduce usage by encouraging employees to turn off equipment and lights outside of normal office hours, and where possible minimise usage during working hours. In essence we encourage all staff to develop a sustainable approach to their work and make the most efficient and effective use of all resources.

Constantia Care encourages office staff to use sustainable modes of transport to commute to work. We aim to deploy carers in tight geographical areas to minimise travel and we are able to offer positions to a number of carers who can walk their 'round' of calls. However due to the nature of the care work and the requirement to provide care in unsocial hours and in rural areas, it remains a challenge to move away from the traditional need for carers with car transport, as public transport and bikes cannot sustain the care provision as a whole, and would undoubtedly impede efficiency or effectiveness.

Political and charitable donations

Constantia Care policy is that it does not donate money, services or facilities to political parties.

Constantia Care endeavours to work with charities and organisations that are either in some way local, or of interest to its employees.

- *We have introduced an annual ballot for employees to select charities to sponsor for each forthcoming year.*
- *Additionally in 2013, the organisation sponsored the 'Carer of the Year Award.*
- *We will encourage and enable staff who wish to undertake voluntary activities to do so and give them the time and opportunity to participate in charitable events. If required, reasonable use of its time and facilities will be allowed.*

Quality Assurance

An annual quality audit of all the organisations policies is undertaken as part of our statutory obligations under the Health and Social Care Act 2008, and in accordance with the Guidance issued by the Care Quality Commission. This is part of our continual quality monitoring system.

This annual review will be undertaken by the director responsible for Corporate Social Responsibility matters and this policy will be reviewed and updated accordingly.

Training

Any member of staff responsible for any of the above will be given adequate training to enable them to carry out the required task. The organisations responsibilities under Corporate Social Responsibilities will be explained to all staff to enable them to understand their own responsibilities to Corporate Social Responsibilities.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Date of Review : 30/06/18

DATA PROTECTION

Constantia Care Ltd

Policy Statement

Constantia Care believes that all records required for the protection of clients and for the effective and efficient running of the organisation should be collected, maintained and kept according to the *Data Protection Act 1998*.

The Policy

Constantia Care is registered under the *Data Protection Act 1998* and all storage and processing of personal data held in manual records and on computers in the organisation will comply with the Act.

Constantia Care understands that, according to the *Data Protection Act 1998*, personal data should:

- Be obtained fairly and lawfully
- Be held for specified and lawful purposes
- Be processed in accordance with the person's rights under the DPA
- Be adequate, relevant and not excessive in relation to that purpose
- Be kept accurate and up to date
- Not be kept for longer than is necessary for its given purpose
- Be subject to appropriate safeguards against unauthorised use, loss or damage
- Be transferred outside the European Economic Area only if the recipient country has adequate data protection.

Under the *Data Protection Act 1998*, the organisation has a nominated data user/data controller. The data user/data controller for this organisation is the Administrator. The data user must keep up to date with all relevant legislation and guidance which has already been mentioned in previous policies (please refer to policies and procedures on confidentiality).

In addition, the following documents must be used in order that this organisation is compliant with all aspects of the *Data Protection Act 1998* regarding the type of data held.

- **Records Management Code of Practice for Health and Social Care 2016 issued by Information Governance Alliance**
- **A Quick Guide to Employment Practices Code issued by The Information Commissioners Office (ICO) (26 pages). www.ico.org.uk**

This guidance has been produced with the needs of small businesses in mind. It is designed to assist them comply with the *Data protection Act 1998* when recruiting and employing workers. There is a separate Employment Practices Code which gives detailed information on good practice and legal responsibilities in respect to employee's data.

- **The Employment Practices Code (96 pages) is also available from the above website.**
- **Subject Access Code of Practice (58 pages) www.ico.org.uk**
This deals with requests from individuals for personal information.

This Code of Practice explains the rights of individuals to access their personal data. It also clarifies what you must do to comply with your duties as a data controller. The Code deals with a request made under Section 7 of the *Data Protection Act 1998* as a “Subject Access Request” (SAR). It details in full exactly what we as an organisation must do and what we must consider in the context of a SAR.

The above guidance is regularly reviewed and updated by the ICO.

Related Policies

Access to Record

Confidentiality

Consent

Cyber Security

Record Keep

Whistleblowing

Training Statement

All new staff should be encouraged to read the policies on data protection and on confidentiality as part of their induction process. Training in the correct method for entering information in clients records should be given to all care staff. The nominated data user/data controller for the organisation will be trained appropriately in the *Data Protection Act 1998*. All staff who need to use the computer system will be thoroughly trained in its use.

This policy will be reviewed by the Registered Manager.

Signed: Morag Collier

Date: 20/02/18

Review Date: 20/08/18

DEATH OF A CLIENT

Constantia Care Ltd.

Policy Statement

It is hopefully a rare occurrence that a death of a client takes place whilst they are receiving a service from this organisation. Nevertheless, it is important that staff are aware of how and, perhaps more importantly, when to respond in order to minimise distress and adhere to any cultural beliefs or preferences that the client, their family or representative have expressed as part of their care and support plan.

The Policy

The policy aims to make clear the process and a step-by-step method of mitigating distress whilst ensuring compliance with any lawful requirements, particularly in regard to other multi-agency partners such as Fire, Police or Health.

Principles

- Staff must remember that the death of a client does not mean that information is not to be protected and that confidentiality is still in place
- This organisation will co-operate fully with multi-agency partners to ensure all lawful requirements are met and will assist where appropriate when asked or directed by a lead agency
- All communication will be dealt with in a sensitive professional manner which promotes the privacy and dignity of the client, their family or representative.

Confirmation or verification of death [applicable to nursing services]

Confirmation or verification of death is defined as deciding whether a person is actually deceased. Confirmation or verification of death can be undertaken by a registered nurse and doctor.

Certification of death requires a registered medical practitioner.

The involvement of healthcare professionals, including nurses, does not stop once an individual has died. Caring for dying people at home requires the use of care pathways that include care after death. Nurses are the health professionals most commonly present at the time of an individual's death. They are therefore ideally placed to verify that a person has died and provide support and information to the bereaved.

Principles of practice

When discussion has taken place between the appropriate medical practitioner and nursing staff - and it has been agreed that further intervention would be inappropriate and death is expected to be imminent - designated nurses may confirm or verify the death. Wherever possible, the relatives should be made aware of the individual's deteriorating condition and of the individual's care plan.

Where the death is unexpected, the nurse has the responsibility to initiate resuscitative measures, as long as they are in the best interests of the individual and unless an agreed statement has been made that resuscitation is not to take place.

These principles for practice can apply in any health care setting. The nurse must be trained and deemed competent to confirm the death, and there must be explicit details in the care plan/end of life plan.

Responsibilities of the Nurse

Record keeping is an integral part of the process and there is an expectation that the nursing and medical records must reflect that the death is expected.

Records should also show details of the confirmation of death, with the time, date and any other observations that were recorded. The time and date the doctor was informed must also be included.

Education and Training

Education and training is made available and nurses should ensure they have enough confidence, competence, knowledge and skills to equip them for undertaking this role.

Education is based on broad principles for practice as identified in the NMC Code (<https://www.nmc.org.uk/standards/code/read-the-code-online/>).

Specific topics that may be included are aspects of accountability, current legislation and the necessary skills and knowledge to determine the physiological aspects of death.

Deaths and the Role of the Coroner

Under English law the coroner is an independent judicial office holder, paid for by the relevant local authority. They must be either a lawyer or a GP sometimes both. Their role is to inquire into certain types of death(s). Where an inquest is held they have a duty to establish the cause of death in so far as this is possible. They are not allowed to determine criminal liability nor who was responsible. The criminal court would decide this. Coroner's officers work under the direction of the coroner and liaise with bereaved families, police, doctors, witnesses and funeral directors. They receive reports of deaths and make inquiries at the direction and on behalf of a coroner.

Reported Deaths

Registrars of births and deaths, doctors or the police report unexpected deaths to a coroner in specific circumstances. These include where it appears that:

- No doctor attended the deceased during their last illness
- Although a doctor attended during the last illness the deceased was not seen either within 14 days before death nor after death
- The cause of death appears unknown
- The death occurred during an operation or before recovery from the effects of an anaesthetic
- The death was due to an industrial accident disease of poisoning
- The death was sudden or unexpected
- The death was due to violence or neglect
- The death was in other suspicious circumstances or
- The death occurred in prison or police custody.

In the event of a death of a client the following process should be adhered to and staff should be supported and assisted throughout. Regardless of the experience of staff in working with the dying it is important to recognise the distress, shock or trauma that can follow, especially where the death is sudden or unexpected.

- If a staff member arrives on a scheduled visit and finds the client has died their first response should be to dial 999 and request an ambulance. It is important to remember that the death has to be medically certified, so no assumptions should be made regarding the status of the client. The body should not be moved or handled in any way before the medical services arrive.
- The office should be informed, this includes the on-call, where the death is discovered out of hours. Full details should be recorded, and an incident form completed.
- The staff member who made the discovery should remain at the address so as to assist fully with any enquiries.
- The medical services will lead and liaise with the office as required upon their arrival, e.g. they may ask that the staff stay until the undertaker or next of kin arrives, or the police may request they stay to secure the premises.

- Where staff are really distressed or anxious a member of the office-based staff may be asked to relieve them, and consideration should be given to the cover arrangements necessary for the rest of their schedule.
- The office will liaise with the lead agency until all formalities are settled, and the office will keep detailed records of any dialogue. The file will then be closed in the usual way.
- Consideration should be given to requests to any funeral attendees from the company. This will take into account such things as how long the client was with us, their regular care workers etc. and the availability of cover.

Constantia Care Ltd will notify the Care Quality Commission (CQC) by email within 24 hours of the death of client during their service provision as required under the Duty of Candour Regulation 20 of the 2014 Regulation.

Please Note

There is currently a closed consultation on changes to the Death Certification process in England and Wales. The responses from the consultation are now under review and proposals to introduce Medical Examiners are currently in the public domain. When the guidance is finalised and the reforms completed this policy will be updated.

Related Policies

Advanced Care Planning
 Consent
 End of Life
 Duty of Candour
 Notifications
 Responsive Service

Training Statement

All staff will undertake appropriate level of training to deliver the required service to the required standard.

This policy will be reviewed annually by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

DEMENTIA CARE

Constantia Care Ltd

Policy Statement

This policy reflects the NICE quality standard [QS30] (Published April 2013),

Dementia supporting people with dementia and their carers in health and social care NICE guidelines (CG42) last updated May 2016 and

Dementia Equity and Rights published in May 2016 **

Constantia Care believes that people with dementia should not be excluded from any services because of their diagnosis, age (whether designated as too young or too old) or co-existing learning disabilities and that our staff should treat people with dementia and their carers with respect at all times.

The Policy

Principles of Care for People with Dementia

At the assessment of need and in the care plan we identify and address the specific needs and, wherever possible, the preferences of people with dementia and their carers:

- Care plans are based on an assessment of the person with dementia's life history, social and family circumstance, and preferences, as well as their physical and mental health needs and current level of functioning and abilities
- There should be a coordinated delivery of health and social care services. This should involve: a combined care plan agreed by health and social services that takes into account the changing needs of the person with dementia and their carers; wherever possible, a named member of staff should operate the care plan. There should be collaboration between staff, the service user and their family to develop the care plan, with formal reviews at a frequency agreed between all those involved at this stage
- Specific needs might include ill health, physical disability, sensory impairment, communication difficulties, problems with nutrition, poor oral health and learning disabilities
- Diversity might include issues of gender, ethnicity, age (young or old), religion and personal care. Wherever possible, we aim to accommodate the diverse preferences of people with dementia and their carers, including regarding issues of diet, sexuality and religion.

Accessing Information

- We help people to access support services who are suspected of having dementia because of evidence of functional and cognitive deterioration but who do not have sufficient memory impairment to be diagnosed with the condition
- Language or acquired language impairment can be a barrier to accessing or understanding services; during the treatment and care we provide information is given in the preferred language or in an accessible format, with the ability access independent interpreters as required
- And require to access information on their right to receive direct payments, individual budgets (where available), and the difference between NHS care and care provided by local authority social services (adult services) so that they can make informed decisions about their eligibility for NHS Continuing Care
- We provide any support required for the individual to access advocates to speak on their behalf.

Consent

Valid consent from people with dementia should always be sought; this should entail informing the person of options, checking that they understand, ensuring that there is no coercion and that the person continues to consent over time. If the person lacks the capacity to make a decision then the provisions of the *Mental Capacity Act 2005* are followed.

People with dementia and their carers are always informed about advocacy services and voluntary support, and we encourage their use; when required, such services should be available for both people with dementia and their carers independently of one another.

People with dementia are given equal opportunity to convey information to our staff and other care professionals involved in their care in a confidential manner. Only in exceptional situations would confidential information be disclosed to others without the person's consent, as identified in our Confidentiality Policy; however, as dementia worsens and the person becomes more dependent on family or other carers, decisions about sharing information should be made in the context of the *Mental Capacity Act* and its Code of Practice. If information is to be shared with others then this should be done only if it is in the best interests of the person with dementia.

Wherever possible, this situation should be discussed with the person who has dementia, while they retain capacity, and with their carer; the following aspects might be considered:

- Advance statements (which allow people to state what is to be done if they should subsequently lose the capacity to decide or to communicate)
- Advance decisions to refuse treatment
- Lasting Power of Attorney (LPA) (a legal document that allows people to state in writing who they want to make certain decisions for them if they cannot, including decisions about personal health and welfare)
- A Preferred Place of Care plan (which allows people to record decisions about future care choices and the place where the person would like to die).

Impact of Dementia on Personal Relationships

The impact of dementia on relationships, including sexual relationships, should be assessed in a sensitive manner. When indicated, people with dementia and/or their partner and/or carers will be supported to maintain their relationships and given information about local support services.

Adult Safeguarding

Because people with dementia are vulnerable to abuse and neglect, all our staff receive information and training, and they abide by local multi-agency protocol. All staff are aware of the need to be vigilant and report to their manager any actual, alleged or suspected abuse.

Training and Development of Health and Social Care Staff

We ensure all our staff have access to dementia-care training (skill development) that is consistent with their roles and responsibilities and meets the changing needs of the person with dementia. We liaise with outside professionals to provide specialist training and support, for example the local Mental Capacity Team or Alzheimer's Society.

Promoting and Maintaining Independence

Through our care planning we aim to promote the independence, including mobility, of people with dementia. Care plans address activities of daily living that maximise independent activity, enhance function, adapt and develop skills, and minimise the need for support.

When writing care plans, the varying needs of people with different types of dementia are addressed using support from outside dementia specialists. Care plans should always address

- Consistent and stable staffing
- Retaining a familiar environment
- Minimising relocations
- Flexibility to accommodate fluctuating abilities
- Assessment and care-planning advice regarding Activities of Daily Living (ADLs), and ADL skill training from an occupational therapist
- Assessment and care-planning advice about independent toileting skills; if incontinence occurs then all possible causes should be assessed and relevant treatments tried before concluding that it is permanent
- Environmental modifications to aid independent functioning, including assistive technology, with advice from an occupational therapist and/or clinical psychologist
- Physical exercise, with assessment and advice from a physiotherapist when needed
- Support for people to go at their own pace and participate in activities they enjoy.

If our service users with dementia develop non-cognitive symptoms that cause them significant distress, or develop challenging behaviour, they will be offered an assessment at an early opportunity to establish likely factors that may generate, aggravate or improve such behaviour.

The assessment should be comprehensive and consider

- The person's physical health
- Side effects of medication
- Social, cultural and environmental influences that affect mental health and behaviour
- Physical environmental factors
- Depression
- Possible undetected pain or discomfort
- Individual biography, including religious beliefs and spiritual and cultural identity
- Behavioural and functional analysis conducted by professionals with specific skills, in conjunction with carers and care workers.

Individually tailored care plans that help carers and staff address challenging behaviour are developed recorded in the notes and reviewed regularly; the frequency of reviews should be agreed by all involved in the service user's care.

Approaches that may be considered, depending on availability and service user choice, include

- aromatherapy
- multisensory stimulation
- therapeutic use of music and/or dancing
- animal-assisted therapy
- massage.

These interventions may be delivered by a range of health and social care staff and volunteers, with appropriate training and supervision.

Following NICE guidelines, we see pharmacological intervention in the first instance only if the person is severely distressed or there is an immediate risk of harm to the person or others; we work closely with GP's and other professionals to find alternative sources of support.

Managing Risk

Recognising the importance of managing risk, we identify, monitor and address environmental, physical health and psychosocial factors that may increase the likelihood of challenging behaviour, especially violence and aggression, and the risk of harm to self or others.

These factors include

- carers at home being unable to cope well with the service user and they become distressed
- service user's own home can create some safety issues as their condition becomes more severe
- Lack of activities
- Staff not trained to deal with challenging behaviour
- Poor communication between the person with dementia, their carer or staff
- Conflicts between staff and carers
- Weak clinical leadership.

We train our staff to anticipate behaviour that challenges and how to manage violence, aggression and extreme agitation, including de-escalation techniques.

Palliative Care and End-of-life Issues

Dementia care is incorporated into a palliative care approach from the time of diagnosis until death. The aim is to support the quality of life of people with dementia and to enable them to die with dignity and in the place of their choosing, while also supporting carers during their bereavement (which may both anticipate and follow death).

Related Policies

Assessment of Need and Eligibility
Care and Support Planning
Mental Capacity Act 2005
Equality and Diversity
Dignity and Respect

Training

All staff receive basic training on dementia care at the beginning of their employment and receive updates to meet the changing needs of the person with dementia.

**Dementia Equality Rights

http://www.raceequalityfoundation.org.uk/sites/default/files/publications/downloads/Dementia%20report%20SCREEN_0.pdf

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

DEPRIVATION OF LIBERTY SAFEGUARDS

Constantia Care Ltd.

Policy Statement

The purpose of this policy is to explain the organisation's approach to people to whom it is providing a service, who might lack the mental capacity to take decisions about their care and treatment and who could have their freedom restricted to the point where they are deprived of their liberty as a result.

Constantia Cares policy has been established to comply with the provisions of the *Mental Capacity Act 2005* Deprivation of Liberty (DOLS) Safeguards, which have applied since April 2009. This Deprivation of Liberty Safeguards policy should be read and used in conjunction with the organisation's broader Mental Capacity Act policy.

The policy sets out to show how the organisation meets the legal requirements to provide safeguards for people who might be deprived of their liberty whenever decisions are needed about their care and treatment, which they cannot take themselves because of lack of mental capacity. A situation where the policy might apply is where the organisation is asked to provide services to someone who might lack the mental capacity to decide whether they need those services and in their provision could be conceivably deprived of their liberty. For example the organisation might be approached for its staff to become a "minder" to a person lacking mental capacity. The "minding duties" are of such a nature that the person might be deprived of their liberty.

The Care Act 2014 received Royal assent (became law) in May 2014. This is the most significant reform of adult social care for more than 60 years, replacing a wide range of existing legislation with a single statute and introducing many new principles and procedures.

For example the introduction of the principle of the promotion of 'wellbeing' as the basis for any action or decision taken in relation to meeting someone's social care needs or service planning. The Act will come into force in two stages – in April 2015 and April 2016, supported by various regulation and statutory guidance, which was issued in October 2014.

Further classification of what has become known as the Cheshire West judgement, which brought D.O.L.S into domestic settings for the first time is awaited from the Supreme Court. The briefing note for health and social care providers issued by Care Quality Commission should be used in conjunction with advice from the Supervisory Body i.e. your local authority.

Please note: Deprivation of Liberty safeguards Code of Practice to supplement the main Mental Capacity Act 2005 Code of practice has been archived

Briefing For: Health and Social Care Providers

http://www.cqc.org.uk/sites/default/files/20140416_supreme_court_judgment_on_deprivation_of_liberty_briefing_v2.pdf

Information for providers and CQC Inspectors

Following the Supreme Court judgement on 19 March 2014, health and social care staff, and CQC inspectors, must be aware of how they should now judge whether a person might be deprived of their liberty.

It is clear that the intention of the majority of the Supreme Court was to extend the safeguard of independent scrutiny.

They said: “A gilded cage is still a cage” and that “we should err on the side of caution in deciding what constitutes a deprivation of liberty.” They also highlighted that a person in supported living might also be deprived of their liberty.

It is certain that, following this judgement, many more requests for authorisations under the deprivation of liberty safeguards will be made for people in hospitals or care homes. Since the deprivation of liberty safeguards apply only in hospitals and care homes, it is also certain that many more applications will be made to the Court of Protection for those in domestic settings with support.

The deprivation of liberty safeguards code of practice lists the factors which may indicate a deprivation of liberty: these are still relevant but must now be read in the light of this decision of the Supreme Court.

The Supreme Court has now confirmed that there are two key questions to ask:

Is the person subject to continuous supervision and control?

It is still not clear what exactly this means: but the three cases in the Annex to this guidance show how wide the definition appears to be.

AND

Is the person free to leave?

The person may seem happy to stay, but the issue is about how staff would react if the person did try to leave or if relatives/friends asked to remove them permanently.

It is now clear that if a person lacking capacity to consent to the arrangements is subject both to **continuous supervision and control and not free to leave**, they are deprived of their liberty.

It may not be a deprivation of liberty, although the person is not free to leave, if the person is not supervised or monitored all the time and is able to make decisions about what to do and when, that are not subject to agreement by others.

The Supreme Court ruled that the following factors are not relevant to whether or not someone is deprived of their liberty:

- the person’s compliance or happiness or lack of objection;
- the suitability or relative normality of the placement (after comparing the person’s circumstances with another person of similar age and condition); or
- the reason or purpose leading to a particular placement though of course all these factors are still relevant to whether or not the situation is in the person’s best interests, and should be authorised.

If a provider suspects, from the initial care plan or prior knowledge of the person, that someone coming in to their care may be deprived of liberty, the authorisation should be in place before the person arrives. It protects the person’s rights; it does not mean they have to restrict the person’s freedoms unless they have to do so in the person’s best interests.

Whenever a person might lack the mental capacity to make their own decisions about care or treatment, providers must work within the principles of the Mental Capacity Act, for example by doing everything possible to empower people to make as many decisions for them as they can.

Care plans for people lacking mental capacity to agree to arrangements for their care or treatment should show evidence of best interest’s decision-making in accordance with the Mental Capacity Act, based on decision-specific capacity assessments.

In particular, providers should ensure that restrictions on the freedom of anyone lacking capacity to consent to them are proportionate to the risk and seriousness of harm to that person, and that no less restrictive option can be identified. Useful guidance on care planning within an empowering ethos is available in the Mental Capacity Act main code of practice.

Read the MCA code of practice on the Ministry of Justice website

Points to note, arising from this judgement:

(1) Widening of scope: The annex to this guidance gives a short account of the cases that were considered by the Supreme Court. These clarify for providers of care to people with learning disabilities the sort of situations that now may come within the definition of deprivation of liberty, but which might not have been recognised as such before the Supreme Court judgement. It is clear, however, from the way the deprivation of liberty safeguards are used already, that the many of the people who might be deprived of their liberty in their own best interests are older people, often in care homes (currently about 75% of all authorisation requests). Following this judgement, more elderly people at risk of deprivation of liberty are likely to be identified in domestic settings such as supported living or extra-care housing. They are living with dementia or with acquired brain injury, for example from a stroke, or with neurological conditions such as Parkinson's disease or Huntington's disease; they often have complex health and care needs.

A typical situation that might now fall within the expanded definition of deprivation of liberty is that of an older person with dementia, living at home with considerable support. Staff monitor her well-being continuously at home because she forgets to eat, is unsafe in her use of appliances, and leaves the bath taps running; she is accompanied whenever she leaves her home because she forgets where she lives and is at risk of road accidents or abuse from others. She shows no sign of being unhappy or wanting to live elsewhere, but, in her best interests, she would not be allowed to leave to go and live somewhere else even if she wanted to.

(2) What is relevant to identifying a deprivation of liberty: It is essential to separate the question of whether restrictions amount to a deprivation of liberty, in terms of the new Supreme Court test above, from whether staff actions are necessary, proportionate, and in the person's best interests. The former determines whether the situation must be assessed independently: the latter are crucial to deciding whether it will be authorised as being in the person's best interests. The most important step for providers who suspect that they may be depriving someone of their liberty is to reduce restraint and any restriction on the person's freedoms wherever possible.

(3) In a hospital or care home: where it seems likely that a person is being deprived of their liberty, and this seems to be in the person's best interests, a referral to the Local Authority deprivation of liberty safeguards team should be made by the provider. If they have not done so even after prompting, a third party, such as a CQC inspector, can contact the local authority directly. If it is apparent that a person lacking capacity to consent to a forthcoming admission to hospital or a care home might be deprived of their liberty, the provider must seek the authorisation in advance of that admission wherever possible.

(4) In a psychiatric inpatient setting, clinical staff may want to review the situation of all informal patients who lack mental capacity to consent to admission, and consider if they are deprived of their liberty. If they are at risk of being deprived of their liberty, the first step is to scrutinise the care plan to see if this could be safely altered to reduce the restrictions so there is no longer a deprivation of liberty. If this is not possible then the provider must decide between using the Mental Health Act and the MCA deprivation of liberty safeguards to protect the person's rights. The criteria for deciding between these have not been changed by this judgement. Professionals should not assume one regime is "less restrictive" than the

other. It is the care plan which imposes the restrictions, not the procedural safeguards that are required if these restrictions amount to a deprivation of liberty.

(5) For all other settings, such as supported living, adult placement/shared lives or domiciliary care, the deprivation of liberty safeguards cannot be used, so an application must be made to the Court of Protection.

In these settings, care providers (where appropriate, with local authority care managers) should examine the situation of people who lack the mental capacity to agree to their living arrangements, to see if they appear to be deprived of their liberty in the light of the Supreme Court judgement. They may wish to seek legal advice, and liaise with the commissioners of the service, if they think they might be depriving someone of their liberty and cannot find a less restrictive option for providing care or treatment.

While this is happening, they must continue to provide care and attention to the person.

(6) CQC inspectors must continue to expect providers to work within the law. Inspectors remain an important safeguard of the rights of vulnerable people who use services, and always have the right and duty to take action as they see fit to ensure this. In the very short term, however, while waiting for further national guidance, it will in many situations be sufficient evidence of providers' attempts and intention to work within the changes brought in by the Supreme Court judgement if they can demonstrate that they are:

- aware of the outline of the judgement, hence reviewing (where appropriate, with care managers or commissioners of their services) situations that might now be brought into the widened definition of deprivation of liberty. The purpose of this review is to assess if the restrictions can safely be reduced or the person's capacity enhanced so that they can make relevant decisions for themselves; and
- in discussion with commissioners of services, and as appropriate either liaising with the local authority supervisory body for the deprivation of liberty safeguards or seeking legal advice, as to how to ensure the protection of the human rights of vulnerable people who use services.

(7) Providers must notify CQC of all applications to deprive someone of their liberty, whether through the deprivation of liberty safeguards or by applying to the Court of Protection, and their outcomes.

Read CQC guidance on notifying deprivations of liberty

Providers and Inspectors must remember that authorisations under the Mental Capacity Act are NOT transferrable. Those given under the deprivation of liberty safeguards only cover that particular hospital or care home. Court Orders only cover what they say they cover.

This is not a full statement of law but is designed to help providers and CQC staff understand the practical implications of the Supreme Court judgement.

Annex: The examples which the Supreme Court decided were deprivation of liberty

An adult (P) with a learning disability living in a bungalow with two other residents, with two members of staff on duty during the day and one 'waking' member of staff overnight. He requires prompting and help with all the activities of daily living, getting about, eating, personal hygiene and continence. P requires further intervention including restraint to stop him harming himself, but is not prescribed any tranquilising medication. He is unable to go anywhere or do anything without one to one support; he gets 98 hours a week of personal support to enable him to leave the home frequently for activities and socialising.

A 17 year old (Q, or MEG) with mild learning disabilities living with three others in an NHS residential home for learning disabled adolescents with complex needs. She has occasional outbursts of aggression towards the other three residents and then requires restraint. She is prescribed (and administered) tranquilising medication. She has one to one and sometimes two to one support. Continuous supervision and control is exercised so as to meet her care needs. She is accompanied by staff whenever she leaves. She attends a further education unit daily during term time, and has a full social life. She shows no wish to go out on her own, but she would be prevented from doing so in her best interests.

An 18 year old (P, or MIG) with a moderate to severe learning disability and problems with her sight and hearing, who requires assistance crossing the road because she is unaware of danger. She lives with a 'foster mother' (commonly called adult placement, or shared lives) whom she regards as 'mummy.' Her foster mother provides her with intensive support in most aspects of daily living. She is not on any medication. She has never attempted to leave the home by herself and showed no wish to do so, but if she did, her foster mother would restrain her in her best interests. She attends a further education unit daily during term time and is taken on trips and holidays by her foster mother.

It is widely accepted that the Cheshire West Judgement confuses the DoLS situation and has led to local authorities being unable to fulfil statutory duties in respect of DoLS. Further guidance has been amended and reissued by the Department of Health in December 2015 to assist in the clarification of the DoLS process, In addition the government has asked the law Commission to undertake a review of DoLS and will report as soon as practical.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/485122/DH_Consolidated_Guidance.pdf

Please Note

On Thursday 10th March 2016 key rulings on the procedural implications of the Cheshire West Judgement on Deprivation of Liberty was handed down by Justice Charles

<https://www.judiciary.gov.uk/wp-content/uploads/2016/03/finaljm.pdf>

Currently the Law Commission has been set the task of defining Deprivations of Liberties given the Cheshire West judgement and its ramifications for Local Authorities

http://www.lawcom.gov.uk/wp-content/uploads/2016/05/mental_capacity_interim_statement.pdf

UPDATE

The law Commission has published in March 2017 its report to Parliament regarding its recommendations for changes to DoLS. These are proposals only and parliament is expected to give its approval by early summer 2017.

Law Commission report number 372

Related Policies

Adult Safeguarding

Meeting Needs

Mental Capacity Act 2005

Notifications

Training Statement

This organisation works closely with its Local Authority, Mental Capacity Act Assessment team and Safeguarding of Barnet to keep up with the continual changes brought about by case law and Supreme Court judgement in Relation of liberty Safeguarding.

This policy will be reviewed by the Registered Manager.

Signed: Morag Collier

Date: 30/01/18

Review Date: 30/06/18

DIABETES

Constantia Care Ltd.

Policy Statement

Diabetes mellitus is a chronic disabling disorder which is increasing in prevalence.

To enhance diabetes care for its clients, this organisation acknowledges the importance of its staff co-operating with the health professionals delivering the diabetic service.

The wellbeing and quality of life sustained by the client will be enhanced by well-planned, comprehensive care and support of staff. Many of our clients have lived with diabetes for many years and it is important that their views and the way they manage their diabetes is incorporated, wherever possible into their diabetic care plan.

The policy

Liaison with community diabetes care service

Regular liaising with the community diabetes team is important for staff to ensure they are up to date with the treatment being given, the assessed risk of hypoglycaemia and other complications for each client.

The Diabetes specialist nurse can provide advice and support, to both the client and staff. Other community-based healthcare professionals, e.g. dietician, podiatrist, and pharmacist, can provide important contributions to optimising diabetes care.

NICE Guidelines and Quality Statements give guidance for both health and social care in relation to the support of people with diabetes.

NICE guidelines [NG17] published August 2015. Last updated July 16 Type 1 diabetes in adults: diagnosis and management

NICE guidelines [NG18] Published date: August 2015. Diabetes (type 1 and type 2) in children and young people: diagnosis and management

NICE guidelines [NG19] Published date: August 2015 Last updated in January 16 Diabetic foot problems: prevention and management

NICE quality standard [QS6] Published date: March 2011 Last updated in August 16 Diabetes in adults

Diet and Nutrition.

Diet plays an important part in controlling diabetes. All clients will have a menu and diet plan in place from the diabetic nurse. Staff involved in preparing food will work with the client and follow this plan. The client's choice and preferences will always be taken into consideration in the preparation of agreed diets.

If the client continually refuses and chooses other foods the carer must record and report immediately to their supervisor or manager who may need to contact other professionals for guidance.

When working with clients it is their choice which foods they eat and this organisation will provide both client and their family with information and support to encourage a healthy diabetic diet and work with health care professionals to this end.

All clients are screened for malnutrition. The MUST tool is used for this purpose.

The presence of co-existing disease may lead to physical and cognitive impairment in a client with diabetes and can make activities such as eating difficult or impossible, and place the client at nutritional risk.

This organisation will work with a dietician, the speech and language team (SALT) and GP or hospital specialist as required.

Care or Support plan

Within their main care or support plan each client will have an individualised diabetes care or support plan.

The agreed objectives summarised in the diabetes care plan will include; diet, foot care, eye care, wellbeing review arrangements, medication and the need for regular medication review. The client is encouraged to be fully involved in this care plan. For those clients assessed as lacking the capacity to make a decision a best interest decision will be made concerning the management of medication and the diabetes following the Mental Capacity Act 2005 Code of practice

Review arrangements of the diabetic care plan

Each client with diabetes requires documented evidence of a review. This will be carried out regularly. The frequency of the review should be decided with the healthcare professional or diabetic nurse. This review will also include measures of walking ability, balance, mood assessment, and cognitive function.

Foot care services

All clients with diabetes should have and will be encouraged to have regular visits by or to a chiropodist to ensure any problems associated with diabetes are picked up as soon as possible.

If these visits cannot be arranged by the client or their family they will be arranged by this organisation Transport and or an escort service will be arranged as required.

Staff are not permitted to cut the nails of the client.

Staff must report any changes to the skin or problems identified by the client immediately to their manager or supervisor.

NICE recommend that people with diabetes have a foot assessment when diagnosed and at least annually afterwards or if any foot problems arise and if admitted to hospital

Well being

Depression is more common in people with long-term conditions but may go unnoticed in older people with complex health problems such as diabetes. Painful neuropathy, foot ulceration and adverse effects of medication can all contribute to depression. We recognise that anything which affects the clients' mental well-being may also affect their ability to successfully manage their own diabetes. Staff are trained to recognise symptoms of depression, so that an early diagnosis can be made by the GP and this will help limit the longer term impact. Screening at the start of the service and at least annually is carried out for clients.

Eye care services

Clients with diabetes are likely to have a high incidence of eye disease this may include macular disease, cataract and refractive error. All clients will be supported to attend appointments at eye clinics as required or be encouraged to have annual eye tests.

An escort service will be arranged as required.

Staff must report any concerns, changes or problems in the client's eye sight immediately to their manager or supervisor.

Please note NICE guidelines recommend that GP's refer people with type1 diabetes to local eye screening as soon as possible or within 3 months from referral. Eye screening should then take place annually

Management of infections

We recognise that clients with diabetes are at increased risk of a range of infections including skin, respiratory, oropharyngeal, and urinary tract. Observing for signs of infection such as a change in mobility, increased confusional state, or worsening lethargy staff are aware of the need to report these signs immediately so that the appropriate medical help can be sought quickly.

Vaccination programme

We recognise that clients with diabetes are a high-risk group for influenza and other serious infections. Each client is encouraged to receive timely vaccinations to reduce risk of serious infections, such as the pneumococcal and influenza vaccinations. The vaccination schedule is included in their care plan along with any other relevant evidence.

Administration of treatments including insulin

Insulin will either be administered by the client or a visiting health care professional. All staff will be trained to recognise signs of Hypoglycaemia and Hyperglycaemia

Referral to hospital

We have in place a Client's Diabetes Passport which goes with the client if they are admitted to hospital. This passport is checked and updated at the 6-8 weekly care plan review. Liaison with the hospital team prior to subsequent discharge of a client with diabetes is essential.

Quality

An audit of our diabetic care is included in our quality monitoring systems.

These include: clinical audit, use of a minimum data set, frequency and completion of care plan review, and implementation of a diabetes care policy.

We audit hospital admission rate, hypoglycemia rate, frequency of infection, pain nutrition, and attainment of high completion rates for annual review to improve the quality of care for our clients.

Related Policies

Assessment of Need and Eligibility
Care and Support Planning
Nutrition and hydration
Medication

Training Statement

There will be opportunities for staff to attend diabetes educational events in the local community following liaison with the community diabetes team.

Access to other educational and training resources such as DVDs, will also be made available to all staff. They will receive regular updates.

This policy will be reviewed annually by the Registered Manager

Signature: Morag Collier

Date: 30/01/18

Date of Review: 30/06/18

DIGNITY AND RESPECT

Constantia Care Ltd

Policy Statement

Constantia Care is committed to the delivery of a quality service that maintains the privacy, dignity and respect of clients at all times. It is often complacency that threatens to undermine these principles, and staff in particular need to be mindful that they are in the client's home by invitation only. Therefore the role of your relationship should be that of a respectful guest.

As some tasks that are undertaken by the carer are of a very personal and sensitive nature, it is imperative that boundaries are in place to protect the privacy, dignity and respect of the client in these circumstances.

The Policy

This document outlines the policy of this organisation in relation to providing services that respect the privacy and dignity of our clients. This organisation aims at all times to respect the right of its clients to privacy and dignity, recognising that these values can easily be threatened by the processes covering the provision of care in a client's home.

Assessing Care Needs

We recognise that making an assessment of the needs of a client can be very intrusive. We are obliged to ask questions about the most intimate areas of a client's life and it is helpful at the outset of our contact to observe a client in their own private environment where care will be delivered. We will do everything possible to limit the embarrassment a client can experience at this stage and to provide all possible reassurances about the nature of our operations generally, but particularly the confidentiality of our information systems and the sensitivity of our workforce.

Some potential clients will wish a carer or representative to be present during the assessment interviews, but we do not assume that they will necessarily be privy to all of the information the client has to provide about themselves. If it seems helpful, we will arrange for some parts of the interview to take place with the client alone.

During the period when we are providing services, we occasionally need to review the situation to ensure both that our services remain appropriate, and to make adjustments to respond to changing care needs. If the staff who undertake a review are not already known to the client then additional sensitivity will be required since, from the client's point of view, they are confronting a stranger. The carer too may pick up some information about a client's changing care needs during the process of service delivery. The staff should check with the client whether they have any objection to details being recorded, though they may have to explain that information does indeed have to be shared with colleagues in the company.

Handling Information about Clients within this organisation

When information about clients has to be passed from a staff to a manager, or between staff, it will always be treated with respect. Arrangements for processing, handling and storing data are based on the need to retain as much privacy for our clients as possible.

Behaviour of Staff

Carers are instructed never to forget that they are guests in the client's home, and to be careful that familiarity does not blunt the respect they should continue to show to their host.

We know that some clients have forms of address for themselves to which they are particularly attached, or, conversely, forms they find particularly offensive. Our carers will make note of and observe such individual preferences; the carer will always address a client by their chosen name, and know that the acceptable usage may vary between people or over time.

We know that many people receiving live-in care find it important that they are helped at a time of day which is convenient for them and we will try to respect clients' preferences in these areas.

Carers who carry out tasks which relate to clients' personal appearance will provide tactful help to ensure that their clients look as they would wish.

We recognise that the carrying out of some tasks, particularly those relating to intimate bodily functions, places clients' privacy and dignity at severe risk. We will ensure that our carers demonstrate great tact in such situations.

Some situations may carry additional sensitivity if the carer is of a different sex from the client; if asked, we will attempt to provide clients with same-sex staff.

Carers have been instructed to be alert to the potential invasion of privacy involved in handling clients' personal possessions or documents, and will always respect boundaries a client chooses to set.

If a client is particularly sensitive about their privacy or dignity in any other area of their lifestyle, carers will tread with particular care.

Clients from Minority Groups

We are aware that issues of privacy and dignity may be especially relevant when the client is from a minority group. We seek to make our carers alert to points of cultural difference they may encounter in their work, and we encourage our clients to draw to our attention any particular matter of which we should be aware. For example, in certain cultures the men are the head of the household and women cannot be spoken directly to or asked any questions of. During the assessment process care must be taken to ensure that these cultural differences are taken into account. Please refer to the Equality and Diversity Policy, PART TWO.

Related Policies

Adult Safeguarding

Assessment of Need and Eligibility

Care and Support Planning

Continuity of Care or Support Workers

Consent

Cyber Security

Data Protection

Duty of Candour

Equality and Diversity

Good Governance

Handling of Money – Clients

Ill Treatment and wilful Neglect

Meetings Needs

Clients Records (HOME)

Client's Home Security

Social Inclusion

Training Statement

This is a fundamental core of delivering services and will be re-enforced during day to day practice.

This policy will be reviewed by the Registered Manager.

Signed: Morag Collier

Date: 20/02/18

Review Date: 20/08/18

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DIRECT PAYMENTS

Constantia Care Ltd.

Policy Statement

This type of payment was introduced in the mid – 90's and they remain the government's preferred mechanism for personalised care and support. These payments, along with personal budgets and personalised care planning, mandated for the first time in the Care Act 2014, provide the platform from which to deliver a modern care and support system.

People should be encouraged to take ownership of their care planning and can be free to choose how their needs are met, whether through local authority or third party provision, by direct payments or a combination of the three approaches. This organisation is committed to working with Direct Payment holders to develop and deliver the services best suited to meet their assessed needs.

Care Act 2014

The Act introduces different ways that Direct Payments can be used and gives detailed guidance to Local Authorities on how to facilitate the changes.

The Act identifies the following conditions in order for a Direct Payment to be accessed. These conditions need to be met if the request for to receive a Direct Payment being declined is to be averted.

The conditions are:

- The adult has capacity to make the request, and where there is a nominated, person that person agrees to receive the payments;
- The local authority is not prohibited by regulations from meeting the adult's needs by making direct payments to the adult or nominated person;
- The local authority is satisfied that the adult or nominated person is capable of managing direct payments either by himself or herself, or with whatever help the authority thinks the adult or nominated person will be able to access;
- The local authority is satisfied that making direct payments to the adult or nominated person is on appropriate way to meet the needs in question.

These are nationally set conditions which apply to all local authorities.

Paying Family Members

This has been classified to include management/administration of the direct payment, but care is still excluded by those living in the same household. Any arrangement should be included in the Care Plan, detailing the Payment amounts.

Care in a Care Home

Respite can be purchased, a maximum of 4 weeks stay, but for longer stays, the government is currently testing this with the aim of introducing this in 2016. Additional statutory guidance will be introduced, when this is being implemented. These are other changes being phased in, which local authorities will implement during 2015 – 2017 and we, as providers, will update our systems as required

The important changes will be reflected in the Care Plan for Direct Payment holders and, again the flexible arrangements that are required to meet the needs of service user will be looked at on an individual as basis and services developed accordingly.

As a general rule, direct payments should not be used to purchase services from the "home" local authority. This does not preclude people from purchasing services from other local authorities.

The Future

For us as providers, it simply means being clear about our role in recording, making sure we comply with our local authority service specification requirements regarding direct payment service user, being vigilant in updating our guidance and working together with our local authority partners to provide the services which individuals need to meet their assessed needs.

Related Policies

Personal Budgets

Statutory Guidance Care Act 2014 ([updated May 2016](#)) Chapter 12

Training Statement

Staff will be updated on the changes being brought in as local authorities develop the guidance and it becomes clear, what changes, if any, need to be implemented.

This policy will be reviewed again as soon as further guidance is available from our local authority partners.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

DISABILITY DISCRIMINATION POLICY

OUTCOME 12, REGULATION 21 (Requirements relating to Workers)

Constantia Care Ltd.

Policy Statement

In Constantia Care Ltd:

- Discrimination on the grounds of disability will be neither practised or tolerated
- All employees, of whatever grade or role, are expected to abide by and adhere to the general principle of equal opportunities and to respect the culture, religion, privacy and dignity of others at times
- Staff will be promoted, employed and treated fairly on the basis of their ability and merits and accordingly to their suitability and nobody will be disadvantaged by a condition or requirement which is not justified by the genuine needs of their job or of the proposed job
- Advertisements and details sent out to job applicants will include the following statement: "Constantia Care Ltd is an equal opportunities employer and we welcome applications from all sections of the community"
- Constantia Care Ltd is committed to challenge any form of disability discrimination it encounters
- Employees or service users with questions or concerns about any type of discrimination in Constantia Care Ltd are encouraged to bring these issues to the attention of the registered person of Constantia Care Ltd
- Any breach of this policy will be reported to the registered person, to a line manager or to a senior responsible member of organisation staff; breaches will be dealt with through Constantia Care Ltd's disciplinary procedures.

Aim of the Policy

The aim of Constantia Care Ltd. is to promote equal treatment for all employees and service users irrespective of race, colour, sexual orientation, nationality, ethnic origin, religion, political belief, disability, age, gender, or marital status. This is managed in compliance with equal opportunities legislation and accepted codes of good practice. We aim to ensure that no job applicant, staff member, volunteer, organisation or individual we provide services to will be discriminated against by us.

Constantia Care Ltd fully complies with the Disability Discrimination Act 1995 and understands disability discrimination to refer to the treatment of one person more or less favourably than another on the grounds of disability. Constantia Care Ltd understands that such discrimination may be direct or indirect. Direct discrimination is deliberate. Discrimination is indirect when an unnecessary condition or requirement is imposed, whether intentionally or inadvertently, such that the proportion of members of one group who can comply with it is considerably smaller than the proportion of other groups.

Procedure for Dealing With Complaints of Disability Discrimination

Employees or contracted staff who believe that they are subject to discrimination at work, either by Constantia Care Ltd or by another employee, have recourse to Constantia Care Ltd grievance procedure as set out in their terms of employment. Allegations of disability discrimination will be taken seriously by Constantia Care Ltd and failure to comply with this policy or proven acts of discrimination by an employee will be handled under Constantia Care Ltd's disciplinary procedure.

Complainants will record:

- The details of what happened or of the specific nature of the complaint
- Details of when and where any occurrence took place
- The names and contact details of witnesses if appropriate.

All complaints will be dealt with as fully confidential.

Training

All new staff are encouraged to read the policies on equal opportunities and disability discrimination as part of their induction process.

All existing staff will be offered training, updates and/or briefings identified through appraisal to enable them to meet the requirements of this policy.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

DISCIPLINARY POLICY

OUTCOME 14, REGULATION 23 (Supporting Workers)

Constantia Care Ltd.

Policy Statement

All employers are unfortunately forced to administer discipline to staff at some time or another. Constantia Care believes that any disciplinary action taken will be aimed at identifying those problems that caused or contributed to the disciplinary action having to be taken, and to assist in correcting them.

Constantia Care believes that it is in the interests of all that disciplinary actions are carried out in a prompt, uniform and impartial way and that the main purpose of disciplinary action is to correct the problem, prevent its recurrence and prepare the employee or self-employed care assistant for satisfactory service in the future.

Constantia Care Ltd. adheres fully to the above Outcome and Regulations from the Care Quality Commission Guidance about Compliance, which relates to the degree to which clients' rights and best interests are safeguarded by Constantia Care's policies and procedures.

Constantia Care Ltd. also adheres fully to the ACAS Code of Practice *Disciplinary and Grievance Procedures*.

Aim

This policy is intended to set out the values, principles and policies underpinning Constantia Care's approach to staff and self-employed care assistant discipline. The purpose of this policy is to ensure a fair and systematic approach to the enforcement of acceptable standards of conduct and behaviour amongst all employees and self-employed care assistants.

Staff Disciplinary Policy

In Constantia Care disciplinary action may be taken in response to one of the following:

1. Unsatisfactory performance at work
2. Improper behaviour at work
3. Persistent lateness or absenteeism
4. Misconduct.

In Constantia Care disciplinary action may take one of the following forms depending on the severity of the problem and the number of occurrences:

1. Verbal warnings
2. One or more written warnings
3. Suspension with or without pay
4. Dismissal.

In Constantia Care the following procedure applies.

1. For offences other than serious or gross misconduct, the employee's or self-employed care assistants immediate supervisor or line manager will first ascertain the facts and review any evidence relating to any breach of rules or discipline. The employee or self-employed care assistant will be interviewed in private and will be asked for an explanation. The immediate supervisor or line manager will then decide upon a course of action.
2. If an informal, verbal warning is decided upon then this will be administered in private by the immediate supervisor or line manager and appropriate notes made in the employee or self-employed care assistants personnel file.
3. If a formal, written warning is required, because an informal warning has already been given for the offence or because of the severity of the offence, only a senior organisation manager or head of organisation will carry this out. Appropriate notes will be made in the employee or self-employed care assistants personnel file.

4. If the offence is repeated or agreed improvements are not made then a second and final written warning may be issued.
5. If standards improve and there is no repetition of the offence then the employee or self-employed care assistant may request that the warning is removed from their file after 12 months. Constantia Care reserves the right to refuse to remove the offence from the file if it feels that the offence warrants or that there is a likelihood of further transgression.
6. An employee or self-employed care assistant may be suspended without pay if Constantia Care deems them incapable of performing their duties or while investigations take place. A written copy of the suspension will be given to the member of staff or self-employed care assistant by the head of organisation.
7. An employee or self-employed care assistant may be dismissed if:
 1. They have already received a final written warning and repeat the offence
 2. They have been suspended and Constantia Care decides that, upon investigation, their offence merits dismissal
 3. They have committed serious or gross misconduct
 4. They have committed an offence that makes their continued employment impossible.

Constantia Care recognises that there are certain types of problem that are so serious they justify either a suspension or, in extreme situations, dismissal, without verbal or written warnings being given.

In Constantia Care the following apply.

1. Disciplinary matters will be dealt with quickly and fairly.
2. An indication will be provided of the disciplinary action that might be taken.
3. Supervisors or line managers can issue verbal warnings.
4. Only the head of organisation or senior organisation management can use written warnings and dismissal.
5. Employees or self-employed care assistant will be told of the complaint against them and be given full opportunity to state their case before a decision is taken.
6. Employees and self-employed care assistants have the right to be accompanied by a trade union representative or fellow employee of their choice.
7. Employees and self-employed care assistants will not normally be dismissed for a first offence, other than gross misconduct.
8. No disciplinary action will be taken before there has been a full investigation.
9. An explanation of any penalty will be given.
10. Employees and self-employed care assistants have a right of appeal.

Written warnings

Written warnings will state clearly:

1. The conduct concerned
2. The improvement required and the time limit for this if appropriate
3. The likely consequences of further offences or failure to improve (eg final warning, dismissal, etc).

The warning will be handed to the employee, who will be informed of the right of appeal.

Appeals

Appeals will not be pursued through Constantia Care's grievance procedure but will be made directly to the head of organisation. Where a final decision within Constantia Care is contested, or where the matter becomes a collective issue between management and a trade union, then appeals will be made via an external body such as ACAS.

Records

Records will be kept in the employee's or self-employed care assistants personnel file detailing the nature of any breach of disciplinary rules, the action taken and the reasons for it, whether an appeal was lodged, its outcome and any subsequent developments. These records will be carefully safeguarded and kept confidential.

The company disciplinary policy will be included in the induction training for all new staff and self-employed care assistant.

This policy will be reviewed by the registered manager.

Signed: Morag Collier

Date: 30/01/18

Review Date: 30/06/18

DNACPR

Constantia Care Ltd

Policy Statement

The policy needs to be implemented in the contexts of the care of terminally ill people, their palliative care, symptom and pain control, and in cases of sudden collapse and medical emergencies.

The policy also aims to be consistent with the Code of Practice developed under the *Mental Capacity Act 2005*, since people in need of resuscitation by definition might also be lacking capacity at the time to take key decisions on their subsequent treatment.

Because of the Tracey Judgement in 2014, all NHS trusts have a legal duty to consult with, give the individuals with capacity opportunity to express their views and inform the individual if a DNACPR order is placed on their records. As Constantia Care, we confirm with our clients and/or their responsible person that they are aware that a DNACPR is in place and have had opportunity to discuss their views. This is an integral part of respecting an individual's dignity. This takes place as part of our assessment process.

The Policy

Constantia Care works on the basis that everyone has the right to make choices and decisions about their treatment in the event of their needing to be resuscitated, and that these wishes should be respected if the situation arises.

There is a prescribed DNACPR form issued by all GP surgeries and signed off by a health professional. This form must be regularly reviewed and amended where necessary to reflect any change in the client's wishes and a record must be kept and available to all staff and carers.

Communication between Constantia Care and our multi-agency partners is crucial to ensuring that the client's wishes are conveyed and respected.

As far as possible, people's wishes should be ascertained and recorded as 'advance decisions' (a term used in relation to the *Mental Capacity Act 2005*) on their service plan, taking into account that this process will require sensitive and careful handling.

The person's capacity to take an advanced decision for her or himself regarding their possible resuscitation also requires consideration. For example, if there is any doubt about the validity of an advanced decision then it would be incumbent to attempt resuscitation or to seek medical help to do so.

If it is clear that the person has made an advance decision against being resuscitated under certain conditions then this needs to be respected, as should any associated wish such as keeping the decision confidential from relatives and others.

Constantia Care may need to clarify its ethical and legal position in cases, for example, where there are doubts about a person's mental capacity to make advance decisions, or where there are doubts about the authenticity of any representation of the person's views. (In such instances there can be no reasonable belief that the person has taken such an advanced decision and attempts at resuscitation would then follow)

Procedures

- Constantia Care attempts to elicit from all of its Clients, in relation to its contractual obligations to them and their care planning, whether:
 - a) They have made an advance decision regarding their treatment, and if so whether this decision has been lodged with their medical practitioner
 - b) They might wish to make such a decision.
- Constantia Care ensures such issues are dealt with, particularly in situations where there is a clear risk that the Client could require resuscitation at some point;
- Constantia Care will clearly communicate to the Client and their representatives its expectations of what its staff should do under those circumstances. These are recorded in the Client Care Plan;
- In incidents of sudden or unexpected collapse, where a person has clearly not made any advanced directive or given any indication of their views on resuscitation, the organisation expects its staff to take all necessary steps to seek emergency help as promptly as possible;
- In all cases, organisation staff are instructed to summon medical help and the emergency services without delay;
- It is the policy of Constantia Care that no attempts at resuscitation are undertaken by its staff; however, they are expected to provide usual standards of help and comfort, e.g. pending the arrival of the emergency services or medical help.
- Constantia Care takes resuscitation and emergency care into account when allocating staffing resources; it cannot be guaranteed that carers will be fully competent or qualified to provide assistance in any given emergency situation, hence the emergency services will always be called; further interventions will then be directed by the medical practitioner and/or paramedical practitioners.
- If the carer is aware that the ill person has made an advance decision, or there is a reasonable belief that they do not wish to be resuscitated, then they should pass this information to the medical team.
- All staff and carers receive guidance and learning opportunities to clarify their attitudes and feelings over such issues and to understand their respective roles and responsibilities in such situations.
- Health professionals have a duty to provide care based on the best available evidence or best practice and to recognise and work within the limits of their competence. Whilst death can be certified only by a registered doctor with a licence to practise or by a coroner, death may be confirmed by other health professionals, including paramedics and nurses. Nurses working in an environment in which they may encounter death or cardiac arrest must ensure that they have the necessary competence to recognise when CPR may be beneficial in restoring a person to a duration and quality of life that they would value and when, realistically, CPR would be of no benefit to the person and would deprive them of a dignified death or could potentially do them harm.

Note:

An advance decision communicates the sort of treatment a person wants for different levels of illness, such as a critical or terminal illness, permanent unconsciousness or dementia in the event of their losing the capacity to communicate their wishes at the time. As a document, an advance decision might include a number of specific advance decisions, of which being either for or against resuscitation might be included.

An advance decision indicates to medical doctors and health care professionals that the person does not want certain types of treatment, such as to be put on a ventilator if in a coma. But it can also say that the person would like a certain treatment, or to receive whatever treatment is available that might keep the person alive.

An advance decision only comes into effect when a person is terminally ill (which generally is held to mean less than six months to live), e.g. with widespread cancer. An advance directive does not let the person choose another person to make decisions for them, unless it specifically appoints a proxy.

Related Policies

Advance Care Planning

Advocacy

Autonomy and Independence

Consent

Death of a Client

Deprivation of Liberty Safeguards

Dignity and Respect

End of Life

Meeting Needs

Mental Capacity Act 2005

Guidance

Resuscitation Council

www.resus.org.uk/dnacpr/

Training Statement

All staff are trained in DNACPR procedures on an individual Client basis.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 20/02/18

Review Date: 20/06/18

DRESS CODE POLICY.

OUTCOME 12, REGULATION 21. (Requirements relating to workers)

Constantia Care Ltd.

Policy Statement

This policy sets out the requirements of all categories of staff within Constantia Care in relation to the wearing of uniforms and standards of dress.

The definition of staff is all workers, staff and management. This includes volunteers, agency workers and self employed contractors who must be appropriately dressed at all times. Students undertaking placements are expected to adhere to the policies agreed between Constantia Care and the relevant education provider.

Aim of Policy

1. To clarify the requirements on all staff with regard to standards of dress. Health and safety demands are such that clarity needs to be in place to ensure that our duty of care to staff and residents is understood and respected.
2. The standard of dress must support infection prevention and control requirements of the Care Quality Commission Regulations.
3. The standards of dress is such that it enhances the safety and wellbeing of staff and presents a professional image to our multi agency partners, residents and local community.

Constantia Care whilst implementing a dress code recognises the diversity of cultures, religions and disabilities of its employees where necessary and will take a sensitive approach when this affects dress or uniform requirements.

The Dress Code Policy is designed to guide managers and employees on the application of standards of dress and appearance. The policy sets out acceptable and unacceptable standards of dress. Staff will use common sense in adhering to the principles underpinning the policy.

All employees are supplied with a Constantia Care identity/ security badge which must be worn and be visible during working hours .or when representing Constantia Care Ltd in an official capacity.

All staff are required to comply with the principles of the Dress Code Policy. Failure to adhere to Constantia Care standards of dress may constitute misconduct and may result in formal disciplinary proceedings.

Employees are responsible for following the standards of uniform/dress laid down in this policy and will understand how this policy relates to their working environment; health and safety, infection control, particular role and duties and contact with others during the course of their employment.

Managers are responsible for ensuring the Dress Code Policy is adhered to at all times in respect of the workers they manage and be mindful of the requirements regarding contractors, agency staff and volunteers etc...

Uniform

All staff delivering personal care to residents must

1. Wear the 'uniform' suggested by Constantia Care in a clean and presentable fashion and all staff must have access to spare, clean clothes in case one becomes soiled. The 'uniform' set by Constantia Care for carers is a white blouse/shirt, black trousers and flat black shoes.

2. Appropriate PPE will also be used e.g. gloves, aprons, bacterial gel, masks etc. As detailed by the requirements of the Health and Safety Policy.

All staff delivering support to residents must

1. Wear the uniform provided by Constantia Care in a clean and presentable fashion and all staff must have access to a spare uniform in case one becomes soiled during the shift. The care assistant will wear a white blouse/shirt, black trousers and flat black shoes.

2 This includes chefs and ancillary staff and agency workers employed by Constantia Care

Volunteers, contractors or self-employed.

This group must be appropriately dressed for the task for which they are engaged to do.

Common sense will be the guiding principle but at all times the following applies

- All tops must cover upper torso completely, vests are not acceptable.
- Shorts if worn must be knee length, tailored for both men and women.
- Shoes must be appropriate for the task and no opened toed sandals will be worn.
- Denim of any type is not acceptable. Chino cottons, linens and similar fabrics are appropriate.
- All appropriate clothing must be safe and acceptable in the workplace e.g. mini, maxi type clothing is not acceptable.
- Clothing will be clean, serviceable and fit for the task in hand.

Managers and office staff.

The dress code for this group of staff is not definitive but must adhere to the following standards.

- Skirts, trousers and tops must be serviceable and of the right length and coverage as detailed above
- No staff in this category is allowed to wear shorts in the office or while visiting prospective residents. The care assistant will wear a white blouse/shirt, black trousers and flat black shoes.
- Shoes will be carefully selected e.g. on days when spot checking staff no opened toed sandals or similar footwear will be worn.
- Appropriate clothing will be worn at all times should the staff member be required to visit their client.

Unless part of an agreement with a member of management, the following items of clothing are examples of unacceptable clothing, either on the grounds of health and safety or for the company's public image: Tracksuits, casual sports T-shirts, leisure shorts, baseball caps/hats, overly tight or revealing clothes, including mini-skirts, leggings worn as trousers, low cut tops or those revealing the midriff and clothing bearing inappropriate slogans, high heels over 4inches or deemed to be problematic to walk in and flip flops (may be worn internally, only with a change of shoes available).

General

1. The uniforms issued must not be altered or added to by the individual. If changes are required, it must be discussed with your line manager.

2. All staff delivering personal care or support will change out of their uniform before going off duty, if this is not possible staff are permitted to travel between home and work in their uniform as long as it is fully covered by a coat. This will be discussed with the appropriate manager to seek agreement for the staff member.

3. The wearing of Constantia Care uniform in public places such as a supermarket is not acceptable.

4. The ID badge will be removed on leaving the premises

5. Maternity uniforms will be provided for staff where necessary.

6. Constantia Care does not provide a laundry service but staff must ensure that uniforms are laundered in accordance with guidance provided on the uniform. In the event of any confusion, staff will contact the ICP lead in Constantia Care for guidance on appropriate washing temperatures

7. Nail varnish, false nails and false eyelashes are not permitted. Nails will be sufficiently short to ensure safe service user contact and good hand hygiene.

8. Visible tattoos are to be discouraged and where present will not be offensive to others. Where they are deemed to be offensive they will be appropriately covered.

9 Jewelry must be kept to a minimum for staff delivering care or support; a plain/wedding ring and one pair of discreet stud earrings are permitted. Wrist watches must not be worn when providing care or support.

Facial/body piercing can be a Health and Safety issue and must be removed before coming on duty.

If staff have piercing for religious or cultural reasons, these must be covered and must not present a quantifiable health and safety or infection prevention and control risk.

10, Hair will be neat and tidy at all times and in the care and support environment long hair will be tied back. Headscarves worn for religious purposes are permitted in most areas, however they are excluded in any clinical areas where they could present a health and safety and cross-infection hazard. Beards will be short and neatly trimmed, unless this reflects the individual's religion where it will be tidy.

Beards will be covered with a hood when undertaking aseptic procedures.

This policy will be reviewed by the Registered Manager

Signature: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

DUTY OF CANDOUR

Constantia Care Ltd

Policy statement

This is a requirement under the Fundamental Standards Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Put simply, candour means the quality of being open and honest. Candour can only work when it is part of a wider commitment to safety, listening and learning, with an organisational commitment to continual improvement. Care and treatment is not risk free and evidence heard at the Dalton review confirmed what was already known.

When things go wrong in health or care settings, families want to know three things,

- To be told honestly what happened
- What can be done to deal with any harm caused
- To know what will be done to prevent a recurrence to someone else.

The Duty of Candour applies to all Health and Social Care providers registered with the Care Quality Commission.

The Duty applies to all cases of “significant harm” This new composite classification would cover the requirements of the reporting duty for NHS and Social Care Providers currently in place with the Care Quality Commission.

These are:

- National Reporting and Learning System (NHS)
- Statutory Notifications (Social Care)

In Social Care this is the “Harm threshold”, which is breached when a statutory notification is required to CQC.

Compassion humanity and candour

The obligations and challenges of candour serve to remind us that for all its technological and forensic advances health and social care are still a deeply human activity. Systems and processes are necessary supports to good compassionate care, but they can never serve as its substitute.

It follows from this that making reality of candour is a matter of hearts and minds more than it is a matter of systems and processes, important as they may be. A compliance focused approach will fail.

Organisations need to start from the simple recognition that candour is the right thing to do. The commitment to candour has to be about values, rooted in the genuine engagement of staff, building on their own professional duties and personal commitment to clients. It is right to be clear about thresholds and enforcement but nothing will be gained if we lose sight of the fundamental purpose of candour, which is to do the right thing for all users of health and social care services.

Hence, the government’s choice of a statutory duty sends an equivocal signal to the health and social care sector that this matters. “Moderate harm” means harm that requires a moderate increase in treatment, and, significant but not permanent harm, moderate increase in treatment “means an unplanned return to surgery, an unplanned readmission, prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment Care transfer to another treatment area (such as intensive care).

“Notifiable safety incident” means any unintended or unexpected incident that occurred in respect of a client during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in:

- The death of a client, where the death relates directly of the incident rather than to the natural course of the client’s illness or underlying condition, or
- Severe harm, moderate harm, or prolonged psychological harm to the client; “prolonged psychological harm” means psychological harm which a client has experienced or is likely to experience for a continuous period of at least 28 days;
- “relevant person” means the client or in the following circumstances, a person lawfully acting on their behalf
- on the death of the client;
- where they are under 16 and not competent to make a decision in relation to their care or treatment, or where the client is 16 or over and lack capacity (as determined by the Mental Capacity Act 2005) in relation to the matter;
- “severe harm” means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions including removal of the wrong limb or brain damage, which is related directly to the incident and not related to the natural course of the client’s illness or underlying condition.

The Guidance set out below should be followed in order to fulfil our duty as a provider.

As soon as reasonably practicable:

- Notify the relevant people that the incident has occurred e.g. family, next of kin, advocate etc
- Provide support to the relevant person, where appropriate, including when informing them of the incident.
- The information should be given in person, when possible
- An account of the incident should be provided, which is factual and true at the date of the notification.
- Advise them of the relevant steps or actions are to be taken
- Include an apology
- Record the incident and the steps and actions taken
- The notification must be followed up in writing, confirming all of the above points.

If the relevant person declines to engage in the process, this should be recorded and include the attempts to engage with them.

In this regulation:

“Apology” means an expression of sorrow or regret in respect of a Notifiable safety incident.

“Notifiable” means to an external regulator e.g. Care Quality Commission, Health and Safety Executive.

Separate guidance is to be issued with regard to this Regulation and this policy will be reviewed and amended in publication of further guidance.

Related Policies

Accessible Information and Communication
Dignity and Respect
Good Governance
Notifications

Training Statement

Constantia Care management need to be fully aware of this legal duty and it will be incorporated in to Induction and a separate briefing will be in place for all managers involved in good governance within their job role. All staff will be made aware of this policy and understand that it will lead to disciplinary process where a culture of openness and accountability is circumvented by intent.

This policy will be reviewed by the Registered Manager.

Signed: Morag Collier

Date: 20/02/18

Review Date: 20/08/18

END OF LIFE

Constantia Care Ltd

Policy Statement

This policy fully reflects the current guidance issued by NICE and the Leadership Alliance for the Care of Dying People 5 priorities of care which are:

Recognise

Communicate

Involve

Support

Plan & Do

The above guidance provides specific, concise quality statements, measures, and audience descriptors to provide the public, health- and social care professionals, commissioners, and service providers with definitions of high-quality care.

The Policy

As an organisation, we seek to adhere to the following statements, and through assessment and planning provide effective and caring end of life care for our service users. We work closely with outside professionals such as cancer care nurses, Macmillan nurses, and GP's to ensure the best possible outcome for the individual.

The following list of statements is taken from the NICE guidelines and reflects the 5 priorities of care:

Statement 1. People approaching the end of life are identified in a timely way.

Statement 2. People approaching the end of life, and their families and carers, are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences.

Statement 3. People approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, with the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.

Statement 4. People approaching the end of life have their physical and specific psychological needs safely, effectively and appropriately met at any time of day or night, including access to medicines and equipment.

Statement 5. People approaching the end of life are offered timely personalised support for their social, practical and emotional needs, which is appropriate to their preferences and maximises independence and social participation for as long as possible.

Statement 6. People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences.

Statement 7. Families and carers of people approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, and holistic support appropriate to their current needs and preferences.

Statement 8. People approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night, and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences.

Statement 9. People approaching the end of life who experience a crisis at any time of day or night receive prompt, safe and effective urgent care appropriate to their needs and preferences.

Statement 10. People approaching the end of life who may benefit from specialist palliative care are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night.

Statement 11. People in the last days of life are identified in a timely way and have their care coordinated and delivered in accordance with their personalised care plan, including rapid access to holistic support, equipment and administration of medication.

Statement 12. The body of a person who has died is cared for in a culturally sensitive and dignified manner.

Statement 13. Families and carers of people who have died receive timely verification and certification of the death.

Statement 14. People closely affected by a death are communicated with in a sensitive way and are offered immediate and ongoing bereavement, emotional and spiritual support appropriate to their needs and preferences.

Statement 15. Health and social care workers have the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and for their families and carers.

Statement 16. Generalist and specialist services providing care for people approaching the end of life and their families and carers have a multidisciplinary workforce sufficient in both number and in the mix of skills to provide high-quality care and support.

What the Quality Statement Means for Us

We ensure that systems are in place to identify people approaching the end of life in a timely way. We use these systems to identify care and support to meet their needs and preferences.

End of life care forms part of holistic care, and as such it should be respected and planned.

As much information as possible is gained following admission during the initial assessment process to ensure that when the death of an individual occurs the relatives are aware of the individual's preferences, for instance the individual's choice of burial or cremation.

Related Policies

Advance Care Planning
Assessment of Need and Eligibility
Basic Life Support
Consent
Death of a Service User
Dignity and Respect
DNACPR
Notifications
Nutritional and Hydration Needs
Person Centred Planning
Prevention of Pressure Ulcers

Guidance

Nice Guidelines NG31 published December 2015 Care of dying adults in the last days of life
End of life care for adult. Quality Standard (QS13) published Nov 2011 updated March 2017

Skills for Care - Common Core principles and Competences for social care and health workers working with adults at the end of life

<http://www.skillsforcare.org.uk/Topics/End-of-Life-Care/End-of-life-care.aspx>

One Chance to get it Right – Leadership Alliance for the Care of Dying People.
(5 Priorities of Care)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf

Training Statement

All staff and carers involved in End of Life Care receive training and support both in house and from outside health professionals to enable them to meet the ever changing needs of the Client and their family.

This procedure will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 20/02/18

Review Date: 20/08/18

ENVIRONMENTAL MANAGEMENT

Constantia Care Ltd.

Policy Statement

Constantia Care believes that environmental issues such as pollution, waste management, energy and water conservation, transport issues and the recycling of resources, should be important items on the agenda of the modern employer.

Constantia Care believes that it has a duty to act in a responsible, sustainable and ethical way and to work towards contributing to nationally-agreed environmental objectives.

Constantia Care understands that the aim of such sustainable development is to maintain the quality of the environment, both now and for generations to come.

This includes:

- The conservation of energy, wood, paper, horticulture and water
- The reduction of pollution, especially pollution by ozone depleting substances, vehicle emissions, asbestos, hazardous substances, batteries, solvents and paints, biodegradables and litter
- The procurement of supplies and resources from renewable or environmentally friendly sources
- Responsible waste management.

The Policy

In order to improve its environmental management and to ensure that all of its activities and developments are as sustainable as possible this organisation will:

- Adopt and implement an environmental and sustainable development policy which will be agreed with all members of staff
- Ensure that all organisations with whom the organisation contracts with and purchases from will be asked if they too have similar policies, and the organisation will gradually move its systems of procurement to more environmentally friendly sources
- Conduct a regular audit of its processes and wastes to identify areas where it can commit to long-term waste reduction targets
- Reduce waste levels by reusing whatever can be reused
- Maintain a recycling system in collaboration with local authorities, other local businesses and waste disposal organisations, particularly in regard to materials such as paper, tins, glass, plastic, cardboard and other packaging
- Recycle printer ink cartridges and consumables wherever possible
- Dispose of all electrical equipment according to the Directive on Waste Electrical and Electronic Equipment (the WEEE Directive), including such things as computer equipment, fridges and freezers
- Use energy efficient and low-power equipment wherever possible
- Ensure that all buildings, pipes and lofts are properly insulated and maintained in such a way as to be as energy efficient as possible
- Conserve power and water by encouraging staff to:
 - turn off non-essential lights and power sources when not in use
 - keep windows and doors closed when using heating
- Report and repair malfunctioning thermostats on radiators and dripping taps immediately
- Only use as much water as is necessary

- Reduce the harmful effects of car exhausts and congestion by maintaining vehicles in good condition and by cutting back on unnecessary journeys wherever possible
- Ensure that potentially dangerous substances are used as little as possible and are disposed of properly
- Ensure that staff are trained to comply with these policies.

TRAINING

All new staff should be encouraged to read the policy on environmental management as part of their induction process.

Related Policies

Good Governance

Premises and Resources

Premises and Management

This policy will be reviewed annually by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

EQUAL OPPORTUNITIES

Constantia Care Ltd.

Policy Statement

Constantia Care is committed to achieving a working environment that provides equality of opportunity and freedom from discrimination on the grounds of race, religion and belief, sex, sexual orientation, age, disability, marriage and civil partnership, pregnancy and maternity, gender reassignment.

Constantia Care is also committed to building a workforce that is diverse and reflects the community around us.

The Policy

The aim of the organisation is to promote equal treatment for all employees and Service Users irrespective of race, colour, sexual orientation, nationality, ethnic origin, religion, political belief, disability, age, gender, or marital status; and that this is managed in compliance with equal opportunities legislation and accepted Codes of good Practice. These codes are regularly reviewed using the Equality and Human Rights Commission Guidance. We aim to ensure that no job applicant, staff member, volunteer, organisation or individual to whom we provide services will be discriminated against by us.

Definition

We understand discrimination to mean the protected characteristics defined within The Equality Act 2010 these are:

- **Protected Characteristics**
- **Definition and Explanation**
- **Age**

Means a person or persons belonging to a particular age group. An age group includes people of the same age and people of a particular range of ages. Where people fall in the same age group they share the protected characteristics of age.

Disability

Within the Act, a person has a disability if they have a physical or mental impairment and the impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities.

For the purposes of the Act, these words have the following meanings:

‘Substantial’ means more than minor or trivial.

‘Long-term’ means that the effect of the impairment has lasted or is likely to last for at least twelve months (there are special rules covering recurring or fluctuating conditions).

‘Normal day-to-day activities’ includes everyday things like eating, washing, walking and going shopping.

People who have had a disability in the past that meets this definition are also protected by the Act.

Progressive conditions considered to be a disability

There are additional provisions relating to people with progressive conditions. People with HIV cancer or multiple sclerosis are protected by the Act from the point of diagnosis. People with some visual impairments are automatically deemed to be disabled. Where people share the same disability, they share the protected characteristics of disability.

Gender Reassignment

This is defined for the purpose of the Act as where a person has proposed, started or completed a process to change his or her sex. A transsexual person has the protected characteristics of gender reassignment.

A woman making the transition to being a man and a man making the transition to being a woman both share the characteristic of gender reassignment, as does a person who has only just started out on the process of changing his or her sex and a person who has completed the process.

Marriage and Civil Partnership

This refers to people who have the common characteristics of being married or of being civil partners. A heterosexual man and a heterosexual woman who are married to each other and a man and another man who are civil partners and women and another women who are civil partners all share the protected characteristic of marriage and civil partnership.

- People who are not married or civil partners do not have this protected characteristic.
- A person who is engaged to be married is not married and therefore does not have this protected characteristic.
- A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic

Pregnancy and Maternity

A woman remains protected in her employment during the period of the pregnancy and any statutory maternity leave to which she is entitled. This is now separate from protection on grounds of sex, which is not available to a woman during her pregnancy and maternity. It is unlawful to take into account an employee's period of absence due to pregnancy related illness when taking a decision about her employment.

Race

For the purposes of the Act 'race' includes nationality and ethnic or national origins. People which have or share characteristics, of colour nationality or ethnic or national origins can be described as belonging to a particular racial group.

Examples:

- Colour includes black or white.
- Nationality includes being a British, Australian or Swiss Citizen.
- Ethnic or national origins include being from a Roma background or of Chinese heritage.
- A racial group could be 'Black Britons' which would encompass those people who are both black and who are British citizens.

Religion or Belief

This covers people with religious or philosophical beliefs. To be considered a religion within the meaning of the Act, it must have a clear structure and belief system.

The Act includes the following examples:

The Baha 'I' faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism.

To be considered a philosophical belief for the purposes of the Act, it must be:

"Genuinely held; be a belief and not an opinion or viewpoint; be a belief as to a weighty and substantial aspect of human life and behaviour; attain a certain level of cogency,

seriousness, cohesion and importance; and be worthy of respect in a democratic society, compatible with human dignity and not conflict with the fundamental rights of others”

The Act cites as examples of philosophical beliefs: Humanism and Atheism.

A cult involved in illegal activities would not satisfy these criteria nor would achieve to a particular football team. People who are of the same religion or belief share the protected characteristic of religion or belief.

Sex (formerly gender)

For the purposes of the Act, sex means being a man or a woman. Men share the sex characteristics with other men and women with other women.

Sexual Orientation

This is defined in the Act as a person’s sexual orientation towards:

- People of the same sex as him or her (in other words the person is a gay man or a lesbian).
- People of the opposite sex from him or her (the person is heterosexual).
- People of both sexes (the person is bisexual)
-

People sharing a sexual orientation mean that they are of the same sexual orientation and therefore share the characteristics of sexual orientation.

Discrimination may be direct or indirect. Direct discrimination is deliberate. Discrimination is indirect: when an unnecessary condition or requirement is imposed, whether intentionally or inadvertently, such that the proportion of members of one group who can comply with it is considerably smaller than the proportion of other groups.

Equal Opportunities Policy

The organisation is committed to a policy of equal opportunities for all and requires all employees to abide by and adhere to this general principle, and to the requirements of the Code of Practice laid down by the Equality and Human Rights Commission.

In particular in this organisation:

- Discrimination on the grounds of race, colour, ethnic or national origin, religion, class, disability, special needs, on grounds of sex or marital status, or membership or non-membership of a trade union will not be practiced or tolerated
- The organisation expects all employees, of whatever grade or authority, to abide by and adhere to this general principle
- Staff will be promoted, employed and treated fairly on the basis of their ability and merits and accordingly to their suitability and no one will be disadvantaged by a condition or requirement that is not justified by the genuine needs of their job or of the proposed job
- The organisation is committed to challenging any form of discrimination it encounters
- In order to provide equal employment and advancement opportunities to all individuals, employment decisions at the organisation will be based on merit, qualifications and abilities
- Employees or Service Users with questions or concerns about any type of discrimination in the organisation are encouraged to bring these issues to the attention of the organisation management or owner
- Any breach of this policy should be reported to the on-duty manager or to a senior, responsible member of organisation staff; breaches will be dealt with through the organisation’s disciplinary procedures.

Procedure for Dealing with Complaints of Discrimination

Employees or contracted staff who believe that they are subject to discrimination at work, either by the organisation or by another employee, can have recourse to this organisation's grievance procedure as set out in their terms of employment. Some discriminatory acts may contravene the *Sex Discrimination Act 1975* or the *Race Relations Act 1976*. These and other forms of discrimination will be taken seriously by the organisation. Failure to comply with the Equal Opportunities Policy and proven acts of discrimination by an employee will be handled under the organisation's disciplinary procedure.

Complainants should:

- Record the details of what happened or of the specific nature of the complaint
- Record details of when and where any occurrence took place
- Record the names and contact details of witnesses if appropriate.

All complaints should be dealt with in a professional and confidential manner.

Related Policies

Equality and Diversity

Good Governance

Recruitment and Selection

Training Statement

All new staff should be encouraged to read the policy on equal opportunities as part of their induction process.

A variety of training courses on equal opportunities and related matters are usually available through organised through the Local Authority. All existing staff will undergo training and/or briefing to enable them to meet the requirements of this policy, and should be offered advice and guidance to ensure they understand their responsibilities within their role and the organisation's policy.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

EQUALITY AND DIVERSITY

Constantia Care Ltd.

Policy Statement

Since coming into force in October 2010 this legislation is probably the least understood and most widely misrepresented. The Act is phrased in due to its complex and overarching legal framework, replacing over 116 separate pieces of legislation into one single Act. The Act simplifies strengthens and harmonises the current legislation (pre 2010) to provide Britain with a new discrimination law, which protects individual from unfair treatment and promotes a fair and equal society.

The 9 main pieces of legislation that have merged are:

- The Equal Pay Act 1970
- The Sex Discrimination Act 1975
- The Race Relations Act 1976
- The Disability Discrimination Act 1995
- The Employment Equality (Religion or Belief) Regulation 2003
- The Employment Equality (Sexual Orientation) Regulation 2003
- The Equality Act 2006 Part 2
- The Equality Act (Sexual Orientation) Regulation 2007

As Constantia Care we are aware of the importance of this Act in relation to Service Users and staff and to the good governance of the organisation generally.

The Policy

The Equality and Human Rights Commission (EHRC) from time to time, publishes guidance, develops different Codes of Practice in line with a timetable set by government. The basis upon which the Equality Act is structured is Protected Characteristics and how they apply both in the workplace and in everyday life.

Protected Characteristics

Definition and Explanation

Age

Means a person or persons belonging to a particular age group. An age group includes people of the same age and people of a particular range of ages. Where people fall in the same age group they share the protected characteristics of age.

Disability

Within the Act, a person has a disability if they have a physical or mental impairment and the impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities. For the purposes of the Act, these words have the following meanings:

‘Substantial’ means more than minor or trivial.

‘Long-term’ means that the effect of the impairment has lasted or is likely to last for at least twelve months (there are special rules covering recurring or fluctuating conditions).

‘Normal day-to-day activities’ includes everyday things like eating, washing, walking and going shopping.

People who have had a disability in the past that meets this definition are also protected by the Act.

Progressive conditions considered to be a disability

There are additional provisions relating to people with progressive conditions. People with HIV cancer or multiple sclerosis are protected by the Act from the point of diagnosis. People with some visual impairments are automatically deemed to be disabled. Where people share the same disability, they share the protected characteristics of disability.

Gender Reassignment

This is defined for the purpose of the Act as where a person has proposed, started or completed a process to change his or her sex. A transsexual person has the protected characteristics of gender reassignment.

A woman making the transition to being a man and a man making the transition to being a woman both share the characteristic of gender reassignment, as does a person who has only just started out on the process of changing his or her sex and a person who has completed the process.

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A woman remains protected in her employment during the period of the pregnancy and any statutory maternity leave to which she is entitled. This is now separate from protection on grounds of sex, which is not available to a women during her pregnancy and maternity. It is unlawful to take into account an employee's period of absence due to pregnancy related illness when taking a decision about her employment.

Race

For the purposes of the Act 'race' includes nationality and ethnic or national origins. People which have or share characteristics, of colour nationality or ethnic or national origins can be described as belonging to a particular racial group.

Examples:

- Colour includes black or white.
- Nationality includes being a British, Australian or Swiss Citizen.
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- A racial group could be 'Black Britons' which would encompass those people who are both black and who are British citizens.

Religion or Belief

This covers people with religious or philosophical beliefs. To be considered a religion within the meaning of the Act, it must have a clear structure and belief system.

The Act includes the following examples:

The Baha 'I' faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism.

To be considered a philosophical belief for the purposes of the Act, it must be:

“Genuinely held; be a belief and not an opinion or viewpoint; be a belief as to a weighty and substantial aspect of human life and behaviour; attain a certain level of cogency, seriousness, cohesion and importance; and be worthy of respect in a democratic society, compatible with human dignity and not conflict with the fundamental rights of others”

The Act cites as examples of philosophical beliefs: Humanism and Atheism.

A cult involved in illegal activities would not satisfy these criteria nor would allegiance to a particular football team.

People who are of the same religion or belief share the protected characteristic of religion or belief.

Sex (formerly gender)

For the purposes of the Act, sex means being a man or a woman. Men share the sex characteristics with other men and women with other women.

Sexual Orientation

This is defined in the Act as a person's sexual orientation towards:

- People of the same sex as him or her (in other words the person is a gay man or a lesbian).
- People of the opposite sex from him or her (the person is heterosexual).
- People of both sexes (the person is bisexual)

People sharing a sexual orientation mean that they are of the same sexual orientation and therefore share the characteristics of sexual orientation.

Types of Discrimination

Direct Discrimination

Direct discrimination occurs when someone is treated less favourably than another person because of a “Protected Characteristic” they have or are thought to have (see perception discrimination below), or because they associate with someone who has a “Protected Characteristic” (see discrimination by association below).

Example

Paul, a senior manager, turns down Angela's application for promotion to a supervisor position. Angela, who is a lesbian, learns that Paul did this because he believes that the team she applied to manage are homophobic. Paul thought that Angela's sexual orientation would prevent her from gaining the team's respect and managing them effectively. This is direct sexual orientation discrimination against Angela.

1. Discrimination by Association

Already applies to age, race, religion or belief and sexual orientation, now extended to cover disability, gender reassignment and sex. This is direct discrimination against an individual because they associate with another person who possesses a “Protected Characteristic”.

Example

June works as a project manager and is looking forward to a promised promotion. However, after she tells her boss that her mother, who lives at home, has had a stroke, the promotion is withdrawn. This may be discrimination against June because of her association with a disabled person.

2. Perception Discrimination

Already applies to age, race, religion or belief and sexual orientation, now extended to cover disability, gender reassignment and sex. This is direct discrimination against an individual because others think they possess a particular “Protected Characteristic”. It applies even if the person does not actually possess that characteristic.

Example

Jim is 45 years old but looks much younger. Many people assume that he is in his mid 20s. He is not allowed to represent his organisation at an international meeting because the Managing Director thinks that he is too young. Jim has been discriminated against on the perception of a “Protected Characteristic”.

3. Indirect Discrimination

Already applies to age, race, religion or belief, sex, sexual orientation and civil partnership, now extended to cover disability and gender reassignment.

Indirect discrimination can occur when you have a condition, rule, policy or even a practice in your organisation that applies to everyone but particularly disadvantages people who share a “Protected Characteristic”. Indirect discrimination can be justified if you can show that you acted reasonably in managing your organisation, i.e. that it is “a proportionate means of achieving a legitimate aim.” A legitimate aim might be any lawful decision you make in running your organisation, but if there is a discriminatory effect, the sole aim of reducing costs is likely to be unlawful.

Being proportionate essentially means being fair and reasonable, including showing that you’ve looked at “less discriminatory” alternatives to any decision you make.

Example

A small finance organisation needs its staff to work late on a Friday afternoon to analyse stock prices in the American finance market. The figures arrive late on Friday because of the global time differences. During the winter some staff would like to be released early on a Friday afternoon in order to be home before sunset – a requirement of their religion. They propose to make the time up later during the remainder of the week.

The organisation is not able to agree to this request because the American figures are necessary to carry on the business, they need to be worked on immediately and the organisation is too small to have anyone else able to do the work.

The requirement to work on Friday afternoon is not unlawful indirect discrimination as it meets a legitimate business aim and there is no alternative means available.

4. Harassment

Harassment is “unwanted conduct related to a relevant “Protected Characteristic”, which has the purpose or effect of violating an individual’s dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual.”

Harassment applies to all “Protected Characteristics” except for pregnancy and maternity, and marriage and civil partnership. Employees will now be able to complain of behaviour they find offensive even if it is not directed at them, and the complainant need not possess the relevant characteristic themselves. Employees are also protected from harassment because of perception and association.

Example(s)

Paul is disabled and is claiming harassment against his line manager after she frequently teased and humiliated him about his disability. Richard shares an office with Paul and he too is claiming harassment, even though he is not disabled, as the manager’s behaviour has also created an offensive environment for him.

Steve is continually being called gay and other related names by a group of employees at his work. Homophobic comments have been posted on the staff notice board about him by people from this group. Steve was recently physically pushed to the floor by one member of the group but is too scared to take action. Steve is not gay but heterosexual; furthermore the group know he isn't gay. This is harassment because of sexual orientation.

5. Third Party Harassment

Already applies to gender, now extended to cover age, disability, gender reassignment, race, religion or belief and sexual orientation.

The *Equality Act* makes you potentially liable for harassment of your employees by people (third parties) who are not employees of your organisation, such as customers or clients. You will only be liable when harassment has occurred on at least 2 previous occasions, you are aware that it has taken place, and have not taken reasonable steps to prevent it from happening again.

Example

Chris manages a Council Benefits Office. One of his staff, Frank, is homosexual. Frank mentions to Chris that he is feeling unhappy after a claimant made homophobic remarks in his hearing. Chris is concerned and monitors the situation. Within a few days the claimant makes further offensive remarks. Chris reacts by having a word with the claimant, pointing out that his behaviour is unacceptable. He considers following it up with a letter to him pointing out that he will ban him if this happens again. Chris keeps Frank in the picture with the actions he is taking, and believes he is taking reasonable steps to protect Frank from third party harassment.

6. Victimisation

Victimisation occurs when an employee is treated badly because they have made or supported a complaint; or raised a grievance under the *Equality Act*; or because they are suspected or doing so. An employee is not protected from victimisation if they have maliciously made or supported an untrue complaint.

There is no longer a need to compare treatment of a complaint with that of a person who has not made or supported a complaint under the Act.

Example

Anne makes a formal complaint against her manager because she feels that she has been discriminated against because of marriage. Although the complaint is resolved through the organisation's grievance procedures, Anne is subsequently ostracised by her colleagues, including her manager. She could claim victimisation.

7. Pregnancy and Maternity

The "Protected Characteristics" are the same as under the old *Sex Discrimination Act 1975*. Women who are pregnant are protected against unfair workplace practices because of their pregnancy.

Example

Lydia is pregnant and works at a call centre. The manager disciplines her for taking too many toilet breaks as they would any other member of staff, despite knowing that she is pregnant. This is discrimination because of pregnancy and maternity, as this characteristic does not require the normal comparison or treatment with other employees.

"Protected Characteristics": Key Notes

Set out below is a guide to any changes under each of the headings of "Protected Characteristics."

Age (No change)

The Act protects people of all ages. However, different treatment because of age is not unlawful direct or indirect discrimination if it can be justified, i.e. if it can be demonstrated as a proportionate means of meeting a legitimate aim. Age is the only "Protected Characteristic" that allows employers to justify direct discrimination.

The Act continues to allow employers to have a default retirement age of 65 until April 2011. After April 2011, all employers should have a clear policy regarding the employment of Retirees. This could include fitness to work checks, review date of fitness to work, yearly extension of contract etc. Women have a graduated transition to retirement at 65 years if born after 1st April 1950.

Disability (New Definition and Changes)

The Act has made it easier for a person to show that they are disabled and to be protected from disability discrimination. Under the Act, a person is disabled if they have a physical or mental impairment which has a substantial and long term adverse effect on their ability to carry out normal day-to-day activities, which would impact such activities as using a telephone, reading a book or using public transport.

As previously, the Act puts a duty on you as an employer to make reasonable adjustments for your staff to help them overcome disadvantage resulting from an impairment (e.g. by providing assistive technologies to help visually impaired staff to use computers effectively).

The Act includes a new protection from discrimination arising from disability. This states that it is discrimination to treat a disabled person unfavourably because of something connected with their disability (e.g. a tendency to make spelling mistakes arising from dyslexia). This type of discrimination is unlawful where the employer or other person acting on behalf of the employer knows, or could reasonably be expected to know, that the person has a disability. This type of discrimination is only justifiable if the employer can show that it is a proportionate means of achieving a legitimate aim.

Additionally, indirect discrimination now covers disabled persons. This means that a job applicant or employee could claim that a particular rule or requirement you have in place disadvantages persons with the same disability. Unless you could justify this, it would be unlawful.

The Act also includes a new provision which makes it unlawful, except in certain circumstances, for employers to ask questions about a candidate's health before offering them work.*

***Please note:**

The Department of Health issued Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related guidance, Criterion 10 states clearly that all services deemed as regulated activities under the *Health and Social Care Act 2008* should ensure that all staff fill in a pre-employment health questionnaire and give information about residence overseas, previous and current illness and immunisation against relevant infections.

Gender Reassignment (New Definition)

The Act provides protection for transsexual persons. A transsexual person is someone who proposes to, starts or has completed a process to change his or her gender. The Act no longer requires a person to be under medical supervision to be protected; therefore, a woman who decides to live as a man but does not undergo any medical procedures would be covered.

If transsexual persons propose to undergo, are undergoing or have undergone gender reassignment, then it would be discrimination to treat them less favourably for a work absence than if they were absent due to illness or injury.

Marriage and Civil Partnership (No Change)

The Act protects employees who are married or in a civil partnership against discrimination. Single persons are not protected.

Pregnancy and Maternity (No Change)

A woman is protected against discrimination on the grounds of pregnancy and maternity during the period of her pregnancy and any statutory maternity leave to which she is entitled. During this period, pregnancy and maternity discrimination cannot be treated as sex discrimination. See Annex 1 for an example. You must not take into account an employee's period of absence due to pregnancy-related illness when making a decision about her employment.

Race (No Change)

For the purposes of the Act 'race' includes colour, nationality and ethnic or national origins.

Religion or Belief (No Change)

In the *Equality Act*, religion includes *any* religion. It also includes a lack of religion; in other words, employees or jobseekers are protected if they do not follow a certain religion or have no religion at all. Additionally, a religion must have a clear structure and belief system. Belief means any religious or philosophical belief, or a lack of such belief. To be protected, a belief must satisfy various criteria, including that it is a weighty and substantial aspect of human life and behaviour. Denominations or sects within a religion can be considered a protected religion or religious belief. Discrimination because of religion or belief can occur even where both the discriminator and recipient are of the same religion or belief. Druids and Pagans are now seen as religions for the purposes of the Act.

Sex (No Change)

Both men and women are protected under the Act.

Sexual orientation (No Change)

The Act protects bisexual, homosexual, heterosexual and lesbian people.

It is important that staff are aware of the changes in the act and of their role in relation to Service Users and colleagues. Within the social care sector, services are often provided which are of a sensitive and private nature. Staff must be made aware of the cultural and ethnic needs of the Service Users in the delivery of the care to the individual concerned.

Please Note

This organisation is aware of the specific guidance which is now available to small businesses via the Equality and Human Rights website. Under their "Advice and Guidance" heading there are now specific guidance notes which assist small businesses and are example led for different situations. This advice and guidance is aimed at all service providers and includes guidance about ISSP.

If you provide services through a website such as direct marketing or advertising you are known as an Information Society Service Provider (ISSP).

This organisation takes the advice and guidance regarding discriminatory advertising seriously and regularly reviews any marketing or advertising on its website

Part Two of this policy is intended as an aide-mémoire for staff who are involved in meeting the needs of any ethnic minority group, it is not exhaustive. Guidance on the cultural and ethnic needs of Service Users should be met in a way that offers privacy, dignity and respect. The attached notes should be seen as the first steps in guiding staff to meet this aim. Further information should be sought where appropriate. The information is set out in such a way that the information can be placed in the Service User's file. The *Human Rights Act 1998* and its Articles are considered to be part of the basis for the new *Equality Act 2010*.

Related Policies

Accident and Incident Reporting (RIDDOR)

Equal Opportunities

Dignity and Respect

Health and Safety

Meeting Needs

Moving and Handling

Recruitment and Selection

This policy will be reviewed by the Registered Manager.

Signed: Morag Collier

Date: 23/06/17

Review Date:

EQUALITY AND DIVERSITY

PART TWO

African-Caribbean Culture

Background

The term 'African Caribbean' derives from the fact that many Caribbean people regard themselves as Africans, their ancestors having been forced out of Africa and transported to the West Indies to work as slaves. There are many different cultural influences within African Caribbean people as well as the West Indies. The Caribbean islands have been invaded and controlled by various European countries such as France, Britain and Spain.

During the 1950's Britain suffered labour shortages, and as a result actively encouraged Caribbean people to come to Britain to work. Many of these people have British passports and British citizenship as a result of British colonial governance. Although there are a variety of African communities within Britain, the majority are from the Caribbean.

Language

The European influences on the islands resulted in different languages being spoken, as African slaves were not permitted to speak their own language. The three main ones are English, Spanish and French. There are, in addition to these main languages, dialects that have evolved over the years. Patois (pronounced *pat-wa*) and Creole are two such dialects, and are languages in themselves. Patois is believed to have developed through the African slaves wanting to talk without their owners understanding them. Both Patois and Creole are continually developing and are used widely within communities. Most Caribbean people living in Britain who originated from countries that are former British colonies speak English.

Religion

The majority of the Caribbean community within Britain are Christians and many attend traditional mainstream Christian churches. Historically many black people were not welcomed into the traditional places of worship, and a preference developed for Evangelical and Pentecostal churches. Other religions include Seventh Day Adventists, Islam and Hinduism.

Colonization of the Caribbean islands in the 17th and 18th centuries led to the oppression of the Caribbean people. In an attempt to restore African identity, pride and dignity, the Rastafarian culture developed. Within Rastafarianism there is a strong emphasis on living in harmony with the natural world. Many Rastafarians abstain from taking alcohol and tobacco. Islam is also a major religion within Africa.

Personal Care and Hygiene

Hair care is particularly important as African hair needs regular specialised care and attention. Washing hair can cause shrinkage, and aggressive drying may break hair. Generally time is taken to grease, relax and brush hair in order to maintain it.

Some difficulties may be encountered around shaving due to the thickness of facial hair and there may be particular preferences of shaving methods.

Implications for Care

- Service providers should not assume an African Caribbean's cultural needs and an individual profile should be drawn up.
- Many Service Users may speak English along with cultural variations, and awareness of this is necessary.
- Preferences of worship need to be respected.
- Extended family and members of the community may play important roles to Service Users; these contacts should be identified and included, if necessary, in meetings, celebrations, and gatherings.

- Strict observation and care should be taken over the choice, storage, preparation and serving of foods.
- Personal care and hygiene is very important, and will need specialised products, and additional time allowed.
- Specialised hair products should be made available.
- Time should be provided for greasing and plaiting hair.
- Moisturising and cleanliness are an important part of daily routines for both men and women.
- Hair and beards are not generally cut.
- There may be a preference for same-sex carers, as dressing and undressing in front of people of the opposite sex may be seen as inappropriate.

Buddhism

Small groups of Buddhists have arrived in Britain throughout the centuries from Sri Lanka, Thailand and Burma. Indian Buddhists and the Hong Kong Chinese came mainly through the new Commonwealth migrations in the 1950s and 1960s. Refugees from Tibet and Vietnamese Buddhists arriving in the 1960s and 1970s have further expanded the number of Buddhists in Britain.

Buddhism was founded on the teachings of SiddhārthaGuatama (also known as Guatama Buddha), a prince in India who left a life of luxury at the age of 29 to embark upon a spiritual quest to understand and alleviate suffering. Whilst meditating he reached enlightenment and became Buddha (the enlightened one). He travelled and taught what he had learnt. Buddha rediscovered the *dharma* (teachings), and is therefore seen as a guide, since he did not claim to have written them himself.

Buddhists claim to have found those teachings valid for themselves, and achieve them through developing qualities of kindness and awareness, which brings about freedom from pain and suffering, and the ability to help others do the same.

The Five Precepts are the basic rules of living for Buddhists and include the intention to refrain: from harming living beings, taking what is not given, sexual misconduct and misuse of the senses, harmful speech, and drink or drugs.

In Buddhist teachings the Noble Eightfold Path is the way to overcome unsatisfactoriness (*dukkha*) and each Buddhist aspires to follow it. It includes right understanding, right intention, right speech, right action, right livelihood, right effort, right mindfulness and right concentration.

Meditation plays a central role in the Buddhist practice. There are two main schools of thought, Theravada and Mahayana although there are many Buddhist traditions, influenced by ethnic origins, schools of thought, and traditions.

Language

In Britain the vast majority of Buddhists speak English and a variety of languages that reflect their origins. A Buddhist temple or monastery can take many forms and reflects the diversity of the culture. They range from ornate buildings to stark simplistic rooms; large buildings to a room in the home. Despite this there are common features and each usually contains a statue of Buddha, and a characteristic form of Buddha architecture.

A temple is commonly used for religious observance and meditation.

All schools within Buddhism use candles (symbolising the light that the teachings bring to the world); carry out the offering of food, flowers (symbolising impermanence), incense (symbolic of devotion) and water (representing bathing) along with chanting and meditation. This takes different forms within each group though.

A small shrine to the Buddha is often found within a Buddhists home and contains a statue of Buddha usually centrally placed, incense, flowers and candles.

Preferences

Buddhism emphasises the avoidance of killing intentionally, however, there are a variety of different practices within the traditions of Buddhism. Some observe vegetarianism, others do not. The precept of right livelihood excludes trading in flesh and this is not accepted.

The degree to which dietary requirements are adhered to varies amongst the community.

Buddhists prefer to wash their private areas after using the toilet and usually prefer showers to baths.

A Buddhist may refrain from taking medication including painkillers in an attempt to ensure clarity of mind and ability to meditate. Prayers are said both at the time of death and afterwards.

Main Festivals

The Buddhist festivals are based on the lunar calendars of the countries concerned. Some of the festivals vary according to different schools of thought and national origin. The main festivals include:

Uposatha Days – These are observed at full and new moons and on days halfway through the lunar fortnight. Usually observed through a visit to the monastery or temple to pray and study.

Parinirvana(February) – Commemorating the passing of Buddha

Buddha's Birthday – Celebrating the birth of Buddha, usually consists of a festival of flowers. Water or sweet tea is ceremonially poured over a statue of the infant Buddha.

Wesak or Buddha Day (May) – Occurs on the full moon in May and commemorates the birth, Enlightenment, and Parinirvana of Buddha. Mahayana Buddhist celebrate these three events on different dates and is also known as Buddha day in the West.

Poson (June) – Celebrate Emperor Asoka bringing the dharma to Sri Lanka and the conversion to Buddhism.

The Rains Retreat (June/July – September/October) – Theravadin Buddhist Monks and Nuns observe this retreat for three months where they remain in one place except for emergencies. Special service days are held to mark the beginning and end.

Asalha or Dharmachakra Day (July/August) – Anniversary of the Buddha's first sermon known as the Turning of the Wheel of the Law, celebrated by Theravadin and Western Buddhists.

Kathina Day (October/November) – Celebrated by Theravadins and follows the Rains Retreat either on its last day or within one month. Monks and nuns are presented with cloth which is made into a monks robe that day.

Samgha Day (November) – Celebration of the spiritual community of all Buddhist, usually observed by Western Buddhists by offering flowers, candles and incense.

Enlightenment Day (December) – Mahayana Buddhist celebrate the Enlightenments of Buddha.

New Year – Not usually a religious celebration, however it is a major festival for Buddhists and occurs on different dates depending on the country.

Padmasambhava Day – Occurs in every Tibetan month. Tibetan Buddhists celebrate the founder of Buddhism in Tibet.

Implications for Care

- Service providers should not assume a Buddhist's cultural needs, and an individual profile should be drawn up.

- Dietary requirements will vary, and individuals will need to be asked their preferences.
- Space may need to be made for personal shrines.
- An area of calm and quietness may also need to be allocated for meditation
- Medication should not be administered without explicit consent.
- Washing facilities will need to be available for use after using the toilet.

Chinese Culture

Background

Chinese culture is rich and diverse and includes beliefs, relationships, medicines, language and many other aspects of life.

Across Britain the Chinese community is relatively dispersed and isolated. In the main conurbations there can be significant communities (e.g. the Chinatowns in London and Manchester). In other towns and cities the Chinese community can be relatively small. A significant percentage of the Chinese community work in the catering and restaurant trades. This means their work involves anti-social working hours, further compounding isolation.

Language

The two most well-known Chinese languages are Mandarin (spoken in Northern China) and Cantonese (spoken in Southern China). However, there are many other language groups and dialects. All Chinese speakers have the same written language, but a Mandarin speaker would not be able to verbalise with a Cantonese speaker (unless the conversation was written down).

The written form of Chinese is considered complex, and historical events have meant that literacy in China has only in the recent past achieved above 80%. The Chinese communities in Britain are likely to be literate but similarly to the rest of the population, there may be individuals who cannot read or write.

Religion

Spirituality is a strong feature of Chinese culture, and subsequently faith continues to be an important aspect of life for many people in the Chinese community in Britain.

Confucianism

Confucianism is a framework of ethics and values—though sometimes described as a religion—that originated with the teachings of Confucius around 2,500 years ago. It is concerned with relationships and obligations. Confucianism establishes the importance of showing respect to individuals who have higher social status whilst conveying the obligation that fall on those who are socially more senior. Such relationships include those between a mother and child, husband and wife, older brother and younger brother, ruler and subject etc.

Taoism

Taoism seeks to promote inner peace and harmony. The word Tao could be translated as “the way.” Taoism has various interpretations or branches. The more philosophical approach encourages individuals to shun earthly ways and to focus on the oneness of life.

Other interpretations of Taoism encourage people to pursue good deeds, which are rewarded with happiness, whilst shunning bad deeds, which result in punishment (pain and suffering). Both Taoism and Confucianism reinforce the Chinese values of collectivism and community (both family and society).

Buddhism

Buddhism first entered China about 1,900 years ago. The main Buddhist school in China is Mahayana. Aspects of Mahayana Buddhism include belief in repetitive prayers, heaven and deities who can help people gain salvation.

Christianity and Islam

Both of these religions are evangelical, and so have extended into China. In the Chinese community in Britain some Chinese people joined Chinese Christian churches to overcome their sense of isolation. About a quarter of Chinese people in Britain are Christians.

Death and Funerals

When a person is near death preparations for their funeral may well start, e.g. ordering a coffin. The social status of the person who is dying or has died will influence the funeral arrangements. If an older person has died then the funeral rites must convey respect. This could entail the family going into debt. If a young adult has died then traditionally the parent cannot offer prayers; only children can perform this rite. In line with this, older members of a family will wash them and dress them in their best clothes. Once the body is placed in the coffin it is not sealed until after the wake.

Family members will gather, traditionally dressed in black, blue or white depending on their particular relationship to the deceased. Close relatives will express their emotions often by crying and wailing.

Incense is often burned and prayers spoken, with verses drawn from Buddhist or Taoist scripture read out if the family are followers of those faiths.

The wake will last at least a day, sometimes longer. At the end of the wake the coffin is sealed and taken to the cemetery for burial. The family members will follow the coffin to the cemetery. Burial is preferred, although cremation does occur in the Chinese community in Britain, partly for reasons of cost. Traditionally the period of mourning lasts for a hundred days.

Festivals

China adopted the Gregorian calendar early in the 20th Century. However, the Chinese New Year is still calculated using the old lunar calendar.

Chinese New Year (Late January to Early February) – Houses are cleaned and decorated, incense burned. On New Year's Eve families gather and share a meal. At midnight fireworks are let off.

Qing Ming (Early April) – It is a time to show respect for ancestors. Graves of relatives will be visited and tended.

ZhongQiu (Late September/Early October) – Families gather and celebrate with a variety of food traditionally associated with this festival.

Other festivals are also celebrated and these could include festivals associated with faiths e.g. Buddhist festivals.

Food and Diet

The Chinese diet is very different from traditional English cuisine. Rice or noodles are staple aspects of most, if not all, meals. A diverse range of meats and seafood could be eaten, but personal choices based on lifestyle or faith will mean individuals may not eat certain meats. Some Buddhists and Taoists are vegetarian. Nearly all vegetables are cooked; uncooked

foods such as salads are Western, not Chinese. Many Chinese prefer boiled water that is left to cool rather than cold water. Chopsticks and a spoon (for soup) are still commonly used.

Personal Care

Physical modesty is very important. Cross gender contact is generally avoided except between husband and wife.

An older person who has personal care needs is likely to feel most at ease if their daughter provides the care. For many older people in the Chinese community this is not possible due to family members working long hours or families being dispersed.

Cleanliness is very important to Chinese people. Some Chinese people dislike baths and would prefer body washes or the use of warm running water.

Medicine and Health

Traditional Chinese medicine and health treatments such as acupuncture are well established. Chinese older people may rely almost exclusively on the diagnosis and treatment identified by a Chinese medical practitioner. Family remedies may also be employed.

Younger Chinese adults may blend the use of NHS resources and traditional Chinese medicine.

Implications for Care

- Personal care needs to be provided in a manner that upholds individual dignity.
- Providing an acceptable diet is crucial to the person's sense of health and well-being. This includes drinks provided for them.
- When individuals are ill they may prefer to access Chinese medical practitioners rather than NHS resources.
- Some Chinese Service Users will have significant support from family and many family members may visit them especially for festivals.
- Some Chinese Service Users are very isolated and may feel a mix of emotions about relying on services.

Christianity

Background

Christianity is the largest single religion in Britain. Missionaries from continental Europe introduced Christianity to the British Isles during the first centuries of the Common Era. Christianity was adopted by the Roman Empire in the fourth century, and owing to the geographic scope of the empire, Christianity became a widespread community. The practices and interpretations of Christianity have diverged over its history, and today the three largest groups are: Roman Catholic, Eastern Orthodox and Protestant. Various denominations are considered Protestant, including: Baptists, Anglican, Methodist, Reformed and Lutheran. Additionally there are significant Pentecostal and Evangelical churches.

Languages

Most Christians in Britain speak English, although other languages may also be spoken as is indicative of the international nature of the religion.

Religion

Christianity is a religion based on the belief that there is one God who created heaven and Earth. The religion is directly and indirectly influenced by the teachings and traditions within Judaism. Christians believe that God came down from heaven to Earth through incarnation and took the form of a living Christ (Messiah), Jesus of Nazareth. Jesus is regarded as fully human and fully divine without sin. There are different names for him and these include: "Son of God", "Son of Man", "Christ", "Jesus Christ", "Saviour" and "Word of God".

The Bible is the Christian holy book, and is divided into two main sections known as the Old and New Testament (covenants). The Old Testament covers the period before Christ, whilst the New Testament is about the time of Christ, the period after his death and his teachings. These scriptures are central to the life of all Christians although their interpretation varies within the different practices of Christianity.

Christians consider the purpose of life is to live according to the model of Jesus' life, which is characterised by sacrificial, and self-giving love. Without the power of God it is believed that the human being is enslaved to sin. Those who believe in God and Jesus are saved from their sin (salvation) and will join God in heaven.

Some Christians believe that their faith in God is continually tested with temptation, and that Jesus was sent to die for them in order to save them from sin; others believe that doing good deeds and helping others is the basis of salvation and passage to heaven; and others believe that good deeds and faith in God will bring salvation.

A person's entry and acceptance of the Christian way of life is marked by their baptism or Christening. This ceremony occurs at different times in a Christian's life depending on the tradition followed. For example, within the Anglican, Roman Catholic, and Orthodox churches the baptism of a person occurs when they are babies or infants; within the Baptist and Pentecostal movements baptism takes place when the person is able to make a personal confession of Christian faith.

Within the different traditions a later ceremony takes place when the person is of an age to be able to confirm their faith. This ceremony varies within the different traditions but generally completes initiation into the way of life and into the community. Within the Roman Catholic community it is known as confirmation, and within Orthodox practices it is known as chrismation.

Christians worship together or individually at home, school, or in a community hall. Where groups gather to worship this is called a 'church', and the buildings in which these take place are called churches. Christians worship and pray individually, and some will say prayers

before sleeping and upon waking. It is customary to attend church regularly. The holy day, known as the Sabbath, is for most Christians on Sunday, and many will visit the church on this day. However, for Seventh Day Adventists the Sabbath begins from sundown on Friday, and they attend church on a Saturday. The cross and the crucifix are symbols of the suffering of Jesus and some Christians have these within their homes. Christians may also have images of the Virgin Mary who gave birth to Jesus.

Food Preferences

There are no specific dietary requirements; however, personal choice and preference (i.e. vegetarian) may mean that certain foods may not be acceptable to an individual. Many Christians will eat fish on Friday each week in honour of Christ's death. Wine is used within religious ceremonies and is blessed. This blessed wine is seen to be sacred and different from alcohol for everyday consumption. In some churches any other alcohol is not permitted, whilst others are alcohol-free environments.

Some Christians will say a brief prayer or give thanks to God for the food before eating.

The period of Lent, which leads up to Easter, is for some Christians a time of fasting to mark the 40 days Jesus spent in the desert on a spiritual journey. During this time abstinence from some foods and/or luxuries may be observed.

Personal Care and Hygiene

Dressing and undressing may be particularly embarrassing, and a choice of same sex carers may be preferred. Jewellery is often worn as a symbol of Christian faith.

Customs

There are clear guidelines within the Old Testament about behaviour, which are known as the Ten Commandments. These relate to respecting neighbours and sexual and marital relationships. Women are seen to be equal; however, as in most societies gender roles are clearly defined. There is a strong tradition of social concern within the Christian community emanating from the teachings of Jesus and found within the Bible.

Some Christians may find comfort in being read passages from the Bible prior to dying. As with most religions and cultures, the death of a family member is subject to a period of mourning. There is usually a funeral service with prayers and hymns, and the body is either cremated or buried. After the service there may be a wake where family, friends and members of the community gather. Refreshments are normally served at this gathering. Family and community members may also visit the bereaved family to offer condolences and pay their respects.

Catholics believe in a final confession before dying and therefore a priest is called to anoint the dying person, to hear final confession and to pray for the person so that they can make their peace with God. For other Christians a priest or minister may be called upon for similar reasons.

Main Festivals

The Western Christian churches use the Gregorian calendar, but some festivals are fixed according to the lunar calendar. Most of the main festivals relate to the significant events in the life of Jesus and these can vary within different traditions.

Advent – Celebration of Jesus “coming” into the world and his “second coming” at the end of time. This four-week long solemn preparatory season traditionally begins on the fourth Sunday before Christmas. Advent also marks the start of the Christian year.

Immaculate conception of the Blessed Virgin Mary (8th December) – Roman Catholics celebrate the belief that Mary, the Mother of Jesus was herself conceived free from original sin in order to bear Jesus.

Christmas (25th December) – Celebrating the birth of Jesus. Many visit church and share a special meal with family and friends, exchanging gifts and glad tidings.

Epiphany (6th January) – Commemorates the three wise men visiting Jesus when new born, and also known as the Twelfth Night of Christmas. Some traditions believe it marks the end of the Christmas period whilst others believe it is the true date of the birth of Jesus.

Shrove Tuesday (February/March) – Also widely known as Pancake Day, this marks the last day before the start of Lent. There are various traditions and cultural customs attached to this day such as the confession of sins before Lent or the using up of food prior to fasting.

Ash Wednesday (February/March) – The first day of Lent commemorating the forty days Jesus spent in the wilderness. Christians may attend church, where their forehead is marked with ash as a sign of mortality and penitence before God. Within the Catholic tradition it is a day of fasting and abstinence.

Lent (February – March/April) – This is a period of forty days, excluding Sundays, between Ash Wednesday and the Saturday before Easter. It is a preparation time before Easter and many will abstain from certain luxuries or foods.

The Annunciation to the Blessed Virgin Mary (25th March) – This celebrates the announcement by the angel Gabriel to Mary that she is to give birth to a son called Jesus.

Mothering Sunday (March) – This is the fourth Sunday of Lent and is also widely known as Mother's Day. Originally it was to commemorate the idea of mother Church. It is now a popular occasion upon which to recognise and thank mothers for all that they do. Many spend time with their mothers and special meals are eaten.

Passion Sunday (March) – The fifth Sunday in Lent, when Christians begin to concentrate their thoughts on the significance of the passion or suffering of Jesus.

Palm Sunday (March/April) – This is the first day of Holy Week and is one week before Easter. On this day Christians are often given pieces of palm leaf in the form of a cross to commemorate Jesus entering Jerusalem days before his crucifixion.

Holy Week (March/April) – The last week of Lent dedicated to remembering the suffering and death of Jesus.

Maundy Thursday (March/April) – The Thursday in Holy Week commemorates the day that Jesus instituted the Holy Communion.

Good Friday (March/April) – The Friday of Holy Week commemorates the day of Jesus' crucifixion and most Christians will attend solemn services recalling how he was betrayed, put on trial and killed for the sins of all people.

Holy Saturday (March/April) – A day of prayerful waiting and preparation for Easter. Some will attend church for the reading of the story of creation and Jesus' resurrection, along with the lighting of a candle and renewal of baptismal vows.

Easter (March/April) – Commemorating the resurrection of Jesus three days after his crucifixion. Many will attend church and receive communion (blessed bread and wine). More secular customs include Easter eggs, which symbolise new life. It is the central Christian festival and is full of joy.

Ascension Day (May/June) – This is celebrated on the fortieth day after Easter, and commemorates Jesus ascending to Heaven. Early morning services are sometimes held on high hills to remember this day.

Pentecost (May/June) – Also known as Whit Sunday; marks the day when Jesus' disciples (followers) were touched by the Holy Spirit in the form of tongues of fire and were inspired to go out and preach the teachings of Jesus to all peoples.

All Saints Day (1st November) – Commemorates all the saints known and unknown.

There are many other Saints and Saints Days remembered by the different traditions.

Implications for Care

- Some may wish to pray soon after rising in the morning and before retiring at night, and can be accommodated by allowing additional time.
- Specific dietary requirements will need to be identified.
- Strict observation and care should be taken over the choice of foods, storing, preparation and serving of it.
- There may be a preference for same-sex carers, as dressing and undressing in front of strangers can be embarrassing.

Christian community life and belief varies within the different traditions. It is always better to ask individuals what their preferred beliefs are and which festivals are observed

Hinduism

Background

The official languages of India are Hindi and English; there are however over 100 different dialects and languages throughout India, and most schools teach English as a second language. In Britain many younger Indians speak fluent English, although for some it is a second language and the older generations may speak little or no English.

Religion

Hinduism is the main religion in India. The main principles of Hinduism are a belief in God, prayer, rebirth, the law of action (we decide our destiny by our past deeds), and compassion to all living things. Brahman is the supreme spirit of creation and the creator of all Gods. Hindus believe in one eternal God able to take any form. They do not worship the images or forms that God takes but God itself. They believe that life is sacred and taking any kind of life is prohibited. A Hindu's goal is to live a moral and ethical life; through serving fellow men and creatures, they can realise God. If they are not able to realise God in their lifetime, Hindus believe they are reborn through incarnation to continue their pilgrimage. A Hindu's path through life is called "Dharma". The life of a Hindu is determined by the actions of the previous life and is known as "Karma". It is suggested that bad behaviour in one's life may result in being incarnated in their next life as an insect or as a person with a disability.

Worship can take place within the home or a temple ("Mandir") and is done usually once a day in the morning by one's self. Special religious gatherings and celebrations are communal affairs. Most Hindu families have a sacred shrine in their house; shoes, alcohol and meat are not permitted in this room. Orthodox Hindus do not let meat or alcohol in their home at all. Hindu society is split into four *varnas* (castes) each has its own societal roles. This caste system is defined as Brahmins (priests and teachers); Kshatriyas (rules and warriors); Vaishyas (farmers and merchants); and Sudras (labourers).

Food Preferences

Most Hindus are vegetarian and do not eat meat or animal by-products including gelatine (often found in sweets); those that do might still not eat beef, as the cow is regarded as a sacred animal. Strict Hindus prefer not to eat food prepared outside of the home, as they are unsure as of how far the food meets their requirements. The preparation and storing of vegetarian foods will be seen as contaminated if near meat. The degree to which these strict dietary requirements are adhered to varies amongst the community. Fasting is a regular occurrence within Hindu culture, and requires abstinence from some or all foods. There are exemptions, which include pregnant women, older people, people with diabetes or those of ill health. Some Hindus that eat meat and drink alcohol may wish to abstain from these during some of the fasting, where discretion is accepted.

Personal Care and Hygiene

Washing hands and rinsing the mouth before and after eating is considered essential. Hindus also prefer to wash their hands in the same room as the toilet and prefer to wash in free-flowing water rather than sitting in a bath. Many people exclusively use their left hand to clean themselves after using the toilet, as they eat with their right; it is seen as unclean to use the left hand at meal times.

Customs

Some Hindus offer food to guests, either invited or otherwise. No visitor should leave hungry. There are traditions as well as religious requirements concerning diets, e.g., some Indians consider it unwise to take milk and citrus fruit when suffering from a cough.

If a Hindu is dying, relatives may wish to bring money and clothes for them to touch before they distribute them to the needy. Some relatives may wish to read to them from one of the four Holy books: *The Bhagavad-Gita*, *The Upanishads*, *The Ramayana*, and *The Mahabharata*. After death the body should remain covered. Relatives may wish to wash the body and put new clothes on; traditionally this ritual is led by the eldest son of the deceased. The mourning period begins immediately on the death of the person and runs for 12 days. During this time family members are not left alone and visitors will visit daily to sit, chat and sing *bhajans* (hymns). A person is cremated in order to release the soul from the body and allow for its reincarnation (unless they have finally realised God). It is traditional for the body to be brought home 1-2 hours before the cremation for family and community to pay their respects and to allow the priest to perform the last rites.

Some Hindus wear sacred threads and jewellery, which can have great religious significance. Traditional women's dress is conservative – either a sari or Punjabi suit (two piece cotton or silk dress worn over baggy trousers). A red dot in the middle of the forehead signifies being married.

Naming systems within Hindu culture can be complicated and inappropriate use can cause embarrassment and show disrespect.

Main Festivals

There are many festivals within Hindu culture. The calendar months referred to apply to the Gregorian calendar.

Shivaratri or Mahashivaratri (February/March) – Worship devoted to Lord Shiva. Some may fast. Celebrated by spending a night at the temple chanting, singing, and pouring milk continually over the symbolic form of Lord Shiva.

Holi (February/March) – Festival of colours associated with Vishnu. Celebrated through the lighting of bonfires, attending temple services, throwing coloured water and powders over friends and family.

Yugadi or GuidParva (March-April) – For many Hindus this festival marks the New Year. Feasting and greetings are common, with the consumption of bitter and sweet foods symbolising things in life.

Rama Navami/HariJayanti (March/April) – Celebrating the birth of Lord Rama, an incarnation of Vishnu. Ramayana is read aloud in the temples and some may fast.

Janmashtami (August/September) – Marks the birth of Lord Krishna. Hindus may decorate their homes, feast and sing hymns.

Navarati (September/October) – Celebrated differently throughout the Hindu culture this festival lasts nine days and celebrates the different goddesses, and good over evil. Fasting by some is followed by feasting, dancing and storytelling.

Diwali or Deepawali (October/November) – Festival of lights when small lanterns are lit, cards and small sweets exchanged. It celebrates Lord Krishna's victory over the demon, light over darkness, and knowledge over ignorance. In Britain fireworks are also used to celebrate this festival. For some, this signifies the New Year.

Annakuta or NutanVarsh (October/November) – This occurs the day after Diwali and large amounts of sweets and other food are taken to the temple and offered to the deities.

Implications for Care

- Provision of a shrine within rooms for individual prayer and worship may be necessary.
- Shoes will need to be removed before entering a Service User's room if they have a shrine.
- Always ask before touching or moving a Service User's shrine, this includes cleaning.
- Strict observation and care should be taken over the choice, storage, preparation and service of foods.
- Separate cooking utensils and equipment should be used in preparing vegetarian food.
- Use toilets with sinks for washing hands, whenever possible.
- Offer a shower rather than a bath, if available.
- Respecting elders is seen as fundamental to the Hindu culture and should be observed at all times
- Some Service Users will only eat with their right hand, as it is seen as unclean to use the left. This should be observed if assisting.
- Washing hands before and after meals is customary. If you are assisting them to eat using a knife and fork you should also observe the washing of hands.
- Remember to present food to guests, this is customary.
- Never remove threads, jewellery or symbolic dots without permission.
- Commodes may not be permitted in bedrooms.
- Clarify preferred terms of address with individuals.

Islam

Background

There has been a significant Muslim culture in Britain since the turn of the nineteenth century, which grew during the labour shortages of the 1950s and 60s. Many of the Muslim communities within Britain have ancestral origins in the Indo-Pakistani subcontinent, migrating either directly to Britain directly or via migrations to East Africa and the Caribbean. Others have their ethnic and national origins from a variety of countries such as Malaysia, Cyprus, Iran and the Middle East. There are also indigenous Britons who have embraced the Islamic faith.

There are two main traditions within Islam: Sunni and Shi'a. There are various other groups, but 90% of Muslims follow the Sunni tradition. In order to become a Muslim, a person must pronounce that there is no god except God (Allah) and that Muhammad is his messenger. Shi'a Muslims also include that Ali is the seal on the will of the prophet; Ali is Muhammad's son-in-law and is seen by Shi'a's as his rightful successor.

Muhammad provided Muslims with the *Shari'ah* (pathway, as defined by God) and this informs how they conduct their lives. It is concerned with prayer, rituals, and attitudes to economics, family life, values and governance.

Jihad is the struggle to protect, promote and live by the messages of the Qur'an (holy book) and is central to Islam. It involves spreading the word of Islam, promoting opportunities to practice freely, self-discipline, and defending Islam.

In Islam, marriage and procreation are important. The traditional role of the man is to protect and financially provide for the females within the family. This includes his wife, children, and—where his father has died—his mother. Muslims believe that it is a duty to marry and, although the ideal family is formed around monogamy, Muslim men can take up to four wives. There are strict regulations around this, including that each wife must be treated equally both financially and socially; should be adequately provided for; and should be in agreement of the man taking another wife. Within Britain a polygamous marriage is not permitted, although where this has been contracted overseas recognition can be accorded.

Modesty is important within the Muslim culture. Men should be covered from the navel to the knees and women are required to cover the whole body.

Language

The British Muslim community is very diverse and there are many languages spoken within the community. In addition to English, Arabic, Bengali, Farsi, Gujarati, Hausa, Malay, Punjabi, Turkish and Urdu are commonly found. The Qur'an is written in Arabic and there needs to be some understanding of Arabic.

Religion

Islam is founded upon seven basic beliefs: in one God (Allah), the books revealed by God, the prophets, the angels, the Day of Judgement, life after death, and that all power belongs to God. It is understood within Muslim culture that the purpose of human life is to exercise authority and trust to manage the world responsibly, and to live in accordance with God's creative will. How each person responds to God's will and revelation determines their eternal destiny. It is believed that a descendant of the prophet will come before the end of time to establish justice on the earth.

In order for a Muslim to live a good and responsible life according to Islam there are five obligations they must satisfy. These are called the Five Pillars of Islam and consist of *Shahadah*: sincerely reciting the Muslim profession of faith; *Salat*: performing ritual prayers in the correct manner five times a day; *Zakat*: paying an alms tax to benefit the poor and those

in need; *Sawm*: fasting during the month of Ramadan; and *Haji*: pilgrimage to Mecca. Following the Five Pillars provides the framework of a Muslim life, binding together their everyday activities and their beliefs; key is that one's faith should be evident in their daily living.

Muslims pray five times a day, and Friday is seen as the congregational prayer day where Muslims meet at the mosque to pray. Shoes are removed before prayer and ritual-washing (*wazu*) takes place before prayer. *Wazu* includes washing of the genital area, hands, face, hair, mouth, nose, forearms, and the feet. During prayer, worshippers face Mecca (South East). Women are not required to pray if they are menstruating, or postnatal, and those who are not fully conscious are also exempt. A Muslim can pray in any clean place and use a prayer mat if they cannot find a mosque.

Food Preferences

Muslims do not eat pork or pig products and will only eat meat that is killed in accordance to the Islamic law (*halal*). Dairy products are acceptable, provided it is *halal*. No alcohol is permitted. Fish and vegetables are permitted. Food containing animal by-products such as animal rennet is not permitted.

The degree to which these strict dietary requirements are adhered to varies amongst the community.

Muslims practice self-denial; they fast in the month of Ramadan, which occurs once a year. The fasting period, lasting for 30 days, begins at sunrise and ends at sunset, and during this time no food or drink can be consumed. Pregnant, menstruating and breast-feeding women, people with diabetes, people who are very ill, or older people are exempt from this.

Personal Care and Hygiene

As well as washing before prayers, Muslims prefer to wash their private parts after using the toilets. Cleanliness is very important within the Muslim culture, as they cannot worship if unclean. The left hand is used for washing after the toilet, and the right hand for eating meals.

Muslims may also have no pubic hair and are required to shave to maintain it, as it is seen as being unclean. Modesty is important to the culture and toileting is required to be done in private. Washing is preferred under free running water. Some Muslims are circumcised at a young age to ensure cleanliness. After menstruating, women will wash themselves to cleanse the body.

Customs

Turning your back to the Qur'an is considered disrespectful, as is passing someone reading it with your back towards. The Qur'an is kept above head height in most homes, and Muslims need to be clean before reading the Qur'an and prayer.

When a Muslim is dying, relatives will recite verses from the Qur'an to comfort them and bring them peace. At the moment of death they will recite a specific line of the text.

A member of the family usually washes the body after death, and words from the Qur'an are spoken throughout this procedure. After washing, the head is turned to face Mecca and traditional preparation of the body is performed. There is no coffin, as the body is wrapped in linen. Muslims are buried as soon as possible after death, usually within 24-48 hours. Post-mortems are forbidden under Islamic law and should be avoided. The mourning period lasts for a month. Usually the family stay at home for three days after the funeral, where family and friends provide food. After this period a ceremony is held. This is repeated 40 days after the funeral and again each year.

Main Festivals

Al Hijrah – The first day of the Muslim year, marking the Prophet Muhammad’s migration from Mecca which led to the creation of the Muslim community.

Ashurah – Commemorates the martyrdom of Imam Husayn; it is held on the tenth day of the Islamic calendar and is an occasion for “passion plays”, and ritual mourning where Shi’a Muslims identify with the pain and suffering of Husayn.

Milad al-Nabi – The Prophet Muhammad’s birthday is celebrated with speeches about his life. It also commemorates his death and can be a subdued affair.

Lailat al-Baraat – Marks the night that the fate of humankind is ordained for the next year. Prayers are said, lamps are lit at graves, and it is a time for fasting and penitence.

Ramadan – Muslims fast from dawn till dusk for the month of Ramadan in order to reflect their devotion to God. It is a time for self-discipline, patience, selflessness and solidarity between Muslims.

Eid al Fitr – This festival marks the end of Ramadan and occurs on the first day of the next month. It is a major festival in the Muslim calendar. Gifts, and charitable donations are made at this time and the festival emphasises unity and togetherness, with often, large gatherings held at mosques.

Eid al-Adha – This is a three day festival and is known as the festival of sacrifice. Muslims traditionally sacrifice an animal, which is then distributed to the poor and shared amongst family and friends.

Implication for Care

- Medicines may need to be checked for contents, as strict Muslims may only accept halal food and drink.
- A separate prayer room may need to be provided
- Cleanliness, privacy and modesty are very important. This should be observed during bathing and using the toilet. Pubic hair may need to be removed to maintain cleanliness and promote worship.
- Strict observation and care should be taken over the choice, storage, preparation and serving of food.
- Use toilets with sinks in the same room, whenever possible, so the person can wash their hands.
- Offer showers rather than a bath, if available.
- Some Service Users will only eat with their right hand, as it is seen as unclean to use the left. This should be observed if assisting.
- Post-mortems are not permitted and can cause deep distress to families; should a post-mortem be performed all organs should be returned to the body before the funeral.

Jainism

Background

Jainism originates from India. Tradition claims that there were twenty four Tirthankara, who were born as human beings but who attained a state of perfection through meditation and self-realisation

The Tirthankara of whom we know most about is Mahavir, who was the last of the Tirthankara. Mahavir was born about 2,600 years ago and died at the age of 72. Mahavir's teachings have been very influential in the development of Jainism, although Jains believe that Jainism already existed before Mahavir. Mahavir reformed Jainism, introduced some of his own ideas and was an effective advocate for Jainism, and impressed many people through his teaching and life.

Today, Jainism has followers across India. The exact numbers are unknown with various estimates between half a million and 12 million followers.

In Britain there are about 30,000 Jains.

Beliefs

Jainism believes the universe and everything in it to be eternal. The human soul is eternal, but is trapped in the human body. Only through a life that seeks to follow the three key requirements of right faith, right knowledge, and right conduct can the soul attain liberation, and live in total bliss (*Siddhasila*), at the top of the universe.

Central to correct conduct are five vows:

- Non-violence – not to cause harm to any living beings
- Truthfulness – to speak the truth only
- Non-stealing – not to take anything not properly given
- Chastity – not to indulge in sensual pleasures
- Non-possession/non-attachment – complete detachment from people, places and material things

Jainism preaches a message of universal love, emphasising that all living beings are equal and should be loved and respected. Hence women and men are equal. Animals and insects must not be killed. Animal welfare, vegetarianism and care of the environment are active expressions of Jain beliefs. Jains practice fasting and self-denial of all material and sensual pleasures.

Mahavir organised his followers into a four-fold order:

- Monks
- Nuns
- Laymen
- Laywomen

Monks and nuns seek to follow the five vows strictly, whilst lay people try to follow the vows as far as their lifestyles permit.

At present there are no monks or nuns in Britain. They can only travel on foot, and the vast majority of monks and nuns live in India. It is possible that a Jain who lives in Britain will decide to become a monk or nun and so start a community here.

Jainism is known for building beautiful temples. They are built to honour Mahavir and other teachers. Images of the Jainist teachers are adorned with flowers and the faithful recite

sacred mantras. However, Jains do not worship God or gods. Jains accept that there are gods but do not see them as creators or protectors. The worship of God or gods to reach salvation is seen as futile. Each individual is responsible for their own destiny. For lay men and women attending the temple is an important aspect of their spiritual life.

The combination of soul and matter produces energy (Karma), the concept of which is important in Jainism. When the soul is engaging in anger, deception, lust, greed etc., then Karma sticks to the soul, imprisoning it. To be free, the soul needs to engage in confession, repentance, penance, self-control, austerity and religious deeds. Like many world religions, there are different branches within Jainism. The division is mainly noticeable amongst the orders of monks and nuns. One branch of monks and nuns wear white robes. The other branch seeks to apply an austere discipline of nakedness (which Mahavir did for part of his life). However, even this branch of monks tends to limit their nakedness to only the time they eat.

Food preferences

Jains take seriously the requirement not to hurt other animals, and so vegetarianism is very important. The preparation and storing of the food is also important. Some Jains are vegans; some Jains avoid root crops e.g. carrots. Fasting is a regular occurrence within Jain culture that can take different forms; it may involve giving up favourite foods or eating less than the person needs or giving up food and water completely for a period. Often fasting takes place during one of the festivals.

Main Festivals

Mahavir Jayanti (March/April) – The celebration of Mahavir's birthday; processions are held and Mahavir's message is explained to all.

Akshyatriya (April/May) – On this day sugarcane juice is ritually offered to those who have observed various types of fasts throughout the year.

Paryusana or Daslaksana Parva (August/September) – This festival lasts between 8 and 10 days. For part of this time Jains will fast, some will fast for all the days, some alternate days; all will fast on the last day. The last day is marked by asking fellow community members for forgiveness for any wrongdoing.

Diwali (October/November) – This festival is celebrated by Hindus as well. In Jainism it marks the day that Mahavir gave his last teaching and attained ultimate liberation. Lamps and candles are lit. Children are often given sweets by parents. Some Jains will fast.

Kartak Purnimu (October/November) – This follows Diwali. In India, Jains may go on pilgrimage to sacred sites.

Mauna Agyaras (November/December) – A daylong observance of fasting and silence. Jains also meditate on the five great beings.

Implications for Care

- Strict observation and care should be taken over the choice, storage and preparation of food.
- A person's decision to fast must be respected.
- Attending a temple is an important aspect of a believer's religious life and should be supported.

Jehovah's Witnesses

Background

The origins of Jehovah's Witnesses can be traced back to around 1870 in Pittsburgh, USA, where a group of people were studying the Bible, led by Charles Russell. One question they sought to answer was when Christ would return. Russell's leadership resulted in the group expanding; this necessitated an organisational structure. A governing body of twelve men, based in Brooklyn, New York was established and continues to exercise leadership and final decision making. The organisation's formal title is the 'Watch Tower Society'. Worldwide, there are about 6 million Jehovah's Witnesses. In Britain there are about 120,000 Witnesses.

Beliefs

Jehovah's Witnesses believe that Jehovah alone is God and that he should be called by his name (Jehovah). Jehovah's Witnesses believe that Jehovah created the Earth and placed humans on it. All people, living or dead, who accord with Jehovah's purpose for a beautiful, inhabited Earth may live on it forever.

Humanity is fallen (disobeys Jehovah) due to Adam and Eve disobeying Jehovah. Jehovah's Witnesses believe that Jehovah created Jesus Christ and that his life and death was paid as a ransom for obedient humans. Witnesses believe Jesus is a lesser person than Jehovah, and do not believe in the Holy Spirit, as Christians do.

Jehovah's Witnesses believe that Christ died on a stake, not a cross, and was then raised from the dead as an immortal spirit. Jehovah's Witnesses believe that 1914 is a pivotal year that marks the end of the 'Gentile Times' and the beginning of a transition period, from human rule to the 'Thousand Year Reign of Christ'.

On the last day, humans will engage in pleasure seeking, pursue money, lack self-control and reject goodness. It is then that Christ will return to Earth and there will be a great war or battle, culminating in 'Har-Magedon' (or Armageddon). Christ will be the victor and his thousand year reign of peace will begin.

Jehovah's Witnesses believe that at this point about 144,000 people will join Jehovah in heaven, whilst a far larger number of people will live peacefully on Earth. The Earth will be cleansed and beautified and people will live forever.

Jehovah's Witnesses believe only active Witnesses doing Jehovah's will, by serving the Watch Tower Society, will survive Har-Magedon.

As a result, the commitment of Jehovah Witness to their beliefs is striking. Most will attend up to five devotional meetings, each of an hour length, every week. Most Witnesses will spend ten hours a month evangelising from door to door and there will be an expectation that Witnesses will devote time to personal study and family study at home.

Witnesses believe everyone apart from active Witnesses will die and not be resurrected (or recreated). Witnesses believe there is no hell, just death, for those who are not an active Witness.

The Watch Tower Society uses its own translation of the Bible called the New World translation (NWT).

Other aspects of Jehovah Witnesses beliefs include:

- Birthdays should not be celebrated. The Jehovah Witnesses claim that the two explicit references to birthdays in the Bible are both negative and there is not mention of prophets, Jesus or his disciples celebrating birthdays.

- Christmas is not to be celebrated, since the exact date of Jesus' birth is not known (which is true). Also the 25th December was originally the festival of a roman god (which is true) and so Witnesses argue that it is a pagan celebration.
- Easter is not to be celebrated; since, as mentioned above, Witnesses argue that Jesus died on a stake, not a cross, the cross is not a visual image that Witnesses use.
- Blood transfusions are forbidden by Jehovah. Witnesses would argue that there are often medical alternatives. Additionally it is worth bearing in mind that many adults ignore or dismiss doctor's advice about what is good for their health (e.g. smokers).

For irreligious individuals, the differences between Christians and Jehovah's Witnesses can seem minor. It may be surprising, therefore, that there is disagreement between most Christians and Jehovah's Witnesses; at best they view each other with indifference, and at worst see each other as following flawed beliefs.

Implications for Care

- Whilst an older person who has care needs will not be as active they used to be they may well want to remain as active as they can be.
- Discuss with the Service User their aspirations in respect of attending weekly religious meetings and other religious activities (e.g. personal study time).
- Discuss with the Service User how they wish to manage days when the service celebrates festivals (e.g. Christmas) or marks someone's birthday.
- There may be a preference for same-sex carers as dressing and undressing in front of strangers can be embarrassing.

Judaism

Background

Jews have been present in Britain for centuries, with the initial settlement occurring after the Norman Conquest. They were later expelled and then readmitted in the 1650s. There are two main traditions within Britain: the Sephardi and Ashkenazi Jews. Sephardi Jews came originally from Spain, Portugal and Arab countries. Ashkenazi came from Central and East European countries. Ashkenazi Jews migrated to England for economic reasons, or else fled from persecution in the Russian Empire, Germany and other European countries. In addition, small numbers have arrived from India.

Like many religions, Judaism has different branches or denominations. Most practicing Jews are Orthodox; there are smaller numbers of Conservative, Reform and Liberal Jews. In Britain, a Jewish person's religious lifestyle is more likely to be influenced by whether they are Orthodox, Conservative, Reform or Liberal rather than whether they are Sephardi or Ashkenazi.

Language

Depending on the origin of a Jewish person, and from where they may have migrated, they will speak the regional or national language of that country. In Britain, most speak English, although some may speak Yiddish. Hebrew is the language of the Bible, prayer and modern Israel. It is the main language of worship and many Jewish people are taught it from an early age.

Religion

Judaism is a religion that has been in existence for about 3,500 years. Jews believe in one God, and that God will send a Messiah; they do not believe that Jesus Christ was the Messiah. They obey the Ten Commandments and love God through study and prayer. The teachings of the Jewish faith and way of life are contained in the Torah, and the rabbinic interpretations found in the Talmud. The Bible is known as TeNakh and includes the Torah (the five books of Moses), Nevim (prophets) and Ketuvim (other writings). The Sabbath (holy day) begins at sunset on a Friday and ends at nightfall on a Saturday. There are restrictions to working on the Sabbath. Orthodox Jews may also not turn lights on or off, and may use a timer. The Sabbath ends with the lighting of a candle and a blessing for the coming week. Friday evenings and Saturdays are times for prayer at the synagogue, overseen by the Rabbi.

Many Orthodox men will usually cover their heads. Men, and often women—particularly Orthodox women—cover their heads when entering the synagogue. Three daily prayers are stipulated: Shaharit (morning), Minhaha (afternoon) and Maariv (evening). Orthodox male Jews may wear Tephilin (small box worn on forehead, and left arm containing sections of the scriptures on parchment) during their morning prayer and ArbaKanfot (a fringe, worn at all times on a vest under their clothes)

Food Preferences

A Jewish diet has to be kosher (permitted), that is animals humanely slaughtered by a shochet (qualified slaughterer) and according to Jewish law. This involves the drawing of blood from any animal as part of its preparation. Kosher meats are all sources of meat with split hooves and that chew the cud; fowl can be kosher, and the eggs from them; for fish to be kosher they must have both fins and scales, e.g. cod. Treif (forbidden) foods include: horses, pigs, rabbits, birds of prey, and non-kosher fish include all shell fish such as prawns, crabs etc. Fruit and vegetables are kosher provided they are not cooked with non-kosher ingredients.

Jewish law prohibits the mixing of milk foods with meat food, and separate utensils and service items should be used for both items, with a time lapse observed between eating the two items. Fish can be served with milk. Fish can also be served with meals that contain

meat. The degree to which these strict dietary requirements are adhered to varies amongst the community and between individuals.

Personal Care and Hygiene

Hygiene and washing is regarded, as with other cultures, as important. Dress codes are normally of a conservative nature when attending the synagogue. Dressing and undressing can be viewed as embarrassing, and same-sex carers can be preferred.

Customs

As is commonly found within many cultures, family and community are seen as very important social structures. Men and women are seen as equal, and gender roles are clearly defined, with women responsible for the care of the family and the home. The door post of a Jewish person's home is often marked with a small prayer box (mezuzah). It is customary for a Rabbi and a relative to be by the bedside of a dying person to recite prayers and provide the opportunity for confession of their sins. Burial arrangements are usually made through the synagogue. A group of people will prepare the body as soon as possible after death, often reading prayers. After death, the eyes and mouth of the person are usually closed by a close relative, the body is washed and placed in a shroud or prayer shawl, and burial is immediate. There is a mourning period of up to seven days where family and the community pay their respects, bring food and ensure the family are not left alone. There are different stages to the mourning period: firstly the initial seven days; then twenty-three days where life returns to normality; and finally, this is followed by a lighter mourning period lasting eleven months.

Coffins are usually plain, and there are no flowers. Mourners will usually fill in the grave before returning to the prayer hall. For many there remains a great kinship with Israel and it has great importance and significance to the Jewish people. Jewish boys are often circumcised on the eighth-day of life. At thirteen, male Jews take on a new role within their community and this is celebrated by way of a Barmitzvah. Some Jewish girls have a Barmitzvah at the age of 12 or 13. Some Jewish people wear jewellery such as the Star of David.

Main Festivals

Rosh Hashana (September/October) – The Jewish New Year, celebrated by the blowing of a ram's horn in the synagogue to remind people of their sins and their spiritual awareness. No work is permitted on this day. At home, an apple dipped in honey is eaten and an apple cake may also be served. This is a ten-day festival and ends with Yom Kippur.

Yom Kippur – A day of atonement wherein fast of food and drink is observed for approximately 24/25 hours. The day is devoted to worship and prayer, and no work is permitted.

Sukkot – The festival of Tabernacles, which commemorates the wandering of Israel's children. Jews celebrate this day by the building of a temporary hut (Sukkot) on the side of houses and synagogues. The festival also commemorates harvest, where a palm branch, citron, willow branches, and three myrtle branches are carried in procession around the synagogue.

Simchat Torah – Celebrates the completion and recommencement of the annual cycle of reading from the Torah.

Pesach or Passover (March/April) – An eight-day festival where unleavened bread is eaten to symbolise Jews leaving Egypt; the story of Exodus is told and a special meal is taken on the first and second evening.

Shavuot – A two-day festival commemorating the Israelites receiving the Torah, in which harvest, olives, dates, grapes and figs are eaten.

Implications for Care

Each house holder or Service User should be asked how they want to be supported to apply their faith and culture. Below are some areas to consider. As always there can be variation within a community.

- Strict observation and care should be taken over the choice, storage, preparation and serving of food.
- Bereavement traditions and customs should be respected.
- Jewellery should not be removed without consent.
- The Sabbath is the day of rest and should be respected. The Sabbath and festivals start on the evening of the day before.
- In care homes some Jewish people may want to place a Mezuzah (small prayer box) on the door post to their room.
- Same-sex carers may be preferred where personal care is required.

Rastafarianism

Customs

Rastafari is a way of life and is guided by a central concept of peace, truth, right and love. It is named after RasTafari who became Emperor Haile Selassie I of Ethiopia. Haile Selassie I is recognised as Jah, the living manifestation of God. Rastafarians believe that salvation can come to black people only through repatriation to Africa after liberation from the evils of the Western world.

Rastafarians often say “I” and “I” instead of “me” and “you” to denote that God (Jah) is within all human beings.

The Bible is seen as the divine word and is interpreted through reasoning: collective drumming, reading, prayer, studying and debate. There are no buildings for worship (reasoning) and each individual or group is autonomous.

Rastafarians believe in reincarnation and the movement of life from one generation to the next through spiritual and genealogical inheritance. There are no special arrangements or ceremonies following death. The extended family and wider community are seen as the support network to help resolve individual and family crises. The use of cannabis is understood to be sanctioned in the Bible.

Food Preferences

Many Rastafarians are vegetarian, avoiding meat, fish and poultry; others are vegan and will not consume any animal by-products, including fat, milk, and gelatine. Some Rastafarians do choose to eat meat, although they may not eat pork as it is regarded as unclean meat. The degree to which these strict dietary requirements are adhered to varies amongst the community.

Rastafarians do not cut their hair or beards, and it needs to be kept clean.

Sikhism

The British Sikh community is the largest outside of India. Sikhism originated in Punjab, India, and was founded by Guru Nanak Dev. A number of Sikhs settled in Britain in the 1920s and 1940s, although the vast majority arrived in the 1950s and 1960s. The majority of these came from Punjab, although some came from East Africa and other former British colonies. Many Sikhs served in the British Indian armies during the First- and Second World Wars.

Guru Nanak Dev preached a message of universal love, peace and brotherhood, emphasised by the worship of one God. He believed that the worship of God in whatever tradition one practiced should be sincere and honest. He settled in Punjab and founded a community of Sikhs (disciples or learners).

Guru Nanak Dev was the first of ten Gurus (divine teachers who convey the word of God). Sikhism emphasises the worship of the Word of God, not object of worship. The tenth Guru, Guru Gobind Singh vested authority in the Guru Granth Sahib (the Sikh scripture) and in KhalsaPanth (path of the pure ones). The Guru Granth Sahib is therefore the eternal Guru embodying the Divine Word.

Guru Gobind Singh introduced Sikhs to "Armit", a ceremony of initiation similar to Baptism whereby Sikhs adopt their name (Singh for men and Kaur for women) and the five symbols of Sikhism. He provided instructions for prayer and how Sikhs should conduct themselves, completing the spiritual and temporal structure of the Sikh faith. Some Sikhs may carry a small prayer book wrapped in cloth which can only be touched with clean hands.

Language

Most Sikhs in Britain speak Punjabi and English, although other languages may also be spoken such as Swahili (those from East Africa) and Hindi (the national language of India). The Punjabi language shares similarities in vocabulary and grammar with Urdu and Hindu.

Religion

Sikhs believe in one God, and this underpins every aspect of life. The creation of the world is understood to have originated from God's will to create, developing from lower to higher forms of life. From air came water; from water came the lower forms of life: plants, birds and animal, and the supreme form of created life on earth: humans. The purpose of human life is to seek its creator and merge with God, breaking a cycle of rebirth. Failure to do so will lead to rebirth, including lower forms of life than humans.

Prayers are normally said in the early morning and before sleeping at night. This can be done individually and within the Sikh's home (some homes may have separate rooms that contain the Guru Granth Sahib), although communal prayer is regarded as particularly important. There is no particular holy day during the week for Sikhs; for convenience, the temple is usually visited on a Saturday in Britain.

Gurdwara (Temple) is open to all irrespective of race, religion, or social status. Each has The Guru Granth Sahib (Sikh holy book), communal kitchen and dining area. It is customary for all that enter the temple to be served food. Shoes are removed and entrants should cover their heads. Smoking and alcohol are not permitted in temples.

Food Preferences

Many Sikhs refrain from alcohol, tobacco and other intoxicants. Meat should only be consumed if it is Jhatka, where the animal has been instantaneously killed with one stroke. Those that eat meat must not eat halal or kosher meat. Many Sikhs are vegetarians. The degree to which these strict dietary requirements are adhered to varies amongst the community. Sikhs do not practice self-denial, therefore they do not fast for religious reasons.

Personal Care and Hygiene

Cleanliness is very important to Sikh communities. Long hair requires regular washing and managing, with hair oil being applied for its maintenance. Leaving the hair uncut applies to the whole body not just to the head and face. Beards are not cut and the Khanga is used to comb the hair every day. Orthodox Sikhs will bath daily and pray twice. The steel bracelet, jewellery or threads that are worn should not be removed without permission.

Women may wear Punjabi suits (two piece cotton or silk dress over baggy trousers). Men tend to wear Western clothes,, although more orthodox Sikhs will wear traditional tunics over baggy trousers.

As with many other religions, Sikhs require the use of the left hand when using the toilet, and leave the right hand for eating.

Modesty is one of the five 'K's (see below) and both men and women observe conservative dress codes.

Customs

Food is always served to those entering the Sikh temples

There are five symbols of Sikhism (the five K's): Kesh (long hair, symbolising holiness); Kanga (the comb symbolising purity); Kara (steel bracelet worn on right wrist to protect the sword arm, symbolises eternity); Kirpan (a small dagger symbolising willingness to fight oppression); and the Kaccha (shorts worn under clothes to symbolise modesty). In addition to this a turban is worn to protect the Kesh. The wearing of these items identifies the person as a Sikh who has dedicated himself or herself to a life of devotion to Guru.

In Britain, the Kirpan is worn by orthodox Sikhs and is exempt from the classification of a dangerous weapon. Sikhs believe in rebirth and after death the body is washed and dressed, with cremation happening as soon as possible. In India, cremation is usually on the same day; in Britain cremation is within two to five days. Post-mortem examinations can be viewed as a form of violation of the body, and are likely to cause significant distress to the family. On the day of the cremation, the body it is usually placed in an open cask; relatives and friends come to pay their last respects, and a priest reads the last rites. The Guru Granth Sahib is brought home from the temple after the cremation and prayers are read, usually lasting a whole morning.

Main Festivals

Dates provided refer to the Gregorian calendar.

Gurpurbs – Celebrations of the birth or death of a Guru are usually by means of prayer, religious lectures, KarahPrashad (blessed, sweet food made from semolina, sugar, clarified butter and water are served after worship) and Langar (free communal meal). There are four major Gurpurbs celebrated in Britain:

Guru Nanak Dev – Celebration lasting 3 days

Martyrdom of Guru TeghBahadur

Guru Gobind Singh

Martyrdom of Guru Arjan Dev

Installation of the Guru Granth Sahib (August–September) – Celebrating the Sikh Scriptures.

Vaisakhi (April) – Marking the day when Guru Gobind Singh founded the Sikh brotherhood Khalsa. Sikhs carry a flag down the streets in a procession to the gurdwara and replace the old one with it.

Diwali (October/November) – Celebration in memory of Guru Hargobind's return from imprisonment and the saving of 52 Hindu Kings. It is celebrated with the lighting up of the Gurdwara.

Implications for Care

- Some may not want a commode in their living areas.
- Space may need to be dedicated to holding the Guru Granth Sahib and for prayer.
- Utmost respect must be observed for the five symbols of faith, and these should not be touched or removed without permission.
- Specific dietary requirements will need to be identified.
- Strict observation and care should be taken over the choice, storage, preparation and serving of food.
- Hair and beards are not generally cut. For many, this extends to all body hair and care will be needed in dealing with this.
- Personal care and hygiene is very important, and will need specialised products, and additional time allowed.
- Specialised hair products should be available.

Travellers Culture

Background

'Traveller' is an umbrella term that encompasses a variety of groups, including: Romanies or gypsies, Irish traveller, New age Travellers, and occupational travellers (circus and fairground workers). Whilst it is commonplace for travellers to be nomadic, some may also live in houses. A person is born a traditional traveller and cannot become one by association. It is thought that Romani people arrived in the British Isles around the 16th Century, travelling to trade, work and entertain. The size of the population is estimated to be 80,000 to 110,000 in Britain. There is no single culture and traveller communities worldwide hold different beliefs, customs and traditions.

Language

Due to the diversity of the population language is not specific and may include Romanies. Within the Irish traveller community Gammon, Shelta, or Cant may be spoken. New Age travellers are a diverse group including people from many different origins and the languages used will vary between them.

Religion

Due to the diversity of this group religious practices or beliefs vary across Britain. Usually the religions and local culture of the country or area in which they settle are adopted. Within Britain, Christian practices are followed, although this varies between groups and area of settlement. It should also be noted that for many religious beliefs may be a mix of traditional beliefs and community-based practices and traditions.

Food Preferences

Travellers mostly adopt the diet of the area or country they live in, although many will not eat horsemeat.

Personal Care and Hygiene

Many prefer to wash under free flowing water and use different bowls for different tasks.

Customs

Although practices vary across different groups there are some general similarities. For example, there may be clear, gender-defined roles within traveller communities. Within some groups women and men will socialise with other same-sex members.

Privacy is highly valued within the community. There may not be a defined community leader, although age is respected. Men are usually self-employed and rely on traditional trade for income, with women often not working outside of the home.

Literacy levels may be low due to the nomadic way of life. Some families believe it to be disrespectful to say the names of those that have passed away. Gold jewellery is sometimes worn as a symbol of wealth and prosperity. Dogs are generally not allowed within the living areas of the family, as they are seen as unclean.

Main Festivals

This will vary depending on the area and "adopted" beliefs of the community.

Implications for Care

- Literacy may be low and care should be taken to read things if required, or assistance provided in completing written work.
- Privacy is valued and should be respected.

- Identifying a person's individual, specific needs by asking them will be important, due to the diversity of the culture
- There may be a preference for same-sex carers, as dressing and undressing in front of strangers can be embarrassing.
- Modesty may also be important, and care should be taken over the choice of the sex of the carer, and over washing and bathing routines.
- Each traveller group has its own culture, traditions, routines, beliefs, and customs. These should be identified and respected.

Related Policies

Disability Discrimination

Equal Opportunities

Maternity

Religion and belief

Sexuality

This policy will be reviewed by the Registered Manager.

Signed: Morag Collier

Date: 30/01/18

Review Date: 30/06/18

FALLS PREVENTION

Constantia Care Ltd.

Policy Statement

The human body is essentially unstable; a vertical column on a narrow base. To be able to remain standing upright involves a complex neuromuscular mechanism involving the eyes, the balance centres in the brain, the associated balance mechanism in the inner ear and the sensory receptors in the soles of our feet. These all send signals to the brain from where return signals are sent to the muscles and the joints to make the necessary adjustments required for balance. Adjustments are being continually made by the brain to maintain the body's balance. Any interruption in this process for whatever reason or cause may result in the body losing its vertical capability and falling.

Constantia Care has identified the importance of staff being aware of the varying causes of falls and supporting Service Users by giving information, carrying out risk assessments and working with outside professionals to reduce their number of falls. This policy reflects the guidance given in the NICE guideline [CG161]. Falls assessment and prevention of falls in older people published in June 2013 and the Quality Standard [QS86] published in March 2015, updated January 2017.

The Policy

At assessment, planning, reviews and in the day to day work with our Service Users we monitor the following aspects of the individuals care and support which may lead to them tripping or falling

- The number of falls that they have had since the last assessment or in the last month
- Uneven floor or ground surface.
- Inappropriate footwear: Footwear that is borrowed, the wrong size (too big too small), too tight/loose, the heels being too high making the wearer unsteady.
- Visual impairment: This can be as a result of poor or failing eye-sight, insufficient or inadequate lighting or the presence of smoke.
- Medical conditions. Individuals suffering from conditions that;
 - Affect balance, such as Parkinson's disease, arthritis, multiple sclerosis and stroke.
 - Cause sudden drops in blood pressure, like postural hypotension.
 - Cause insomnia or incontinence which means you are frequently getting in and out of bed at night thus increasing the risk of falling.
 - Cause confusion and other physical disabilities such as Alzheimer's disease or other forms of dementia
- Non ambulant people or those with little mobility. Joints and muscles become stiff and this makes standing and walking difficult and painful
- Mental illness: For example individuals suffering from psychiatric or physical conditions which cause delusions or the presence of the visual cliff effect. Depression has also been identified as being a cause of people falling.
- Mobility aids: These can cause people to fall if they are not the correct type or height and if used inappropriately can be a hazard.
- Poly pharmacy: Older adults are often prescribed many different drugs for different medical conditions. However sometimes this mix of medication can cause an older person to become confused, depressed, and drowsy or at times giddy leading to an increased risk of falls. Medications such as laxatives, diuretics, anti-depressants or sedatives, can contribute to falls.

- Hazards: This can include obstacles left in walkways, rugs, ill-fitting carpets, trailing wires, wet or slippery surfaces, uneven surfaces, unfamiliar environments,
- Poor lighting prevents obstacles being seen and also creates shadows.

Falls and Injury Prevention Strategies

If the care or support needs assessment identifies that the individual is at any risk of falling a falls risk assessment will be carried out immediately prior to or when the service commences. The appropriate professional will also be contacted e.g. falls risk advisor, occupational therapist if there are changes in the Service Users health or they begin to fall a falls risk assessment will then be carried out.

From the assessment and the outside professional advice any or all of the following may be put in place.

- **Shock absorbent pads** in undergarments (hip protectors). When wearing these protectors if the individual falls the pad absorbs the shock from hitting the ground and in the majority of cases prevents the hip from fracturing. It is important that the manufacturer instructions are followed and that they are the correct size and worn all the time.
- **Adjustable beds**, pressure alarms and personal alarms. The adjustable bed makes it easier for the individual to get in or out of bed independently and therefore reduces the potential of a fall. Pressure alarms and pads immediately alert staff that a person is out of bed or the chair and staff can then quickly support an individual who may be likely to fall
- **Exercise and activity:** for balance, strength and mobility
Exercise improves balance, strength, mobility and general well-being. Falls are reduced most significantly when exercise is individually tailored and supported by staff trained to provide exercise for older people. Some Community Centres or Local Authorities offer exercise programmes for people from the community. Individual and group exercise has wider benefits, including improved general social interaction and well-being.
Staff are trained to work with physiotherapists to define one-one exercise plans, exercise sessions or activity classes. External trainers that provide regular armchair exercise,
Service Users, who have fallen can attend outpatient 'balance' classes or physiotherapists' 'falls prevention classes'.
- **Calcium and vitamin D supplements.** It is essential that a good level of calcium and vitamin D is maintained in the body. This strengthens bones and help prevent fractures. Osteoporosis occurs when these levels drop and the bones become brittle and more likely to fracture. It is not always necessary to take drugs for this condition but vitamin D and calcium supplements will be prescribed. The calcium and vitamin levels will be monitored by the GP because if the levels of calcium in the body are excessive kidney stones can develop. If there is excessive vitamin D, your kidneys and tissues may be damaged.
Too much calcium can cause constipation.
Too much vitamin D can cause nausea and vomiting, constipation, and weakness.
Calcium and vitamin D may interact with other medicines. A drug interaction happens when a medicine you take changes how another medicine works. One medicine may make another one less effective, or the combination of the medicines may cause a side effect you don't expect.
- **Changing the medication regime.** The individuals prescribed medication may be a cause of falls. For example sedatives causing drowsiness, diuretics causing the person to rush to the toilet and codeine based analgesia causing constipation and confusion in the elderly person. A regular review of medication type, strength and time of administration should be regularly carried out by the pharmacist or GP.

- **Improved Vision.** Sight plays an important part in balance and gait stability so the selection of appropriate glasses for those who wear them is very important. Bi-focal and tri-focal glasses are often used by older individuals to provide for the ability to read and perform normal every-day functions without the necessity of changing glasses for each change of activity. Glasses used for reading, are not suitable for general use and very often not even for watching television. The changed focal point can make these glasses dangerous in certain situations. Particularly in the elderly different glasses for different tasks are more suitable, even with the added problem of confusion. Individuals must be encouraged to request assistance as needed. Regular eye tests should be encouraged and when required staff should ensure that glasses are clean and fit well.
- **Footwear.** Individuals are encouraged to wear non-slip footwear. Footwear should also be comfortable and well fitting. Sloppy slippers or shoes will add to the danger of falling and must be discouraged.
- **Foot care.** Hard skin or corns cause pain and this causes mobility problems. It is important that where prescribed creams are applied, skin softening creams may be used after bathing and visits to the chiropodist should be regularly encouraged, arranged and appointments kept.
- **Appropriate seating** should be provided. If seats are too low they cause problems in getting up and can lead to a loss of balance. If too high and the feet do not touch the ground there is also the problem of overbalancing. Adjustable beds also assist individuals in keeping independent by making getting in and out of bed easier.
- **Walking Aids** When first receiving a walking aid staff should check that the individual is clear how to use it properly and they should be monitored until they are confident. An occupational therapist or physiotherapist must always be involved in choice and use of walking aids.
Walking Aids should be regularly:
Checked for damage.
Cleaned to prevent cross infection.
Rubber ends regularly checked and replaced as necessary to prevent slipping.
Regularly reviewed as the individual's needs change.
Walking aids should always be kept within easy reach of the individual.
- **The Environment.** The Service User should be encouraged to keep their home free from potentially unsafe conditions. Good housekeeping is essential and staff must be vigilant and put equipment away so as not to create a hazard.
- **Physical Intervention.** For example, cot sides must be fully risk assessed and discussed with the relevant professional before being used or implemented.
- **Individuals and family members must be involved** It is important that the individual with capacity understands what is being suggested to help prevent falls and also that they consent to what is being put in place. The individuals understanding and co-operation is essential for the process to work effectively. They will be required to sign and consent to any reviews of the care or support plan. It is essential especially in the individuals own home that family or friends support and work with the individual in maintaining their independence while helping to reduce the risk of falls. Where appropriate the family should be included at the development stage of any personal safety plan.
- People who lack capacity will need a plan that is clear to staff in how they support them and prevent falls but does not deprive them of their liberties. A DOLS referral should be obtained if necessary.
- **Effective staff training** is important. Staff need to be aware of who is "at risk. Good communication and recording plays an important part in recognising potential risks to the individual and prevention of falls. Understanding why people fall and what can be done to prevent it assists the worker to keep the individual safe

- **Incontinence management.** People often fall when rushing to the toilet for fear of incontinence. The individual's medication needs to be considered, the dose and time of day prescribed. The individual needs to know where the toilet/commodore are and the necessary aids should be in place to enable them to use it safely. Doors that are easily opened. The use of incontinence aids that reduce the fear to the individual of "having an accident"
- **Postural Hypertension management.** Postural hypotension is a medical condition where blood pressure falls rapidly after the body changes position most commonly occurring after standing up after sitting for long periods of time. It is also known as orthostatic hypertension or postural hypotension. Individuals with postural hypertension experience symptoms of low blood pressure when the condition occurs. Postural Hypertension is quite common among the elderly and doctors regularly see symptoms in peoples as young as their mid 30's. People that have postural Hypertension often experience symptoms immediately upon a body position change. Common occurrences are getting out of bed or bath, standing up from a seated position, or getting into a car. Management of this condition may greatly reduce the likelihood of a fall. This includes the individual learning to move slowly when standing up and to be aware of potential risk of falling when doing such moves.
- **Personal items should be kept in easy reach** or accessible to the individual. For example the phone, spectacles, radio. This will prevent unnecessary movement for someone with poor mobility or balance. However mobility is important so this goes along side keeping the area free of hazards so people can walk around safely.
- **A multi-disciplinary team approach** is required for an effective outcome to all of the above.

When a fall happens

If an individual is involved in a fall and they are unable to get up again without more than a little assistance, a top to toe first aid survey should be carried out to make you aware of the possible extent of any injury. If no obvious injury is found and the individual is not complaining of any pain and is able either to get up themselves or with a minimal amount of assistance they should be assisted to their feet and sat down to recover. Advice should be sought from the office in these circumstances. When they are sufficiently recovered gentle questioning should take place to determine the reason for the fall. All this must be documented in the individual's notes and reported to the person in charge. A cause may or may not be established but the GP must be informed who with further tests will be able to determine the cause, if this is thought necessary. It is important that all necessary notifications to CQC or RIDDOR are carried out as soon as possible. If the individual is complaining of any pain then the paramedics should be called and the individual must not be moved.

Related Policies

Accident and Incident Reporting (RIDDOR)

Dignity and Respect

Health and Safety

Meeting Needs

Moving and Handling

Training Statement

These organisations have links with local NHS and the Local Authority falls services or co-ordinators that provide training and support for staff. We ensure that at induction and at regular intervals staff are given awareness and updated on falls prevention.

This policy is to be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

FINANCIAL IRREGULARITIES

Constantia Care Ltd.

Policy Statement

Constantia Care is committed to the highest standards of moral and ethical behaviour. Employees of the organisation are expected to report known or suspected financial irregularities.

Constantia Care believes that its Clients have a right to expect that the organisation will be run in an honest and sound financial basis, with robust procedures for dealing with and protecting the financial interests of Clients

The Policy

This policy is intended to set out the values, principles and policies underpinning this organisation's approach to financial irregularities in the management of the organisation and in the management of Clients' money and finances. The goal of the organisation is to ensure that Clients' financial interests are safeguarded by staff working for the organisation.

Policy on Financial Irregularities

In Constantia Care:

- Written records of *all* transactions with Clients should be maintained and kept securely
- Open, transparent and robust accounting and financial procedures should be adopted and annually audited by an independent firm of auditors
- Annual accounts will be prepared and submitted by a professional independent accountant
- Any member of organisation staff who suspects that a Service User may be being cheated, defrauded or robbed, or that a Service User is no longer capable of managing their own finances, should report their suspicions to their line manager or supervisor; any member of organisation staff who suspects financial irregularities or corruption by organisation staff or managers should report their suspicions immediately to the owner of the organisation, followed by the appropriate Safeguarding action.
- All organisation staff are encouraged to raise any genuine concerns about any: malpractice, suspected crime, breach of legal obligations, miscarriage of justice, danger to health and safety or the environment, financial malpractice, fraud, corruption and breach of regulations—or any cover-up of these—that they may come across which affects the organisation, its Clients or other staff; individuals who so disclose information have statutory protection in line with the *Public Interest Disclosure Act 1998* and the organisation's Whistleblowing Policy, provided that concerns are raised in the right way and they are acting in good faith
- All financial irregularities or suspected financial irregularities will be fully investigated by the owner of the organisation as per the organisation's Disciplinary Policy
- Any evidence of fraud or criminal activities will be immediately reported to the police
- All members of organisation staff should co-operate fully with, and make any documents available to, the police and/or their appointed auditors upon investigation of any allegations of financial irregularities
- The organisation will maintain a register (that is open to inspection) within which the organisation's owners and managers should declare, in writing, any interest or involvement with: any other separate organisation providing care or support services or responsible for commissioning or contracting those services, including where partners or other close family members own or manage at a senior level; other organisations providing domiciliary, day, residential or nursing care

- Where financial information is held on a computer or in a database then the requirements of the *Data Protection Act 1998* should be followed
- All parties involved with a financial irregularity must handle the reporting and investigating with utmost confidentiality and objectivity.

Related Policies

Duty of Candour
Good Governance

Training Statement

All new staff should be encouraged to read the policies on handling Clients' money and involvement with Clients' financial affairs as part of their induction process. Existing staff should be provided with regular training updates. It is extremely important for the organisation to impress upon staff the importance of maintaining high standards in dealing with Clients' money.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/09/2015

Review Date: 30/06/18

FINANCIAL PROCEDURES POLICY

OUTCOME 26, CQC REGULATION 13 (Financial Position)

Constantia Care Ltd.

Policy Statement

Constantia Care Ltd. believes that its service users have a right to expect that Constantia Care will be run on a sound financial basis with robust procedures for dealing with money and accounting.

Constantia Care adheres fully to outcome 26, regulation 13 of the Care Quality Commission (Registration) Regulations 2010, which relates to the extent to which the continuity of the service provided to service users is safeguarded by the accounting and financial procedures of the company.

Aim of the Policy

This policy is intended to set out the values, principles and policies underpinning Constantia Care's approach to the management of finances in Constantia Care.

Policy on Financial Procedures

1. This business has a financial plan for Constantia Care as part of its business plan which is open to inspection and reviewed annually and includes a current cash flow forecast for the business set over a 12-month period.
2. Open, transparent and robust accounting and financial procedures are adopted and annually audited by an independent firm of auditors.
3. Annual accounts are prepared and submitted by a professional independent accountant, and include:
 - a. A profit and loss account
 - b. A balance sheet
 - c. An auditors' report signed by the auditor
 - d. A directors' report signed by a director or the secretary of the company
 - e. Notes to the accounts.
4. Insurance cover is in place against loss or damage to the assets of the business.
5. Insurance cover is in place to cover business interruption costs including loss of earnings.
6. All self-employed care workers are expected to be covered by their own personal accident and third party liability insurance; their insurance details are always checked upon registration with the company and insurance recommended for those who don't have it in place.
7. Records are kept of all transactions entered into by the registered person and Constantia Care.

The accountant for Constantia Care is **Simkap Accountants**.

The insurance broker for Constantia Care is **Ace Europe**.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

FIRST AID

Constantia Care Ltd.

Policy Statement

Constantia Care recognises its responsibility to ensure that all reasonable precautions are taken to provide and maintain working conditions which are safe, healthy and compliant with all statutory requirements and codes of practice. This includes the provision of Qualified First Aiders in the organisation, who are qualified to deal with minor injuries. In order to ensure that we have enough first aid provision this organisation undertakes a First-aid needs assessment as recommended by the Health and Safety Executive. <http://www.hse.gov.uk/> and our First Aid Provision reflect this assessment.

The Policy

Constantia Care understands 'First Aid' to refer to:

- the initial and appropriate management of illness or injury which aims to preserve life or minimise the consequences of injury and illness until professional medical help can be obtained;
- the treatment of minor injuries that do not require the attention of a medical practitioner or nurse.

First Aiders

Constantia Care ensures that a Qualified First Aider is available at all times that there are staff working. They should be contacted via the main office, where there is a list displayed with their names. In addition to Qualified First Aiders, the organisation also supports a number of staff trained in Basic Life Support to assist the Qualified First Aiders.

First Aid Container

All employees in the Constantia Care office should have access to a 'First Aid Box' whilst at work. The principal First Aid Box is carried by the on-call First Aider who is responsible for checking its contents and ensuring that it is replenished when necessary.

The box should contain the following:

- A Health & Safety Executive (HSE) leaflet giving general guidance on First Aid
- 20 individually wrapped sterile adhesive dressings (assorted sizes)
- 2 sterile eye pads
- 4 individually wrapped triangular bandages (preferably sterile)
- 6 safety pins
- 6 medium sized (approximately 12 cm x 12 cm) individually wrapped sterile non-medicated wound dressings
- 2 large (approximately 18 cm x 18 cm) sterile individually wrapped non-medicated wound dressings
- 1 pair of disposable gloves.

In Constantia Care, tablets or medicines should never be kept in the First Aid Box, and items that are out of date should be replaced and disposed of immediately.

First Aid Information (Signs and Posters)

First Aid signs and posters are prominently displayed in the main office informing staff, visitors and Service Users what to do in the event of an emergency and from whom to obtain First Aid assistance. This should include emergency contact telephone numbers. Similar information is included in all staff induction packs and should be carried by staff at all times. All staff must familiarise themselves with the First Aid arrangements and with the names and locations of Qualified First Aiders or Appointed Persons and First Aid Boxes.

Record Keeping

In all situations where staff are injured at work and requiring First Aid the accidents procedure should be followed and the appropriate accident forms should be filled in and witnessed. An incident record should also be made in the Accidents form if required.

First Aiders must keep a record of all treatment that they provide by completing a First Aid Treatment Record. This information helps to identify accident trends and can be used for reference in future First Aid needs assessment.

Injuries at work are also covered by RIDDOR (the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995*) and may require a report to be made to the HSE (see Accident Reporting Policy)

Related Policies

Accident and Incident Reporting (RIDDOR)

Health and Safety

Record Keeping

Training Statement

Any staff member who wishes to become a Qualified First Aider should contact their line manager or supervisor and register their interest. The organisation will support and sponsor training for Qualified First Aider and Refresher Courses in so far as the organisation requires a sufficient pool of qualified staff to cover shifts.

A Qualified First Aider must hold a valid certificate of Competence in Emergency First Aid at Work or Basic Life Support, issued by an organisation whose training and qualifications are recognised by the HSE. Such certificates are valid for three years; refresher training and re-testing must take place before the qualification expires.

This policy will be reviewed by the Registered Manager.

Signed: Morag Collier

Date: 30/01/15

Review Date: 30/06/15

FIT AND PROPER PERSONS: DIRECTORS

Constantia Care Ltd.

Policy Statement

Regulation 5 of the *Health and Social Care Act (Regulations 2014)* are a new requirement for directors, and, by definition, extends these requirements to the senior management team. This organisation sets out below its process for ensuring compliance with the regulation.

The process covers the following all relating to directors and specific, identified posts:

1. Recruitment and selection
2. Employment checks
3. Appraisal arrangements for specific identified posts
4. Code of conduct.

The Policy

Recruitment and Selection

All directors and specific, identified posts will be subject to the following robust stages of recruitment:

- All such posts will be advertised externally, in order to open up the process
- Directors and specific, identified posts will have job descriptions that detail their role and responsibilities, duties, and the limits to their accountabilities
- A person specification will form part of the recruitment process
- Interviews will use an assessment criteria to ensure transparency for all candidates and records will be a contemporaneous account of the interview.

Employment Checks

All of the identified posts will be subject to the following checks:

- Right to work check, to comply with current immigration requirements
- Reference checks, both written and a with verbal confirmation of their integrity
- Qualifications (originals), to be validated and then copied for file retention
- A disqualified directors check, made via the Companies House register or the Insolvency Service Register for England and Wales (Scotland and Northern Ireland have their own insolvency registers).

In order to meet the regulatory requirements, all of the above checks must meet the good character and unfit persons tests in part one of the Schedule that applies to the specified posts.

Part 1: Unfit Person Test

1. The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
2. The person is the subject of a bankruptcy restrictions order, or an interim bankruptcy restrictions order, or an order to like effect made in Scotland and Northern Ireland
3. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the *Insolvency Act 1986*
4. The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
5. The person is included in the children's or adult barred list under Section 2 of the *Safeguarding Vulnerable Groups Act 2006* or in any corresponding list maintained under an equivalent enactment in force in Scotland and Northern Ireland
6. The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

Part 2: Good Character

7. Whether the person has been convicted in the UK of any offence or been convicted elsewhere of any offence which, if committed in any part of the UK, would constitute an offence
8. Whether the person has been erased, removed, or struck-off a register of professionals maintained by a regulator of health care or social care professionals.

Please note:

If during any of these checks it becomes apparent that the proposed post holder is not of the required calibre, appropriate employment law advice should be sought. The final decision of whether or not to employ rests with the employer, not with the CQC. An open and transparent process must be in place for all decisions in regard to these specified posts to be validated and an audit trail of evidence available, if requested.

Appraisal Arrangements

It is important that all staff, no matter where they sit in our organisation, are, from time to time, appraised in regard to their contribution to the company and in their skills, knowledge, and competency (specific to their role).

Code of Conduct

Every specified post will receive a copy of the code of conduct. As a provider of health and social care, the code is based on the five domains identified by the CQC. It is important to stress that the code is *in addition to* any professional codes of conduct issued by professional bodies such as the following:

- Nursing and Midwifery Council (NMC)
- Health and Care Professions Council (HCPC)
- Institute of Directors (IoD).

The code sets out the organisation's ethos and philosophy in delivering its services, reminding and affirming the objectives of the business in relation to our service-users.

Identified Specified Posts

At present, this is the post holders list to which this policy applies whenever a vacancy arises. Prior to 1 December 2014, appointees were recruited before these regulations were in place. Regulation 5 states that people who have "director level responsibility" for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role:

Post Holder List*

Chief Executive	Compliance Manager
Managing Director	Internal Auditor
Director	Registered Manager
Lay Director	Deputy Manager
Quality Assurance Manager	

**This list is not exhaustive, it merely serves as an illustration of various posts which could be considered for the list.*

Related Policies

Good Governance	Recruitment and Selection
Staffing	Duty of Candour

This policy will be reviewed by the Registered Manager

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

CODE OF CONDUCT (All Specified Posts)

As part of your responsibilities and duties this Code of Conduct sets out the importance of all specified post holders adhering to the principles set out below; The commitment to the domains, linked to the inspection regime and the importance of the inspection ratings to the quality of service provided cannot be overstated.

As a minimum, a rating of “Good” is the benchmark for the organisation.

The Domains: Are Services:

Safe

Effective

Caring

Responsive

Well-led

All staff must understand their responsibilities and duties in respect of these domains. Nowhere is this more important than at the strategic level of the business.

All specified post holders have specific duties under Regulation 5 which this Code acknowledges and reinforces.

The domain of Well-led is the responsibility of everyone to whom this Code applies. Unless the organisation is Well-led the domains of Safe, Effective, Caring and Responsive are unlikely to meet the benchmark.

All references to the masculine gender include the feminine.

A specified post shall:

- Exercise leadership in respect of their individual and collective responsibility that contributes to the smooth running of the board and senior management team.
- Be diligent in exercising and discharging his duties to the organisation and must acquire a broad knowledge of the business activity including the regulatory framework of the Care Quality Commission.
- Endeavour to attend all board or senior management meetings.
- Contribute to the board, establishing its vision, mission and ethos of the company, setting strategy and delegating appropriately;
- Insist that the board or senior management team maintains access between auditors, internal and external that is open and unimpeded.
- Comply with relevant legislation, regulations codes of practice which includes those relating to the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.
- At all times, have a duty to respect honesty, openness and truth to promote trust in the exercise of all his responsibilities.
- Be prepared, when necessary, to express disagreement with colleagues, including the chairman, chief executive, or managing director.
- Set high personal standards by being aware of and promoting this Code, both in spirit and in the letter; of its intent. Personal adherence to the generally accepted principles of integrity, honesty, professionalism and justice should determine behaviour, including his non-business life.

Although some aspects of this Code may appear to apply specifically to commercial companies, its principles are fundamental to all organisation types and thus to all entities, whether they are or, or not for, profit.

FOOD HYGIENE

Constantia Care Ltd

Policy Statement

Constantia Care believes that, where care provided to Clients includes help with the cooking, storing, preparing or serving food, then the organisation has a duty to ensure that all Clients are protected from food-related illness through the adoption of high standards of food hygiene and preparation.

The Policy

Constantia Care believes that the effective management of food safety relies heavily on having effective operational policies for the safe preparation, storage and handling of food.

Therefore, this organisation operates the following procedures:

- All food should be prepared, cooked, stored and presented in accordance with the high standards required by the *Food Safety Act 1990* and the *Food Hygiene (England) Regulations 2006*.
- In all cases where food is to be prepared in a Client's home, a preliminary risk assessment of the available food preparation and storage facilities should be carried out. Where a home requires improvements or changes these should be discussed with the Client or their family prior to food preparation taking place. Where conditions are assessed as unacceptable alternative methods of food provision should be sought.
- Staff should keep all food preparation areas, storage areas and serving areas clean while they are using them. All tools and equipment such as knives, utensils and chopping boards must also be cleaned regularly during the cooking process.
- Adequate sanitary and hand-washing facilities should be available within the kitchen, including a supply of soap and paper towels for hand drying. All staff MUST wash their hands before and after handling foodstuffs. All foodstuffs should also be washed before use.
- Everyone in a food handling area must maintain a high level of personal cleanliness and food handlers must wear suitable, clean and where appropriate protective clothing.
- Staff preparing food should take all reasonable, practical steps to avoid the risk of contamination of food or ingredients.
- Food storage areas should protect food against external sources of contamination such as pests.
- Food handlers must receive adequate supervision, instruction and training in food hygiene.
- When serving food, appropriate hygiene standards should be scrupulously observed by all staff.
- Suspected outbreaks of food-related illness should be reported immediately to the Client's GP.
- Any member of staff who becomes ill whilst handling food should stop work at once and report to their line manager/supervisor; such staff should see their GP and should only return to work when their GP states that they are safe to do so.

In addition staff should:

- Always wash their hands after visiting the lavatory
- Ensure that all food stored in the refrigerator is covered and adequately chilled
- Ensure the thorough cooking and re-heating of all meat, especially poultry
- Ensure that deep frozen food is thawed before cooking (especially important when using a microwave oven)

- Be aware of the risk of Salmonella infection associated with foods containing uncooked eggs such as mayonnaise and certain puddings
- Wash hands after handling raw meat or eggs, particularly before handling other foods
- Never re-use utensils with which raw eggs or meat have been prepared without first washing them with hot water and detergent
- Never allow juices from raw meat to come into contact with other foods (cooked food and uncooked food should not be stored together)
- Avoid serving raw eggs (or uncooked foods made from them) to vulnerable people such as the elderly and the sick (all eggs should be cooked until they are hard — both yoke and white).

Allergens

From December 13th 2014 new Regulations regarding food allergens are introduced and information regarding the 14 allergens identified below must be declared by businesses which provide food pre-packed, loose, or prepared in a restaurant or canteen etc.

The allergens are:

- Cereals containing gluten (wheat, spelt, barley, rye and oats.)
- Crustaceans such as prawns, crabs, lobster, every fish and langoustines etc.
- Eggs
- Fish
- Peanuts
- Soybeans
- Milk
- Nuts namely almonds, hazelnuts, walnuts, pecan, brazil, pistachio, cashew, macadamia or Queensland nut
- Celery
- Mustard
- Sesame
- Sulphur dioxide or sulphites (where added and is < 10 mg/kg in the finished product. Often found in dried fruit and wine)
- Lupin
- Molluscs such as clams, scallops, squid, mussels, oysters and snails

Whilst this may not be relevant within domiciliary, it is important that these allergens are part of the assessment of need process and incorporated into care plans as an identified risk. The care plan will then detail how any identified allergens risks will be mitigated and managed by the provider.

Related Policies

Accident and Incident Reporting (RIDDOR)

Health and Safety

Infection Control

Protective clothing and Equipment

Training Statement

All staff involved in the provision of food to Clients should be appropriately trained and assessed to ensure that their catering skills and infection-control techniques are of an acceptable standard.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

FREEDOM OF INFORMATION

Constantia Care Ltd.

Policy Statement

The Freedom of Information Act 2000 provides access to information held by public authorities and is different to the Data Protection Act 1998 which is concerned with personal data held by all companies registered to hold such Data.

Public Authorities

These include government departments, local authorities, unitary authorities, the NHS, state education sector, police forces etc. It does not however cover every organisation that receives public funding e.g., charities, or certain private sector organisations that perform public functions.

Definition of “Information”

The Act covers any recorded information that is held by a Public Authority in England, Wales and Northern Ireland.

Recorded information includes:-

Printed documents

Computer files

Letters

Emails

Photographs

Sound or/and Video recordings.

The Act ensures information is available in two ways.

Public authorities are obliged to publish certain information about their activities, and

Members of the public are entitled to request information from public authorities.

Principles

“Openness is fundamental to the political health of a modern state. The white paper marks a watershed in the relationship between the government and people of the United Kingdom. At last there is a government ready to trust the people with a legal right to information.”

“Unnecessary secrecy in Government leads to arrogance in governance and defective decision making.”

YOUR RIGHT TO KNOW 1997

The main principle behind Freedom of Information is that, quite simply, people have a right to know about the activities of public authorities, unless there is a good reason for them not to. This is sometimes described as a presumption or assumption in favour of disclosure. This means that:-

Everybody has a right to access official information Disclosure should be the default-in other words information should be kept private only when there is a good reason and it is permitted by the Act.

An applicant (requestor) does not need to give a reason for wanting the information on the contrary, public authorities must justify the refusal.

They must treat all requests equally, except under some circumstances relating to vexatious requests and personal data. The information someone can obtain under the Act should not be affected by who they are. All requestors should be treated equally whether they are journalists, local residents, public authority employees, or foreign researchers and because they should treat all requestors equally, they should only disclose information under the Act if they would

disclose it to anyone else who asked. In other words you should consider any information released under the Act as being released to the world at large.

Schedule 1 of the Act contains a list of public bodies that are covered by the Act.

Section 5 of the Act gives the Secretary of State the power to designate further bodies as public authorities.

With effect from 1st September 2013 public authorities now include companies wholly owned:-

By the Crown

By the wider public sector or

By both the Crown and the wider public sector.

Who can make a request?

Anyone can make a freedom of information request you do not have to be a U.K Service User or a U.K citizen. They can be made by organisations e.g. newspaper, campaign group or company.

Requestors should direct their request for information to the public authority they think they will hold the information.

When appropriate, Constantia Care will assist individuals to access freedom of information requests by signposting to sources of advice such as Citizens Advice Bureau etc.

Related Policies

Corporate Social Responsibility

Good Governance

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

GIFTS AND LEGACIES POLICY

OUTCOME 14, REGULATION 23 (Supporting Workers)

Constantia Care Ltd.

Policy Statement

Constantia Care Ltd. believes that its service users have a right to expect that Constantia Care will be run on an honest and sound financial basis with robust procedures for dealing with and protecting the financial interests of service users. Constantia Care fully complies with Outcome 14, Regulation 23 of the Care Quality Commission Guidance about compliance, Essential standards of Quality and Safety, which relates to the degree to which service users' financial interests are handled and safeguarded.

Aim of the Policy

This policy is intended to set out the values, principles and policies underpinning Constantia Care Ltd's approach to the giving of gifts to organisation staff by service users or their relatives. It also aims to set out Constantia Care's policy on legacies. With the Bribery Act currently before Parliament, further clarification will be added to this policy will the impact of the new Act warrant such adjustments. It is due for introduction on July 1st 2011.

Policy on Gifts and Legacies

It is not uncommon for service users who have developed sometimes long and close relationships to individual staff to offer gifts or gratuities or to seek to include a member of staff in their will. However, such activities can lead to accusations of coercion, exploitation and fraud. It is vitally important to Constantia Care that its staff at all times uphold the highest standards of Constantia Care and always act in an honest manner with the best interests of service users in mind.

Therefore, in Constantia Care Ltd:

1. Personal gifts will never be accepted by a member of staff if the value of the gift is estimated to be more than £10
2. Organisation staff will never, under any circumstances, accept valuables belonging to a service user or monetary gifts
3. Any gift given to a member of staff must be declared as soon as is reasonably practicable and details recorded in the Gifts Record in the central office; this must include the date that the gift was given and its monetary value and it must be signed by the recipient
4. Organisation staff will never become involved with the making of service users' wills or with soliciting any form of bequest or legacy from a service user, they will never agree to act as a witness or executor of a service user's will nor become involved in any way with any other legal document — if a service user does need help with making a will or requests help from organisation staff then the service user will be referred to an impartial or independent source of legal advice, such as the local citizens advice bureau or local law society which will hold lists of local solicitors
5. Failure to declare a gift, the accepting of a gift in excess of £10.00, the involvement in a will or attempting to solicit money or items through a service user's will or legacy will be considered a disciplinary offence.
6. This policy is cross referenced and linked to the policy on Bribery. Please refer as appropriate.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

HEALTH AND SAFETY POLICY

OUTCOME 10, REGULATION 15 (Safety and Suitability of Premises)

Constantia Care Ltd.

Policy Statement

Constantia Care is engaged in the provision of quality care and support to individuals and recognises its responsibility to ensure that all reasonable precautions are taken to provide and maintain working conditions that are safe, healthy and compliant with all statutory requirements and codes of practice.

Constantia Care adheres fully to Outcome 10, Regulation 15 of the Care Quality Commission Guidance about compliance, Essential standards of Quality and Safety, which relates to the degree to which staff and clients are protected by Constantia Care Ltd's policies and procedures.

Legal Requirements

The legal requirement to have a health and safety policy is a direct obligation arising from the Health and Safety at Work Act 1974 et al. It requires that every employer with five or more employees must prepare and revise as often as necessary a written health and safety policy for the workplace and must explain the arrangements for putting that policy into force.

This policy and any revision must be brought to the notice of employees. The failure to have a written health and safety policy can result in the issue of an improvement notice ordering the matter to be attended to within a fixed period. Non-compliance can result in prosecution and a fine.

Aim of the Policy

This policy is intended to set out the values, principles and policies underpinning Constantia Care Ltd's approach to safe working practices.

Health and Safety at Work Policy

Constantia Care is committed to ensuring the health, safety and welfare of its staff, so far as is reasonably practicable, and of all other persons who may be affected by our activities including visitors, contractors, clients and their relatives. Constantia Care will take the following steps to ensure that its statutory duties are met at all times.

1. Each employee will be given such information, instruction and training as is necessary to enable the safe performance of work activities.
2. All processes and systems of work will be designed to take account of health and safety and will be properly supervised at all times.
3. Adequate facilities and arrangements will be maintained to enable employees to raise issues of health and safety.
4. Competent persons will be appointed to assist in meeting statutory duties including, where appropriate, specialists from outside Constantia Care Ltd.
5. This document will be regularly monitored to ensure that its objectives are achieved. It will be reviewed and, if necessary, revised in the light of legislative or organisational changes.

Duties on Constantia Care Ltd

Constantia Care recognises its responsibility under the Health and Safety at Work, etc Act 1974 and the Management of Health and Safety at Work Regulations 1999 (MHSWR) to ensure that all reasonable precautions are taken to provide and maintain working conditions which are safe, healthy and compliant with all statutory requirements and codes of practice. Employees, clients, contractors and visitors are expected to abide by safety rules and to have regard to the safety of others at Constantia Care.

Constantia Care policy will be, so far as is reasonably practicable, to apply the following:

1. Make a suitable and sufficient risk assessment of all work activities and of every client's home before a member of staff is allocated to that home
2. Negotiate appropriate risk management measures to reduce any identified risks or hazards to an acceptable level
3. Communicate agreed risk management measures to all necessary persons and staff involved and to ensure regular monitoring of risk levels
4. Provide and maintain equipment such that it is safe and appropriate to use
5. Provide any relevant and appropriate protective equipment or clothing required by staff to perform their role safely
6. Arrange for the safe and healthy use, handling, storage and transport of articles and substances
7. Provide the information, instruction, training and supervision required to ensure the health and safety, at work, of employees and others
8. Control and maintain Constantia Care offices in a safe condition, with appropriate risk assessments and management as above
9. Provide a safe means of access to and exit from the place of work
10. Maintain a working environment that is safe, healthy and equipped with adequate facilities and arrangements for welfare at work
11. Conduct, record and implement the findings from regular risk assessments performed in accordance with Regulation 3 of the *Management of Health and Safety at Work Regulations 1999*
12. In the event of any accident or incident (such as a near miss) involving injury to anybody to make a full investigation and to comply with statutory requirements relating to the reporting of such incidents
13. Appoint a Health and Safety Manager.

The Health and Safety Manager for Constantia Care is Emma Coulstock

Duties on employees

The successful implementation of this policy requires total commitment from all employees. Each individual has a legal obligation to take reasonable care for their own health and safety, and for the safety of other people who may be affected by their acts or omissions.

It is the policy of Constantia Care that, under s.7 of the *Health and Safety at Work, etc Act 1974*, it is the duty of every employee at work:

1. To take reasonable care of their own health and safety and those of any other person who may be affected by their acts or omissions at work
2. As regards any duty or requirement imposed on their employer by or under any of the relevant statutory provisions, to co-operate with the employer, so far as is necessary, to enable that duty or requirement to be complied with.

In addition, no person employed by Constantia Care shall intentionally or recklessly interfere with or misuse anything provided in the interests of health, safety and welfare in pursuance of any statutory provisions. Failure to abide by this policy will be considered a disciplinary offence.

Training

All new staff will be encouraged to read the policy on health and safety as part of their induction process. In addition, all staff will be appropriately trained to perform their duties safely and competently and those carers who need to use specialist equipment will be fully trained.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

HOT WATER AND SURFACES

Constantia Care Ltd.

Policy Statement

In the interests of health, safety and the wellbeing of Clients and staff hot water and hot surfaces are appropriately monitored to avoid injury or in the worst case scenario, a fatality.

Constantia Care provides care for Clients in their own home who may be exposed to risk from hot water or hot surfaces. Those at risk include people with reduced mental capacity or temperature sensitivity, and people who cannot react appropriately, or quickly enough to prevent injury.

The Policy

Appropriate assessment of potential scalding and burning risks in the context of the vulnerability of those receiving care and general assessment of the premises should identify what controls are necessary overall, and how the systems should be managed and maintained. This is then supplemented by the inclusion of hot water and hot surface considerations in Clients care assessments. The assessment will detail any specific controls that are necessary to protect them. These controls can only be put into place however with the Client or relevant person's consent.

Assessment

The results of the general risk assessment should be taken into account when completing an individual's care assessment. An individual's assessment needs to consider whether:

- The person is likely to try to run a bath or shower or add water when unattended. This is a particular issue for people whose mental capacity is impaired;
- The person's lack of mobility means they are unable to respond safely to hot water or surfaces (e.g. safety get in/out of the bath or shower, or move away from a radiator);
- The person's sensitivity to temperature is impaired;
- The person's mental state means they cannot recognise or react to hot water or a surface that is too hot;
- The person can summon assistance;
- Any lifting or other aids limit mobility in the bath or elsewhere;
- Any furniture, fixtures and fittings restrict movement away from the source of heat.

The assessment and care package agreement should also consider what adaptive aids may be necessary for safe bathing. This might include the fitting of thermostatic mixing valves⁸, or fitting a shower thermometer between the shower head and supply hose. These should be agreed with the Client or their representative, following suitable advice from an occupational therapist or similar professional where necessary

Funding for adaptive aids may be available through the local authority. The supply of adaptive aids would not normally form part of a domiciliary care contract.

HSE Information Sheet HSIS6 makes clear however that, where social care is provided in a private, domestic household, "the requirement to fit devices (e.g. thermostatic mixer valves or radiator covers) would not necessarily apply."

As Homecare providers we need to be alert to the risks of using showers which are not fitted with a thermostatic mixing valve (TMV) limiting temperature to 41°C and have the responsibility to suggest to Clients, family carers and local authority commissioners that these should be fitted.

"A council was fined by the Health and Safety Executive in 2012 for not having a TMV fitted on a shower at a respite care facility, leading to a Client who was showering unaccompanied being scalded. The HSE inspector stressed it was essential that adequate control measures are in place when there was a risk of scalding for vulnerable people". Although as homecare

providers we are not in control of premises, we have a vital role in identifying risks and alerting others to the need for suitable control measures.

Hot water

If hot water used for showering or bathing is above 44°C there is increased injury or fatality. Where large areas of the body are exposed to high temperatures, scalds can be very serious and have led to fatalities.

Where electric showers are fitted, these should be designed so that water cannot be delivered at a temperature that may cause scalding. Domestic electric showers are likely to have temperature regulation features but water temperatures above 44 °C may still occur if there are fluctuations in flow or pressure.

If this is the case, and people are at risk, additional, measures will be required. This may include installing “healthcare standard” shower which are designed to prevent unsafe hot water temperatures under all conditions. NHS standards require these to be fitted in healthcare settings.

This should all be discussed with the Client, family and commissioners at assessment.

Hot surfaces

Contact with surfaces above 43 °C can lead to serious injury. Prolonged contact often occurs because people have fallen and are unable to move, or are trapped by furniture. Incidents often occur in areas where there are low levels of supervision, for example bedrooms, bathrooms and some communal areas.

Control Measures Hot surfaces

Many radiators and associated pipework re likely to operate at temperatures which may present a burn risk. Where assessment identifies that vulnerable people may come into prolonged contact, such equipment should be designed or covered so that the maximum accessible surface temperature does not exceed 43 °C.

The risk of burns from hot surfaces may be reduced by:

- Providing low surface temperature heat emitters
- Locating sources of heat out of reach
- Guarding the heated areas (e.g. providing radiator covers, covering exposed pipework)
- Reducing the flow temperatures, although this should not reduce their effectiveness or increase risk from legionella.

Again these options should be discussed with the Client, family or commissioners.

Maintenance and monitoring

- The client, family or those responsible for installation should adequately maintained any temperature controls.
- Staff are instructed to report any obvious defects immediately to the client and the office
- Where identified in the care plan prior to whole-body immersion staff carry out testing of outlet temperatures using a thermometer to provide additional reassurance. (Maximum 44°C for a bath using a non- glass thermometer). This is recorded in the clients care plan
- Where identified in the care plan, prior to a shower staff carry out testing of outlet temperatures using an integral or a scoop thermometer (Maximum 41°C for a shower). This is recorded in the client care plan

Related policies

Accident and Incident Reporting (RIDDOR)

Adult Safeguarding

Health and Safety

Risk Assessments

Training Statement

Adequate training and supervision is provided to ensure that staff are aware of the dangers of hot water and surfaces, understand risk and precautions and complete temperature records as required.

This policy will be reviewed by the registered manager

Signature: *Morag Collier*

Date: 30/01/18

Review date: 30/06/18

INFECTION CONTROL

Constantia Care Ltd

Policy Statement

Infection control is the name given to a wide range of policies, procedures and techniques intended to prevent the spread of infectious diseases amongst carers and clients. All of the carers working at Constantia Care are at risk of infection or of spreading infection, especially if their role brings them into contact with blood or bodily fluids like urine, faeces, vomit or sputum. Such substances may well contain pathogens that can be spread if carers, care co-ordinators and management visiting clients homes do not take adequate precautions.

Constantia Care believes that adherence to strict guidelines on infection control is of paramount importance in ensuring the safety of both Clients and Carers. It also believes that good, basic hygiene is the most powerful weapon against infection, particularly with respect to hand washing.

Note:

Under the *Health and Social Care Act 2008*, [Regulations 2014], Reg.12 Safe Care and Treatment, all Managers are required to comply with the "Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance, which was updated in July 2015".

The Code of Practice on the prevention and control of infections applies to registered providers of all Health and Social Care in England. The Code of Practice sets out 10 criteria against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with the infection prevention requirement which is set out in the regulations.

As an organisation we have read and considered this document and its application throughout our service.

Although the Code is not mandatory, as an organisation we will use the Code for guidance in meeting our regulatory requirements

The Policy

The aim of Constantia Care is to prevent the spread of infection amongst carers, service users and the local community.

Goals

The goals of the organisation are to ensure that:

- Clients, their families and carers are as safe as possible from acquiring infections through work-based activities
- All carers at the organisation are aware of, and put into practice, basic principles of infection control.

The organisation will adhere to infection control legislation:

- The *Health and Safety at Work Act etc. 1974* (HSWA 1974) and the *Public Health Infectious Diseases Regulations 1988*, which place a duty on the organisation to prevent the spread of infection
- The *Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 1995* (RIDDOR), which place a duty on the organisation to report outbreaks of certain diseases as well as accidents such as needle-stick accidents
- The *Control of Substances Hazardous to Health Regulations 2002* (COSHH), which place a duty on the organisation to ensure that potentially infectious materials within the organisation are identified as hazards and dealt with accordingly

- The *Environmental Protection Act 1990*, which makes it the responsibility of the organisation to dispose of clinical waste safely
- The *Food Safety Act 1990*
- The *Health and Social Care Act 2008*, and the accompanying Code of Practice “Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance, July 2015”

Code of Practice

Criterion 1

- There is a clear governance structure and accountability that identifies our Infection Prevention Control lead and whom they are required to report to **Sinead Brooks**.
- As an organisation we will ensure there are adequate resources in place to secure the effective prevention of infection.
- Risk assessments have been carried out which support us in the decisions about what parts of the 10 criterion apply to our service
- This organisation will produce the evidence to support any decisions made in infection prevention and control and this will include; implementation of an infection control and cleanliness programme, the infrastructure in place to support this programme and the monitoring and reporting of infections
- All carers will receive suitable, sufficient information, supervision and training required to prevent the risks of infection and when and how to access outside infection control expertise.
- All carers are required to make infection control a key priority and to act at all times in a way that is compatible with safe, modern and effective infection control practice
- Any carers member who does not feel that they have access to sufficient facilities and supplies of appropriate equipment, in order that they can implement effective infection control procedures and techniques, have a duty to inform their line manager or supervisor.
- Key policies are in place, processes in place to ensure they are being followed and regularly updated

Risk Assessments

- At the commencement of care or support, risk assessments are carried out on individual clients in relation to the prevention of infection
- When risks are identified, steps are put in place to control these risks.
- The identified risks and actions required to be taken to reduce these risks are recorded in the client’s care or support plan
- These actions are monitored and any further steps required are implemented.
- Where necessary, outside professionals are involved in the implementation of infection control precautions.

The Infection Prevention Control Lead should:

- be responsible for the organisation’s infection prevention cleanliness, and water safety programme.
- The above programme should have set priorities and objectives to meet the needs of the organisation in ensuring the safety of the clients, social care workers and the public
- oversee the implementation of organisational policies
- report directly to the registered manager
- challenge inappropriate practice including antimicrobial prescribing practice
- set and challenge standards of cleanliness
- be an integral part of the organisations’ governance on infection prevention and control
- produce an annual statement in regard to compliance and practice and make it available on request
- the annual report will include the progress against the objectives set in the infection control and cleanliness programme
- The IPC lead has 24 hour access to specialist infection control expertise

Monitoring and Audit

- an audit programme is in place to ensure appropriate policies have been developed and implemented
- The annual statement is reviewed and where indicated, acted upon
- Antimicrobial prescribing decisions are regularly reviewed by the appropriate health professional

Co-operating with other providers

As an organisation we recognise the importance of sharing relevant information with other providers, this will include any relevant infection prevention and control issues when a client;

- moves to or from a care or health setting
- goes into hospital
- is transported by ambulance
- attends a hospital or other health outpatients department

Carers are trained and aware of the need to send information when a client is being moved along with the need of confidentiality and data protection responsibilities as laid out in our corresponding policies.

Criterion 5

Carers are trained and regularly updated to recognise the signs of an infection. Prompt recognition enables the GP to diagnose and treat quickly and any isolation procedures being put in place to reduce cross infection. The GP and our carers will draw on professional expertise on infection prevention and health protection.

Criterion 6

- As an organisation we ensure that everyone working in the care setting, including agency carers, volunteers and contractors understand and comply with the requirements of preventing and controlling infection.
- All workers including volunteers have infection control responsibilities in their job description
- Infection prevention and control is part of induction and training is received annually or whenever a situation changes in relation to infection control or further information is required.
- If carers are required to develop skills for invasive techniques or aseptic techniques specialised training is given by a health professional and this includes further infection control and prevention knowledge.
- Regular carers competency observations are in place to monitor working practice in all areas of infection prevention and control

Criterion 7

When carers are working with a client in their own home all basic infection control precautions are taken to prevent any infection being transferred to other clients. If the client requires specialised support in relation to infection control then advice would be taken from the local Health Protection Agency and any further precautions would be put in place with the involvement of the client.

Criterion 8

This criterion does not apply to Adult Social Care.

Criterion 9

Risk assessments and the guidance given in the Code of Practice will assist registered providers decide which policy areas might apply to them.

The Use of Protective Clothing

- Adequate and suitable personal protective equipment and clothing should be provided by the organisation.

- All carers should who are at risk of coming into direct contact with body fluids, or who are performing personal care tasks, should use disposable gloves and disposable aprons.
- Sterile gloves are provided for clinical procedures such as applying dressings. These should be worn at all times during client contact and should be changed between clients. On no account should carers attempt to wash and reuse these gloves.
- Non-sterile gloves are provided for non-clinical procedures.
- The responsibility for ordering and ensuring that supplies of gloves and aprons are readily available and accessible lies with the Administrator.
- Any member of carers who suspects that they or a client might be suffering from an allergic reaction to the latex gloves provided should stop using them immediately and inform their line manager. They should then consult their GP.

Aseptic Technique.

- If carers are required to have these skills for an individual client then they are trained by a health professional.

Outbreaks of Communicable Diseases.

Carers are trained to recognise the signs of infections and to understand what actions they are required to take.

In the event of the suspected outbreak of an infectious disease at the organisation, advice on outbreaks can be sought from health protection nurses at Public Health England. If there is an outbreak or suspected outbreak of infection, it should be reported to Public Health England (PHE) for collation. PHE are responsible for advising on outbreak control and monitoring the outbreak.

If it is a suspected food related outbreak advice can be sought from Environmental Health Departments

The Disposal of Sharps (e.g. Used Needles)

Following NICE Clinical guideline [CG139] Healthcare-associated infections: prevention and control in primary and community care Published date: March 2012 Last updated: February 2017 (**1.1.4 Safe use and disposal of sharps**)

- sharps should not be passed from hand to hand and handling should be kept to a minimum
- sharps should be discarded immediately after use by the person generating the sharps waste
- used standard needles should never be bent, broken or recapped before disposal
- sharps—typically needles or blades—should be disposed of in proper, purpose-built sharps disposal containers complying with BS7320.
- sharps should never be disposed of in ordinary or clinical waste bags.
- sharps boxes should be in a safe position to avoid spillages, at a height that allows the safe disposal of sharps, away from public access and is out of the reach of children.
- boxes should be temporarily closed when not in use
- boxes should never be filled above the fill line
- boxes must not be used for any other purpose other than the disposal of sharps
- when full, boxes should be sealed, marked as hazardous waste and clearly labelled with the client's details.
- carers should never attempt to force sharps wastes into an over-filled box.
- used, filled boxes should be sealed and stored securely until collected for incineration according to individual arrangements.
- sharp boxes should be disposed of every 3 months even if not full, by the licensed route in accordance with local policy
- sharp safety devices should be used if a risk assessment has indicated that they will provide safer systems of working for carers or clients
- all carers must be trained and assessed in the correct use and disposal of sharps and sharps safety devices

In the event of an injury with a potentially contaminated needle carers should:

- Wash the area immediately and encourage bleeding if the skin is broken
- Report the injury to their line manager immediately and ensure that an incident form is filled in
- Make an urgent appointment to see a GP or, if none is available, Accident and Emergency.

Cleaning and Procedures for the Cleaning of Spillages

- Carers should consider every spillage of body fluids or body waste as potentially infectious and treat as quickly as possible.
- When cleaning up a spillage carers should wear disposable protective gloves and aprons and use the disposable wipes provided wherever possible.

The Handling and Disposal of Clinical and Soiled Waste

- A risk assessment has been carried out assessing risk and measures are in place to manage the risk and the monitoring and auditing of work arrangements.
- A waste management policy is in place which is monitored and audited.
- All clinical waste should be disposed of in sealed yellow plastic sacks and each sack should be clearly labelled where available or follow individual care plan waste disposal procedures.
- Non-clinical waste should be disposed of in normal black plastic bag, following individual care plan procedures.
- When no more than three-quarters full, yellow sacks should be sealed and stored safely to await collection by an authorised collector as arranged.(where applicable0
- Carers should alert the organisation office if they are running out of yellow sacks, disposable wipes or any protective equipment
-

The Handling and Storage of Specimens

- Specimens should only be collected if ordered by a GP.
- All specimens should be treated with equally high levels of caution.
- Specimens should be labelled clearly and packed into self-sealing bags before being taken to the doctors.
- Non-sterile disposable gloves should be worn when handling the specimen containers and hands should be washed afterwards.

Food Hygiene

- All carers should adhere to the organisation's Food Hygiene Policy and ensure that all food prepared for clients is prepared, cooked, stored and presented in accordance with the high standards required by the *Food Safety Act 1990* and the *Food Hygiene (England) Regulations 2005*.
- Any member of carers who becomes ill while handling food should report at once to their line manager or supervisor, or to the organisation office.
- Carers involved in food handling who are ill should see their GP and should only return to work when their GP states that they are safe to do so.

Reporting

The *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995* (RIDDOR) oblige the organisation to report the outbreak of notifiable diseases to the Local Environmental Health Officer, who will inform the Health and Safety Executive (HSE). Notifiable diseases include: cholera, food poisoning, smallpox, typhus, dysentery, measles, meningitis, mumps, rabies, rubella, tetanus, typhoid fever, viral haemorrhagic fever, hepatitis, whooping cough, leptospirosis, tuberculosis and yellow fever.

Records of any such outbreak, specifying dates and times, must be retained, and a completed disease report form sent to the HSE.

In the event of an incident, the Registered Manager is responsible for informing the HSE.

RIDDOR information is found on the HSE website and reports should be made using an online form.

Notifications must be sent to CQC as required in Regulation 20 "Duty of Candour"

Dress Code

This organisation has a dress code policy in place which ensures clothing worn by carers when carrying out their duties is clean and fit for purpose.

Immunisation of clients

- A record is kept by the registered managers of all immunisations given to clients
- This record is regularly reviewed in line with guidance from Public Health England.
- We liaise closely with the clients GP surgery or district nurse and offer all clients immunisation as required according to national schedule.

Criterion 10

Constantia care will access the appropriate Health Service in each of the areas we operate.

Related Policies

Accidents Incidents and Emergencies Reporting (RIDDOR)
Contingency and Emergency Planning
Co-operating with Other Providers
Confidentiality
Data Protection
Death of a Client
Dress Code
Food Hygiene
Good Governance
MRSA
Notifications
Prevention of Pressure Sores
Protective Clothing and Equipment
Vaccinations

Guidance

NICE guidelines (CG139) on Infection: Prevention and control of healthcare-associated infections in primary and community care

Infection prevention and control NICE quality standard QS61 published April 2014
<https://www.nice.org.uk/guidance/cg139>

Royal College of Nursing - Essential practice for infection prevention and control www.rcn.org.uk/professional-development/publications/pub-005940

Training Statement

All new carers should be encouraged to read the policy on infection control as part of their induction process. Existing carers should be offered training covering basic information about infection control. In-house training sessions should be conducted at least annually and all relevant carers should attend.

Training will cover all areas required by the Code of Practice for the prevention and control of infection and related guidance especially the areas listed in Criterion 10 of this Code.

The Registered Manager is responsible for organising and co-ordinating training.

This policy will be reviewed by the registered manager.

Signed: *M Collier*

Date: 20/02/18

Review Date: 20/08/18

JOB DESCRIPTIONS AND PERSON SPECIFICATION POLICY

OUTCOME 12, REGULATION 21 (Requirements relating to Workers)

Constantia Care Ltd.

Policy Statement

Constantia Care believes that an accurate job description and person specification is an essential requirement for every post and for all recruitment purposes. Constantia Care believes that the more accurate that job descriptions and person specifications are, the fairer recruitment will be with all candidates being clear prior to interview as to exactly what is required for the job.

Job Description Policy

In Constantia Care a job description is understood to be a written document detailing the main duties and responsibilities of a post, describing a role and what is required to do the job. They will always be written with the job in mind and will not be written to describe any existing individual member of staff or how they do their job.

Accurate job descriptions act as:

- A tool in recruitment — to assist in the writing of job advertisements
- A tool in selection — to help make decisions about who to employ
- A basis of employment contracts — making it clear what is required of a member of staff
- Part of the organisation's defence in cases of discrimination or unfair dismissal
- A means by which the organisation's expectations, priorities and values are communicated to new members of staff.

Person Specification Policy

In Constantia Care a person specification is understood to be a written document which states the knowledge, skills and experience that a post holder would be expected to have in order to competently undertake the duties and responsibilities outlined in the job description. It is used for recruitment purposes.

Creating and Updating Job Descriptions and Person Specifications

A job description will exist for every role within the organisation and a new job description will be constructed for every new role developed within the organisation. An existing job description will be reviewed whenever a post becomes vacant, or after an appraisal.

Job descriptions will always be clear and concise and contain the following sections:

- Job title
- Hours of work
- Disclosure and Barring Service clearance level required
- Organisational arrangements (i.e. the job title of the person the employee would be accountable to managerially, etc)
- Job purpose (i.e. a summary of the overall purpose of the job)
- Main duties and responsibilities (this section will include a list of the main activities or tasks carried out by the jobholder, phrased wherever possible in terms of what the job holder is expected to achieve; words such as: "plans", "prepares", "produces", "implements", "provides", "completes", "maintains", "liaises with" and "collaborates with" will be used to put tasks into context and any deadlines to work to will be included where a job task is performed under supervision, this will be clearly stated).

Person specifications will detail the qualifications, knowledge and experience that are required to fit the post. These will be listed as either “essential” to carry out the role in the case of qualities which must be attained for new candidates or as “desirable” in the case of qualities which can be used in recruitment situations where there are two equally suitable candidates.

Person specifications will contain the following sections:

- Education, training and qualifications (here the type and level of qualification will be stated, e.g. NVQ3 or 4 or Diploma (QCF) level 3 or 5 additional qualifications a post holder may have which are not needed for the duties and responsibilities of the post will not be included)
- Skills and abilities (this area will list items such as standard or advanced keyboard skills, manipulation of fine tools, etc)
- Experience (this will detail exactly what experience is required and how the experience may be gained, e.g. “three years experience in domiciliary care organisations”).

Training

All staff involved in the drawing up of job descriptions or person specifications will read this policy. All staff involved in recruitment will receive training in interviewing and the recruitment process.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

LONE WORKING POLICY **OUTCOME 14, REGULATION 23 (Supporting Workers)**

Constantia Care Ltd.

Policy Statement

Constantia Care believes that lone workers will not be at more risk than other employees.

Constantia Care understands lone workers to be those who work without close or direct supervision or company for substantial periods of time. This includes most domiciliary care staff who visit and care for clients in their own homes.

In this context Constantia Care understands its duty as an employer being to assess any risks to lone workers and take steps to avoid or control those risks where necessary.

Constantia Care recognises that staff working alone in potentially isolated conditions have no immediate back up or support and so are at a greater risk of injury through aggression or violence directed towards them from clients, relatives, carers or the general public.

Constantia Care also recognises that staff working alone need to rely on their own judgement and initiative and may be at a greater risk of making mistakes or errors.

Constantia Care Ltd. believes that training is particularly important for lone workers and research shows that adequate training is the single most critical factor in avoiding panic reactions in unusual situations. In particular lone workers need to be deemed competent to work alone, to be sufficiently experienced and to understand the risks and precautions needed fully.

Constantia Care understands its duty as an employer to ensure employees are competent to deal not only with the day to day facets of their work but with circumstances which are new, unusual or beyond the scope of their training, for example, if threatened with aggression and violence.

Constantia Care Ltd. adheres fully to Outcome 14, Regulation 23 of the Care Quality Commission Guidance about compliance, Essential standards of Quality and Safety, which relates to the degree to which staff and service users are protected by Constantia Care's policies and procedures.

Lone Workers' Supervision Policy

By definition lone workers are those who work without constant supervision throughout their working day, therefore procedures must be put in place to monitor lone workers to ensure they remain safe and to provide supervision on a regular basis. This includes supervisors periodically visiting and observing those working alone and regular contact between the lone worker and supervision by telephone.

Constantia Care believes that supervision helps to ensure that employees understand the risks associated with their work and that the necessary safety precautions are carried out. The extent of supervision required depends on the risks involved and the ability of the lone worker to identify and handle health and safety issues.

Lone Workers' Security Policy

When a member of staff visits a client in their own home he or she may be at risk through health and safety hazards in and around clients' homes and of physical or verbal assaults and hostility from clients, relatives and the general public. Recent evidence suggests that

such incidents may be on the increase and home visiting protocols will take this into account, particularly in high risk areas such as high crime rate areas.

In Constantia Care:

- The assessment of all new referrals will include a risk assessment which includes threats from health and safety hazards and from aggression and violence and other threats to lone working
- Lone workers will carry panic alarms and mobile phones so that they can summon help quickly, all phones will include an emergency number which will be attended at all times that staff are working
- Lone workers will call in at regular intervals to report that they are safe, including at the end of a shift
- Administration staff in the central office will log and keep details of all home visits as well as having access to the names, addresses and telephone numbers of clients
- Administration staff in the central office will contact the duty manager in the event of any emergency situations
- In a situation where a lone worker feels under immediate threat of their physical safety they will contact the police directly or inform the duty administrator who will contact the police for them; the administrator will be careful to take all appropriate information from the lone worker, such as location and telephone number, and to pass this on to the police, after the incident the lone worker will fill in an incident for.

It is strongly advised that staff carry in their cars the absolute minimum amount of equipment and that they always park their car in a well lit, public place if at all possible. Thefts from cars are a major area of concern and muggings of care staff are a real threat, especially in high crime areas. If on foot then care staff will avoid dark, unlit, isolated routes to work.

In cases where care is to be provided in a high crime area or to a client with a known history of aggression or violence associated with them, then a full risk assessment will be completed by the supervisor/manager. Where there is significant risk then the care plan will be altered accordingly, either by reviewing the case with the relevant case manager or by arranging for care workers to attend in pairs.

Untoward Incidents

Untoward incidents, including all incidents which involve the use or threat of aggression or violence, will be reported, recorded, regularly reviewed and audited.

Training

All staff will read this policy and be trained in personal security procedures. Security training will be included in the induction training for all new staff and in-house training sessions on security will be conducted at least annually and all relevant staff will attend.

As part of the induction process supervisors must satisfy themselves that each member of staff is competent and safe to work alone and that they are clear about how to act in ways that will maximise their own safety and about what to do in an emergency situation.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

MATERNITY POLICY

OUTCOME 14, REGULATION 23 (Supporting Workers)

Constantia Care Ltd.

Aim of the Policy

It is the policy of Constantia Care to provide maternity benefits which comply fully with the law on maternity rights. The policy applies to all female members of staff and aims to inform them of their entitlement to contractual and statutory maternity rights, and to ensure that those rights are understood. The policy was written to comply with all relevant employment law regarding maternity, including the Working Time Regulations.

Maternity Leave Entitlement

In Constantia Care the following policy applies.

1. Maternity leave for all employees is for a period of 52 weeks regardless of how long they have worked for Constantia Care.
2. An employee must, wherever possible, give notice in writing of their intended date of starting maternity leave, at least 15 weeks before the expected week of confinement. The member of staff must inform Constantia Care:
 - a) That she is pregnant
 - b) The week her baby is expected to be born
 - c) When she wants her maternity leave to start.
3. Employees must provide medical evidence of the EWC in the form of a maternity certificate (MATB1) obtained from their GP or midwife.
4. If an employee is absent with a pregnancy related illness during the six weeks prior to the expected week of confinement, maternity leave will start automatically from the date of absence.
5. If the baby is born prematurely, ie before maternity leave has started, maternity leave will commence on the day the baby was born.
6. An employee may not return to work within two weeks of giving birth. This is a requirement of health and safety legislation. Employees returning to work at the end of their maternity leave need give no prior notice of their return.
7. An employee who intends to return to work at the end of her full maternity leave entitlement is not required to give any further notification to Constantia Care. An employee wishing to return early from maternity leave will give eight weeks' advance notice in writing.
8. During the maternity leave period an employee can agree with her employer to work for up to 10 "keeping in touch" days without losing her right to statutory maternity pay or bringing the maternity leave period to an end. Employers are not, however, obliged to offer such days, nor is the employee obliged to agree to accept such work.

Payments during Maternity Leave

In Constantia Care:

1. Maternity pay (SMP) for employees is paid for 39 weeks as follows:
 - Six weeks at 90% of employee's average salary, based on last three months' pay (the Earnings Related Rate)
 - 33 weeks paid at the set Government rate (the Lower Rate SMP)
2. A MatB1 form signed by doctor or midwife giving the expected week of confinement must be given to the employer before any SMP can be paid.

Risk Assessments

In Constantia Care risk assessments of working environments will be routinely carried out in order to be able to protect the safety of mother and child for any member of staff who may become pregnant. Will her working environment or her duties pose a threat to her health and safety, her duties will be modified or alternative work of a suitable nature will be found for her. Will this not be possible she will be suspended from work on full pay on medical grounds.

Antenatal Appointments

In Constantia Care a member of staff will be entitled to time off without pay in order to attend antenatal appointments, which may include classes. The relevant authority may require her to produce an appointments card from her clinic.

Benefits during Maternity Leave

In Constantia Care during the maternity leave period (paid and unpaid) the contract of employment continues in force. All terms and conditions of employment continue with the exception of stipend or salary. Continuity of service is maintained, and any standard incremental progression which may take place during the maternity leave period (paid or unpaid) will be implemented. Employees on ordinary or additional maternity leave are entitled to all non-pay benefits provided as if they are still working, e.g. accrued holiday entitlement, private health care, Christmas bonus, etc.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

MEDIA AND PUBLIC RELATIONS

Constantia Care Ltd

Policy Statement

Constantia Care takes seriously its responsibility to convey and reflect, within the public domain, a professional response to any media-led interest in our activities. This policy sets out the key principles which govern contact with any media enquiry received by the company. We recognise that in today's fast moving digital communication world there is a significant role played by any media interest or coverage in people's perceptions and of the effect such perceptions can have on our business.

Handling a Media Enquiry

Should any member of staff be approached by local or national journalists, or, free-lance writers, they should respond with "no comment" and immediately pass the enquiry to the Registered Manager. This person is responsible for responding to the enquiry and will make a judgement about any advice which might need to be sought before the response is forthcoming.

Media Statements

These are generally a written response to articles, complaints or a regulatory visit, e.g. from the local authority or Care Quality Commission. Any media statement must be approved and signed off by a Director prior to release.

Press Releases

These are used as the main way to highlight good news stories. They can include stories on staff awards/achievements, fund raising or grant awards for specific areas of work e.g. dementia etc. Advertorials are used in much the same way. All press releases must only be compiled, edited and released by a Director; unauthorised publishing will be subject to disciplinary action.

Interview Reports

Such requests are sometimes accompanied by requests for access to film or photographs. This is usually in response to a proactive press release, or, in reaction to an unplanned story. All such requests must be approved, appropriate consent sought where required and forwarded to the Media Manager. Staff need to exercise caution if approached whilst on duty in the event of reporters posing as someone else (undercover), if they suspect this to be the case they should report it immediately to the Registered manager or Director. Any requests involving Clients are subject to the usual safeguarding controls i.e. consent, capacity to consent, family or best interest decision considerations and duly recorded.

Requests from police

These are usually received when the Police require assistance from the public to progress a criminal investigation. These need sensitive handling, particularly where a Client is a victim of the crime. The usual safeguarding controls should be actively in place and followed before any approval is given.

Confidentiality and Consent

The usual roles of sharing information must be adhered to and are particularly relevant where the situation is still ongoing e.g. complaint investigation, disciplinary action, criminal investigation and where necessary any discussions between multi-agency partners as to who is best placed to make the response. Only the authorised officer from each organisation will be permitted to discuss and agree the response. Consent, as defined within the Mental Capacity Act 2005, will be sought, recorded and signed off.

Related Policies

Confidentiality

Consent

Cyber Security

Data Protection

Good Governance

Monitoring and Accountability

Social Media and Networking

Training Statement

All post holders identified above are competent and able to fulfil media duties.

This policy will be reviewed by the registered manager

Signed: *Morag Collier*

Date 20/02/18

Review Date 20/08/18

MEDIA CONSENT FORM

I hereby give my consent to be:

Interviewed

Photographed

Filmed

Date:

Name:

OR

Signed on behalf of _____

as their legal guardian/ power of attorney.

Name

Relationship

Tel. No

Signature _____

Medication Policy & Procedures

Constantia Care Ltd

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1.0 Policy Statement

This is one of the most complex areas within the live-in care sector. Constantia Care is aware of the need for clear and practical guidance for carers involved in this area of work.

Most Clients who require care are prescribed some form of medication at some time as part of their treatment by their doctor or nurse. A few Clients are able to be responsible for their own medication, but in most instances require help from the Constantia Care carer. Constantia Care believes that any aid offered by our carers to assist a Client to take their medication or to administer medication, must be agreed with the Clients or their POA Care & Medication and recorded in their Care Plan and their Client file according to the Constantia Care Medication Policy.

Constantia Care understands that taking medication is essential for the health and well-being of the Client, but also understands that there are circumstances wherein some Clients may fail to comply with the prescribed treatments; wherein self-medicating Clients may fail to take their medication as directed; or non-self-medicating Clients may refuse prescribed medication, or fail to swallow it and then dispose of it. In such cases Constantia Care is clear that its carers have no right to force non-compliant Clients to take their medication, but they do have a duty to report cases of non-compliance to the Clients GP and to their Constantia Care Co-ordinator.

1.1 Legislative Framework

Medicine Act 1968 (and Amendments)

Misuse of Drugs Act 1971

Misuse of Drugs (Safe Custody) Regulations 1973

Access to Health Records 1990

Control of Substances Hazardous to Health (COSHH) Regulations 1999

Hazardous Waste Regulations 2005

Health and Social Care Act 2008 (Regulation 2014)

This list is not exhaustive, but highlights the complexity of this area. All medication training will be delivered by a qualified and trained member of carers or health professional. All carers will complete this course within 6 months of commencement of duties, or before if required.

It is the intention of Constantia Care to build up good community-based relationships with local pharmacies, whose advice and guidance is invaluable and appreciated.

Any reference to competence assessed training by appropriate person(s) includes the following:

- District nurse
- Nurse practitioner (NP)
- McMillan nurse
- Pharmacist
- General practitioner (GP)
- Physiotherapist
- Occupational therapist
- Clinical practice managers

1.2 Prescribing Medication

“**Prescribers**” are NHS professional who can write (prescribe) NHS prescriptions.

The process by which medicines are prescribed is determined by statute.

GP, Dentists, Physiotherapists, Chiropractors and radiographers are all “**Prescribers**” in law, and are recognised as an appropriate person.

The following are **excluded from the NHS list**: Any complimentary Health Practitioner, Medical Herbalist, Chiropractor, Osteopathic Practitioner & Health Shop Assistant.

Note: Due to the developing roles within the NHS and local Clinical Commissioning groups, there is an ever- widening range of “**Prescribers**”.

All references to **Carer** means the self-employed carer used by Constantia Care.

All references to **observations requested** means any observations requested and recorded in the Care Plan (these requests must come via a Health Professional, e.g. District nurse, GP).

The Policy

1.3 Assessment of medication needs

- Adults who are supported in their own homes by Constantia Care are often responsible, together with their relatives or representatives for their own medicines - both prescribed and non-prescribed. Some are able to fully administer their own medicines, others may require a little support enable them to continue being self – administering. This is identified through a risk assessment. **(This is called general Support)**
- With consent the carer may administer prescribed medication (including controlled drugs) to a Client, so long as this is in accordance with the prescriber’s directions (*Medicines Act 1968*). **(This is called “Administering Medication”).**
- Where medication e.g. PEG feeding is given by “Specialised Techniques,” carers will need additional specialised training. No carer will participate in any specialised technique unless they have the express permission of the manager, the process is entered in the Care Plan, the appropriate level of specialist training has been undertaken and the level of competency assessed by the health professional. This training must be carried out for each individual.
- Carers must not offer advice to a Clients regarding “over the counter” medicines or complementary treatments.

Constantia Care will, during the care assessment stage, determine the level of support required and ensure that the appropriate carer training and record keeping needs are met.

A separate Medication Care Plan will be updated and reviewed as necessary for each Client.

Where multi-agency partners are involved in a package of care, agreement needs to be reached about which provider takes lead responsibility for support with medication. This must be recorded in the Clients Care Plan.

Constantia Care believes that, as far as possible, all Clients should be enabled to manage and self-administer medications wherever possible. At the assessment of needs stage, information must be *sought* and *recorded* in order that the level of support required is properly indicated and that a risk assessment is completed.

1.4 Consent

Every Client must be presumed to have the mental capacity to consent or refuse treatment or medication, unless they are unable to do the following:

- Take in and retain information about the medication or treatment provided by carers, particularly regarding the likely consequence of refusal
- Understand the information given about the medication/treatment or condition from which they are suffering
- Weigh up the information as part of the process of arriving at a decision.

This assessment of the Client is a matter for the Care Manager / Assessor with the Client or relevant person, in conjunction with one or all of the professionals mentioned earlier in this policy. This assessment should be clearly documented, dated, signed and a review date set in the Care Plan.

General Action

- Where Clients are capable of giving or withholding consent to medication or treatment, neither should be administered without their agreement.
- Any Carer or health professional who fails to respect the views of a Client with mental capacity to consent to or refuse medication may be guilty of a criminal offence, including a breach of human rights.
- When a Client is suspected of being or assessed to be incapable of making an informed decision, it is the responsibility of the Care Manager to seek guidance and advice from the GP and put in place a best interest's decision.
- The relevant person should be involved in these best interest's discussions.
- All referrals, discussions and decisions should be clearly dated, documented, signed by the relevant people and the relevant health professionals and filed in the Clients personal file.
- It is the Care Manager's responsibility to complete the Clients risk assessment and care plan for each client.
- The method of administering medicines should be agreed with the GP and pharmacist and then documented in the Clients Care Plan; all carers should then be made aware of the process.
- When required, regular support should be offered to encourage the Client to take their medication by giving regular information, explanation and encouragement.

1.5 MAR Sheet

Constantia Care must have a record of all medicines that the client is currently taking; this must include both prescribed and bought medication.

The MAR sheet is pre-populated by the Constantia Care office and supplied to every client's home each month. This covers the number of days in that month. In the event that the new MAR sheets do not arrive on time the carer must note the medication given on the daily report in the medication section and when it does arrive write O into the missing days and write the detail of why the day(s) is not signed in the allocated box.

NOTE: Constantia Care is currently introducing the on-line Care Plan system; should this goes down for any reason the hard copy of the MAR sheet will be used. Once the computer system is up and running again O will be placed in the missing days and an explanation of where the meds have been signed for will be done in the allocated box.

MAR sheets will be collected by a Constantia Care member of staff every 6-8 weeks during a Spot Check or in the case of the new computer system checked daily on-line by the care co-ordinator.

See Appendix J for detailed MAR sheet procedure.

2.0 Supply, Storage and Disposal of Medication

The care needs assessment and the Medication Care Plan will record full pharmacy details. The pharmacy will deliver the medication; **or** the family/responsible person will collect the medication on the Clients behalf **or** the Carer will collect the medication. It will be the Care Co-ordinators responsibility to ensure these details are accurately recorded on the MAR chart. Medicines will usually be dispensed by the community pharmacist in an appropriate container or medication aid appropriately labelled with:

- The Clients name
- The name of the medicine(s)
- The dose
- The time to be administered
- Any special instructions (e.g. after food)

Where a Client is receiving medication from a blister pack or dosette box, there may be additional medication which is dispensed in bottles or boxes; for example, short courses of antibiotics, liquid medication or where the medication is not stable enough to be dispensed in an aid. The same checks apply to the labelling of these medicines and the carer must contact the office before administering such medication.

- All medicines prescribed or non-prescribed must be stored in conditions which maintain their potency and in accordance with the manufacturers advice. This should be clearly documented on the box/label.
- After use, the carer should return the remaining medication to the storage place.

2.1 Medication must by law be disposed of in a responsible and timely manner

Prescribed medicines which are not labelled as above should not be left in the Clients home, but instead be returned to the dispensing pharmacy with the consent of Clients or responsible person and recorded on the appropriate form.

The Care Plan should detail who is responsible for the disposal of prescribed medication. Where appropriate, the family should be encouraged to take responsibility. Where the carer has the responsibility, the appropriate forms should be taken to the pharmacy and signed.

Procedures

Any carer who is unsure of what to do regarding medication in any given situation should contact their Care Co-ordinator or a Constantia Care manager immediately.

2.0 Self-Administering Clients

Constantia Care understands that 'self-administering Clients' are responsible for collecting, storing and taking their own medication without any help being required from Constantia Care carers.

Constantia Care believes that every Client has the right to manage and administer their own medication if they wish to and are safe to do so.

- In cases where there is evidence that a self-medicating Client is failing to comply with their prescription, or is taking the wrong amounts of a medicine, then the case should be referred to the Clients GP as well as a Care Manager and the Care Co-ordinator.
- Any subsequent request for support from carers should be assessed before being implemented; this is to ensure that the role being requested is appropriate and can be performed safely and competently by the carers. No carer should proceed with care involving the administration of medication (tablets, liquids or creams) or support of self-medication until they have the explicit agreement of a Constantia Care manager and this has been recorded in the Care Plan and on the MAR sheet.

- All self-medicating Clients should be offered help and assistance to maintain their self-medicating status whenever possible and wherever an assessment indicates that this is possible or appropriate.

In such cases the following forms of support should be considered:

- the use of compliance aids, such as monitored dosage systems (where daily medication is set out by a pharmacist into compartmentalised containers)
- Support by carers and responsible others, such as reminders and regular checks.

3.0 Non-Self-Administering Clients

Constantia Care understands 'non-self-administering Clients' will require help from Constantia Care carers in the collecting, storing and/or taking of their medication. Such help can range from helping a Client to take their medication out of a bottle, packet or monitored dosage system to administering the correct amounts and helping the Client to take it. All such help should be entered into the Medication Care Plan and agreed by a Constantia Care manager prior to the help being given.

- Where Clients are helped with or have medication administered by carers, those carers should encourage compliance by ensuring that Clients take their medication at the time that it is given. Carers should directly observe the taking of medication and medicines should never be left to 'be taken later' unless clearly identified in the Care Plan. Carers should only sign a Clients MAR chart after the direct observation that medicines have been taken.
- Carers should always be aware of the medication being taken by Clients and should immediately report any change in condition that may be due to non-compliance to their Care Manager and Care Co-ordinator. The Care Manager or Care Co-ordinator should then discuss the case with the Clients GP and/or nurse, as well as the community pharmacist.
- A Client has the right to refuse medication and such refusal should be recorded. All such incidents should then be referred back to the prescriber, the Clients GP and/or nurse, or community pharmacist as well as the Care Co-ordinator detailing what you have done about the refusal.
- Carers may make such efforts to encourage the Client to take their medication as are reasonable and appropriate under the Medication Policy but carers have no right to force Clients to take their medication. The use of undue pressure on a Client by a carer will be recognised as abuse by Constantia Care and the basis for disciplinary action.
- Medical advice should be sought immediately if a carer believes that refusal to take medication constitutes a risk to the Client.

4.0 Non-Compliance with Medication

5.1 Refusal

If a Client refuses the prescribed medication:

- Record on the MAR chart that the Clients has refused the medication by using the correct code. Include the date, time and why the client refused the medication together with what action was taken.
- Inform the care co-ordinator or out of hours duty officer at the earliest opportunity.

5.2 Difficulty in Swallowing

If the client is unable to take the medication because of difficulties with swallowing, the Clients GP must be contacted to inform them of the problem and ask if there are suitable alternatives which can be prescribed or if the medication can be reviewed.

If no suitable alternative formulations are available and the medication is still required, it **may** be possible to crush the tablet or open a capsule; with the written consent of the GP and **MUST ONLY** be done following the advice of a pharmacist to ensure that the pharmaceutical properties of the medication are not altered and that it is safe to administer the medication in this way. The advice of the pharmacist, including the name of the pharmacist contacted, must be recorded in the care notes. The method of administration must be agreed by the GP and recorded in the Medication Care Plan and on the MAR chart.

5.3 Removal of Medication

Neither the medication(s) nor the MAR should be removed from the Clients home unless asked to do so by the office.

5.4 No MAR

If the MAR is not available, the medication must not be administered; the care worker should also contact the office or duty officer immediately and record the reason for not giving the medication in the attendance record in the Clients home.

5.5 Raising Concerns

Carers must raise any concerns about a person's medicines with their care co-ordinator or their manager when:

- The Client is declining to take their medicine
- medicines not being taken in accordance with the prescriber's instructions
- possible adverse effects (including falls after changes to medicines)
- the Client stockpiling their medicines
- medication errors or near misses
- possible misuse or diversion of medicines
- the Clients' mental capacity to make decisions about their medicines changes
- there is changes to the Clients physical or mental health.
- Any other situation that causes concern to the carer

6.0 Covert Medicines Administration- (Disguising medicines in food and drink)

NICE Quality Statement 6 (QS85) Published March 2015

Disguising medication in the absence of informed consent may be regarded as deception; however, a clear distinction should always be made between those Clients who have the capacity to refuse medication and those who do not. Clients who have the capacity to refuse medication should have their views upheld and respected at all times.

Clients who do not have the capacity to accept or refuse medication should be assessed by the Care Manager in conjunction with the GP, consultant, family or relevant person according to the Mental Capacity 2008 Code of Practice.

As a general principle, by disguising medicines in food or drink the Client is being led to believe that they are not receiving medication when in fact they are; the Care Manager,

together with any or all of the above health professionals involved in the decision to covertly medicate a Client, will need to be sure that what they are doing is in their best interest and that they will be held accountable for that decision having made a Best Interest Decision. To that end, it must be decided and documented that such treatment must be necessary in order to save a life, prevent deterioration or to ensure an improvement in the Clients physical or mental health.

As stated, although it may be necessary to covertly medicate a Client there are only a few circumstances where disguised medication is recognised in law.

The following points must be adhered to:

- Medicines should not be administered covertly until after a best interests meeting has been held. If the situation is urgent, it is acceptable for a less formal discussion to occur between the carers, prescriber and family or advocate making an urgent decision. However, a formal meeting should be arranged as soon as possible.
- No tablets should be crushed or given covertly, i.e. hidden in food or drink unless specifically prescribed by the GP.
- A written signed and dated protocol should be developed which is specific for that Client which gives details of the medication, the strength and dosage, how it is to be disguised, how it is to be covertly administered.
- the reason for covert administration must be detailed, the name of the prescriber, a start and finish date and a review date.
- If the authorisation is longer than 6 months' monthly reviews of the covert medication, involving family and healthcare professionals must be carried out and recorded.
- Where appointed, a Relevant Persons Representative (RPR) should be fully involved in any discussions and review so that if appropriate an application for a part 8 review (under DOLs code of practice) can be made, re authorisation.
- Any change of medication or treatment must trigger a review where such medication is covertly administered.
- This protocol and authorisation must be clearly identified within the care/medication plan See Appendix J

7.0 Medication Errors

7.1 Protection of Individuals and carers

From time to time errors can occur in the prescription, dispensation or administration of medicines. The majority of such errors do not harm the Clients; however, on rare occasions, they can have serious consequences. It is important that errors are recorded and the cause investigated so that we can learn from the incident and prevent a similar error happening again.

Carers must immediately report any error or incident in the handling or administration of medicines. This report should be made to the Care Co-ordinator, manager or person in charge as appropriate, in order that senior managers are able to take decisions regarding, Regulation 18 of the CQC (Registration) Regulations 2009. The error report form must also include near misses.

An error is a learning exercise and it is important that within a medication management system, errors are reported so that all can learn from the incident. It is imperative that when dealing with medicines you are focussed and concentrating on the task at hand. Near misses are recorded so that they can be used as empirical evidence for medication training sessions.

Medication errors are regarded as potentially serious events and carers must follow the Royal Pharmaceutical Society Administration of Medicine Guidelines. NICE produce

guidelines and quality statements for the administration of medicines in Care Homes. At Constantia Care, we follow the good practice from these guidelines as it relates to live-in care.

7.2 Medication error investigations

All medication errors will be investigated and the following will be considered:

- a) The experience of carers with regard to any previous incidences/errors
- b) The events which participated the error, together with the clinical effect upon the Clients.

Any of the following events are classified as errors:

- a) Medicines are given that are not prescribed
- b) Medicines are given at a time other than that prescribed
- c) Medicines are given via a route other than prescribed
- d) There is an error or omission in recording
- f) There is an omission of a prescribed medicine (other than a specifically recorded omission).

Procedure

- The carer informs the Care Co-ordinator who then informs the GP or a doctor about the incident and records it on the appropriate form
- The GP or doctor will decide on any medical attention
- The Manager and doctor will investigate the incident, and an appropriate course of action will then be decided upon.
- Out of hours the manager can ring NHS 111 for advice

8.0 Controlled Medication

We are aware that carers are particularly vulnerable when being asked to manage or assist with the management of controlled drugs in a live-in care setting.

A controlled medication register is not required in domiciliary care/live-in care. Details of administration should be recorded on the MAR chart following administration procedures. However wherever two carers are present it is good practice that they should both witness the administration of a controlled drug and sign the MAR sheet.

Controlled drugs that are no longer required should be returned to the pharmacy for disposal. As good practice if carers have the responsibility of returning controlled medication two carers witness the removal and record accordingly.

9.0 Warfarin (and other anticoagulants)

Current guidance from the National Institute for Health and Care Excellence - NICE Clinical Knowledge Summaries Anticoagulation-oral, last revised October 2015 Scenario 3 Warfarin. <http://cks.nice.org.uk/anticoagulation-oral#!scenario:3>

In November 2015 The Regulation and Quality Improvement Authority issued good working practices regarding warfarin (and other anticoagulants) in nursing and care homes These procedures below set out the principles and values underpinning the Constantia Care approach to the safe handling of medicines in regard to warfarin (and other anticoagulants).

NOTE: Constantia Care Live-in Carers follow the directions given by the District Nurse who will advise what part you play in this NICE guidance. If you have any queries what so ever, you must call your Care Co-ordinator for further guidance.

Constantia Care follows these good working practices

- has this written procedure for the safe management of anticoagulants in place and readily available for carers to reference
- ensures all designated carers are trained and deemed competent in the management of Warfarin and other anticoagulants
- ensures that where necessary carers are familiar with NPSA Alert - NPSA/2007/18, March 2007 as per link, for anticoagulants and associated information <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59814>
- has a specific care plan in relation to Warfarin for each Client who requires it.
- ensures all written confirmation of Warfarin regimes is obtained and located in an appropriate place for reference at administration
[Location: Warfarin Record Book supplied by District Nurse]
- ensures all obsolete Warfarin regimes records are discontinued & securely archived
- ensures a separate Warfarin administration record is maintained (MAR chart)
- ensures any transcribing of Warfarin regimes on the separate administration record should involve the District Nurse and the carer & the entry should be signed by both
- ensures that the carer checking and signing the record is trained and deemed competent to do so and should be aware of the responsibility he/she is undertaking
- where possible, has two trained carers administering and witnessing each dose.
(best practice, but not a requirement in live-in care)
- requires that the least number of tablets required to provide the specific dose of warfarin should be administered
- requires that a record of the date of opening should be recorded on Warfarin containers and other anticoagulant medicines to facilitate audit
- requires that Warfarin is administered from original packs and should not be included in monitored dosage medicine systems
- ensures that the date of the next INR (International Normalised Ratio) blood test and collection of results must be clearly recorded and communicated to all concerned
- includes the management of anticoagulant medicines in the audit process every six weeks during the Spot check.

10.0 Administration of Oral Medication

The 6 rights (R's) of administration:

- right person
- right medicine
- right route
- right dose
- right time
- person's right to decline

Following the assessment of need and completion of the Medication Care Plan, the carer will assist with the administration of medicines. Wherever possible this should be administered by the carer from a In exceptional circumstances, e.g. a short course of antibiotics, Clients boxes or bottles may be used.

Carers should only administer medication when they have been assessed as competent to carry out the task after appropriate training.

An up to date record of those carers able to administer medication should be kept in the Clients Care Plan

If they are in any doubt regarding the medicine(s) or the physical or mental health of the Clients then they should not administer, but instead contact the Care Co-ordinator or out of hour's duty officer immediately for further advice.

Before administering they should check

- the Clients name

- dosage instructions
- the MAR chart to ensure no other carer/professional has already administered

Identify the appropriate medicine container(s), checking the labels match the record, including:

- the Clients name is on the container
- the medication
- the dosage
- the time to be administered

Prior to administration of a medicine the carer should:

- explain the procedure to the Clients
- wash their hands
- if they know they have a strong allergy or reaction to a particular medicine wear disposable gloves prior to the handling of the medicine

If the instruction on the MAR chart does not coincide with the label on the container (except where the medicine to be given is Warfarin, for which the instructions will be clearly written on the card or in the Clients Warfarin record book) no dose should be given until written instructions have been received from the dispensing pharmacist, medical practitioner or the community nurse or prescriber.

10.1 Antibiotic administration

- follow safe handling of medicines procedures
- the Clients should take antibiotics for the entire time period that they are prescribed even if the symptoms have improved, it is essential that the Clients keeps taking the full course of antibiotics
- sometimes Clients start to feel better before all of the bacteria has been destroyed depending on the medical condition, antibiotics usually have to be taken for several days or sometimes even weeks before the infection clears up
- it is important that the Clients understands the importance of completing the course of antibiotics and if they refuse this must be recorded as per the Constantia Care procedure and advice requested from the GP; and reported to the Care Co-ordinator
- generally speaking, there should be no tablets left in the package when the course is finished
- one package contains the right amount for one course of antibiotics
- If there are some tablets left over, they should **not** be kept for later use, but returned to the pharmacy
- throwing medication into a bin or the toilet is bad for the environment and can also contribute to the development of antibiotic resistance
- medications can only work when they are used correctly, follow instructions on the Patient Information Sheet and on the medication packaging
- tablets must only be crushed or broken when written permission is gained from the GP
- antibiotics are usually taken with water because taking them together with fruit juices, dairy products or alcohol can affect how the body absorbs some drugs
- after taking antibiotics, Client **may** need to wait for up to three hours before eating or drinking any dairy products – check medication instructions
- grapefruit juice and dietary supplements containing minerals like calcium may also make other medication including antibiotics less effective
- some antibiotics need to be taken at the same time of day, others are meant to be taken before, with or after a meal, or taken at set times so that their effect is spread out evenly over the day

- antibiotics can interact with other medications, such as some blood thinners & antacids

When antibiotics are being administered, carer must also

- ensure that the Clients understands the need to complete the course
- monitor the Clients for side effects or allergic responses and report any signs immediately as it may become life threatening
- If there are any signs that the Clients is having an allergic response to antibiotics do not administer any more antibiotics but wait for guidance from GP
- monitor the effect of the antibiotic and inform the GP if there are no obvious positive effects once the course is complete

10.2 P.R.N. Medication Definition – ‘When required’

PRN medication is administered when the Clients presents with a defined intermittent or short-term condition i.e. not given as a regular daily dose or at specific time

The PRN medication should be administered at the request of the Clients or when care carers observe the need.

Consideration should also be given to the Clients ongoing capacity to refuse the medication.

Where a Client is prescribed ‘PRN’ medication, a specific plan for administering this must be documented in the medication care records.

The Clients medication plan should state

- Commencement date of the PRN medication as identified on the MAR
- name of drug
- route of administration for drug
- dose of drug
- frequency of drug
- minimum time interval between doses
- maximum number of doses in 24 hours
- why the medication was administered
- the effectiveness of the medication
- date to review

10.3 Time -Sensitive Medicine

This is a medicine that needs to be taken or given at a specific time where a delay in receiving the dose or omission of the dose may lead to serious harm, for example insulin injections for diabetes or specific medicine for Parkinson.

When these medications are prescribed to our service users who require support in medication administration the medication will be given at the prescribed times.

Staff are aware of the importance of giving these medications at specific times and any errors relating to time will be documented on a medication error sheet and the office informed.

11.0 Homely

A homely or household remedy is another name for a non-prescription medicines available over the counter in community pharmacies and are used mainly for the **short term management of minor, self-limiting conditions** e.g. toothache, mild diarrhoea, cold symptoms, cough, headache, occasional pain, etc.

When a Carer starts in a new position with a Client they may be using some homely medicines and at the assessment have expressed their wish to continue.

NOTE: A Carer may not recommend the use of homely drugs under any circumstances.

When the administration of medication is part of the service delivered;

- All homely medicines that the Clients wishes to take must be documented and their GP is contacted to confirm that it is safe to continue taking these medications with their prescribed medication
- Homely remedies should only be administered in accordance with the manufacturer's directions and only to those Clients who's GP has agreed to their use.
- A record of that agreement should be made in the Clients Medication Care Plan along with the list of the homely medicines.
- Administration of medication must follow the above procedures.
- All homely medication is recorded on the Medication Administration Record (MAR) and administered by trained carers.
- If the GP recommends to the Clients that they stop taking the homely medication this must be advised to the Care Co-ordinator and recorded in the medication care plan so that the medication is not administered by other carers
- Expiry dates should be checked regularly.

If the administration of medicines is not part of the service provided, the following circumstances may come to the attention of the carer.

- If the Clients tells the carer that they have started taking some over the counter (homely) medication, it is good practice for the carer to remind them to check with their GP before taking or using 'homely medicines' in order to avoid potential adverse effects or interaction with existing prescribed treatment.
- The Carer should seek advice from their Care Co-ordinator if they are concerned that a person is using 'homely medicines' inappropriately or excessively.

12.0 Special Arrangements

12.1 Arrangements for Clients attending day services/hospital

If attending hospital or a day centre, the carer responsible for the administration of medication should make sure that the Client has their regular prescribed medication for the day and any required documentation for recording.

If a Client is admitted to hospital for longer, follow the instructions issued with the appointment from the hospital; their Hospital Passport, which includes their Medication List of all medication, their Contacts sheet and their medical list, must accompany the Client.

Be aware that changes may be made to Clients medication following a stay in hospital.

12.2 Arrangements for Clients going on holiday

Prior to going on holiday the carer must discuss medication needs, and where applicable, the administering process and recording method with the Client and the family/representative who is taking the Client on holiday.

A photocopy of MAR sheet (original to be retained in the home) and blister packs are to be given to the Clients or family member/ representative for safe keeping for the duration of the holiday. Client/families will be requested to sign for receipt of medication on daily contact sheet.

The name and contact details of the Clients GP and any other relevant information needed in an emergency must accompany the Clients.

All blister packs, medication and signed MAR sheet to be returned to their home on arrival back from holiday.

The family/ representative must account for any medication that has not been taken or is missing etc.

12.3 Arrangements for Clients who are admitted to hospital.

When a Client is admitted to hospital their **Hospital Passport** must accompany them; **it is extremely important that this is kept up-to-date at all times.** We do not send any medication with the Clients unless it is a medication that may be needed in an emergency e.g. before the hospital pharmacy has had a chance to dispense the required medication for that Clients i.e. Inhalers / epi- pen etc.

Please be aware that changes may be made to Clients medication following a stay in hospital

NICE guidelines [NG5] Published March 2015

Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes.

This guideline offers best practice advice on the care of all Clients who are using medicines and also those who are receiving suboptimal benefit from medicines.

At Constantia Care we work closely with our health partners in relation to Clients medication reviews and the monitoring of its effectiveness.

13.0 Training Statement

Constantia Care ensures all their carers have completed a “Safe Handling of Medicines Course” before administering medication to Clients. All carers are monitored and attend medication updates regularly every 12 months **or updated as new regulations are put in place.** Staff involved in the monitoring of carers and auditing process are given the relevant support and training in this area.

Nursing carers must keep their medication Continuing Professional Development (CPD) current. Nursing carers will also be part of the monitoring process.

14.0 Related Policies

Accident and Incident Reporting (RIDDOR)

Care Planning and Support

Control of Substances Hazardous to Health (COSHH)

Co-operating with other providers

Collection of Prescriptions

Duty of Candour

Health and Safety

Notifications

Record Keeping

Appendices

A Application of Creams, Lotions or Ointment

Following assessment and appropriate recording in the Medication Care Plan, the Carer will assist with the application of creams lotions and ointments. The Carer will apply prescribed creams, dusting powders, lotions or ointments when they:

- Have received appropriate training
- Have been assessed as competent to carry out the task by an appropriate health professional.

If the carer is in any doubt regarding the products, or the physical or mental health of the Clients, they should not apply the product but instead contact the office or Care Co-ordinator immediately.

The Carer can apply non-prescribed products when they are:

- As part of the Clients personal hygiene regime, such as moisturisers, face creams, etc.
- To assist with the rehydration of skin, such as aqueous cream used to wash - E45 etc.

The Carer can apply the prescribed products except when:

- The area of skin to be treated is broken
- The product contains topical corticosteroids and is not listed as a prescribed item
- There is, or appears to be, inflammation or infection present, unless the product is being used to treat inflammation or infection.

When the product to be applied is recorded on the medication record, the carer must, from the medication record, check:

- The Clients name
- Application instructions
- That no other carer or professional has already administered the product

Identify the appropriate container(s), checking that the label(s) match the record, including:

- The name on the product is that of the Clients
- The product
- The instructions for use
- The time(s) to be applied

Prior to administration of a medicine, the care worker should:

- Explain the procedure to the Client
- Wash their hands
- Put on a pair of gloves

If the instructions on the administration record do not coincide with the label on the product container, it should not be applied until written instructions have been received from the community pharmacist, medical practitioner or the community nurse. Carers should ensure that they give every encouragement and opportunity to Clients who might initially refuse application of the product.

Under no circumstances should carers compel a Client to accept any kind of treatment.

If the Client refuses the prescribed product:

- Record it on the MAR chart that the Client has refused the application of the product
- Inform the office or on call at the earliest opportunity.

Immediately after assisting the Client with the administration of the product, the carer must:

- Remove and dispose of gloves
- Wash their hands thoroughly
- Complete and sign the MAR
- Record any comments relating to the product applied, including any observations requested
- Return the product to where it is stored.

Neither the product nor the MAR chart should be removed from the Clients home unless instructed to do so by the District Nurse or Care Co-ordinator

If the medication records are unavailable, the prescribed product must not be administered; the carer should also inform the Care Co-ordinator immediately and record the reason for the product not being administered in the Clients attendance record.

B Instillation of Eye Drops and Ointments

Following from the assessment of need and appropriate recording in the Medication Care Plan, the carer may assist with the instillation of eye drops and ointments. The Carer will only administer eye drops or ointments:

- From their original container
- When they have received appropriate training and been assessed as competent to carry out the task
- At the appropriate time according to the prescriber's instructions.

If a carer is in any doubt regarding the eye drops or ointments, or the physical or mental health of the Clients, they should not assist with the instillation of the eye drops or ointment but instead contact the Care Co-ordinator, District nurse or the on call duty officer immediately.

From the MAR chart, check

- The Clients name
- Dosage instructions
- That no other carer/professional has already administered the eye drops or ointment

Identify the appropriate container(s), checking that the label(s) match the recording, including:

- The name on the drops or ointment is that of the Client
- The label states clearly which eye the product is to be used for
- The dosage
- The time to be administered

Prior to administration of any eye drops or ointments, the carer should:

- Explain the procedure to the Clients
- Wash hands, wear disposable gloves

If the instructions on the MAR chart do not coincide with the label on the drops/ointment container then none should be instilled until written instructions have been received from the prescriber.

The carer should collect the equipment and lay it on a suitable surface near the Client where there is a good light source; they should then explain the procedure to the Client.

The carer should then check the following:

- Which eye the drops/ointment are prescribed for

- The date the bottle was first opened
- Expiry date on the label.

Once the carer has washed their hands and put on their gloves they should:

- Assist the Client to obtain a comfortable position, with the head well supported and tilted back
- Remove the lid(s) from the drops or ointment
- Hold the Clients lower eyelid down by pressing gently with a clean folded paper tissue
- Ask the Client to look up immediately prior to the instillation of the drops/ointment.

Eye Drops

- The dropper should be held approximately 2.5cm from the Clients eye, if they are being instilled without the use of an aid
- Gently squeeze the bottle
- Ask the Client to close their eye, keeping the tissue in place for one to two minute(s). Wipe away any excess from the Clients face.

When two different preparations in the form of eye drops are required at the same time of day, dilution and overflow may occur when one immediately follows the other, e.g. pilocarpine and timolol in glaucoma. Therefore an interval of 5 minutes should be left between the instillation of each preparation.

Immediately after completing the instillation of the eye drops, the carer should:

- Dispose of gloves and wash their hands thoroughly
- Complete and sign the MAR chart
- Record any comments relating to the product applied, including any observations requested
- Return the product to where it is stored.

Eye Ointment

- Wash hands and put on gloves
- Before applying the ointment, pull down the lower eyelid
- Squeeze approximately 2.5cm of the ointment inside the lower lid from the nasal corner outwards
- Ask the Client to close their eye, then remove the excess ointment with the tissue
- Advise the Client that blurring of vision will occur for a few minutes.

Immediately after completing the instillation of the eye ointment, the care worker should:

- Dispose of gloves, wash their hands thoroughly
- Complete and sign the MAR chart
- Record any comments relating to the product applied, including any observations
- Return the product to where it is stored.

C Instillation of Ear Drops and ointments

Following from the assessment of need and appropriate recording in the Medication Care Plan, the carer will assist with the instillation of eardrops.

Carers will only administer ear drops when they:

- Have received appropriate training and been assessed as competent to carry out the task.

From the MAR chart, check:

- The Clients name
- Dosage instructions
- That no other carer or professional has already administered the eardrops.

Identify the appropriate container(s), checking that the label(s) match the recording, including:

- The name on the drops is that of the Client
- The label states clearly which ear the product is to be used for
- The dosage
- The time to be administered.

If a carer is in any doubt regarding the ear drops, or the physical or mental health of the Client, they should not assist with the instillation of the ear drops but instead contact the Care Co-ordinator or on call duty officer immediately.

Once the carer has explained the procedure to the Client and washed their hands and put on gloves, they should:

- Assist the Client into a lying or seated position and explain the procedure
- Assist the Client to obtain a comfortable position, with the head well supported and tilted to one side, if possible
- Remove the lid(s) from the ear drops container
- Gently pull the top of the ear (pinna) outwards and upwards in order to straighten the outer ear canal
- Gently squeeze the bottle, instilling the prescribed number of drops into the ear
- Ensuring they are comfortable, leave the Client with head to one side for a few minutes.

Immediately after completing the instillation of the eardrops, the care worker should:

- Wash their hands thoroughly
- Complete and sign the MAR chart
- Record any comments relating to the product applied, including any observations requested
- Return the product to where it is stored
- Assist the Client to sit up and adopt their choice of position and location.

D Inhalers

Medication via inhalers are mainly used in the treatment of Asthma and Chronic Obstructive Pulmonary Disease (COPD).

There are different types of inhalers, for different types of medicine. The carer supporting the Client to administer the medicine receives training before supporting them in the administration of the medicine via this route. The Medication Care Plan clearly indicates the reason for using the inhaler or inhalers when multiple types are prescribed. We work closely with the Client and their family and GP or specialist nurse in this area.

Inhalers also come in various colours. Relievers are usually blue and preventers are usually brown (but some can be orange).

'Press and breathe' metered dose inhalers (MDIs) are often called 'puffers'. MDIs work better with a spacer. Spacers collect the medicine inside them, so that the person does not have to worry about pressing the inhaler and breathing in at exactly the same time. This makes these inhalers easier to use and more effective.

An MDI inhaler uses a small canister with a mixture of the medicine and a gas or liquid that turns the medicine into a very fine spray as the canister is pressed. Most people call this a 'puff' of medicine. To get the best result shake the inhaler before each puff so that the medicine mixes well before use.

'Breathe in normally' breath actuated MDIs are usually given to people who have difficulty using a standard 'puffer'. These inhalers are activated by your breath so that when you

breathe in normally through the mouthpiece, it releases medicine in a fine spray form. With this inhaler you don't have to push the canister to release a dose.

Autohaler and Easi-breathe are examples of breath actuated MDIs. These inhalers need to be shaken before each puff so that the medicine mixes well before use.

'Breathe in hard' dry powder inhaler (DPIs), release medicine in very fine powder form instead of a spray; when breathing in through the mouthpiece. The Client needs to breathe in fairly hard to get the powder into the lungs. Examples of DPIs include Accuhalers, Clickhalers, Easyhalers, Novolizers, Turbohalers, Diskhalers and Twisthalers.

Supporting the Clients to use their inhaler

General for all inhalers

- The Client will have had some instruction about using an inhaler from the person who prescribed this treatment. Ensure they understand and identify how much support they need in the administration of this medicine
- Encourage the person to breathe out fully or as much as possible to create more space in their airways for the next breath in. This allows for a deeper and longer breath when inhaling the medicine enabling it to reach smaller airways deep inside the lungs
- If the person has been advised to hold their breath after taking in the inhaler then it is important for them to do so. This allows more time for the medicine to reach the deeper areas of the lungs. Hold for 10 seconds or as long as it feels comfortable then breathe out slowly through the nose.

Press and breathe MDI Inhaler

- Shake the canister before use and between puffs, so that the medicine and propellant mix together to form an aerosol
- It is important that the person only starts to inhale once the canister has been pressed, this is to allow enough time for the medicine to be inhaled before running out of breath
- It is also as important not to inhale too late. It takes less than half a second from the time the canister is pressed for all the medicine to be released. If the person inhales too late then the medicine stays in the mouth and is not carried down to the lungs
- Shake the canister between puffs and wait 30 – 60 seconds before taking the next puff. This gives the medicine and propellant enough time to mix together
- If using a spacer remove the cap from the canister and shake, place the canister in the back of the spacer. Breathe out, place the mouthpiece of the spacer in the mouth and take a deep breath and hold for 10 seconds. Gently breathe out through the nose. Repeat as above as required.

When the inhaler is for administering steroids encourage the person to brush their teeth, gargle and spit out after using this preventer inhaler, use a spacer with the preventer inhaler

If the person is having problems using their inhalers carers must report this to the GP or specialist nurse is informed quickly; as well as reporting this to your Care Co-ordinator

There are other types of inhalers that may be prescribed and it is important to get instruction on use from the GP or specialist nurse and read Patient Information Leaflets.

Storage

- Always keep the inhaler cap on when not using it. This prevents objects getting stuck in the mouth piece and causing a choking hazard when next used.
- The inhaler should be stored at the correct temperature. Extreme high or low temperatures can affect the medicine. Check the inhaler label or information sheet, especially if going abroad on holiday.

Cleaning

The patient information leaflet (PIL) included with the medicine explains the best way to use, clean, store and look after the inhaler.

Press and breather metred dose inhaler

- Never wash or put the metal canister in water, only wash the plastic parts
- Remove the metal canister from the plastic casing and remove the mouthpiece cover
- Rinse the plastic casing thoroughly under warm running water
- Dry thoroughly inside and outside
- Put the metal canister into the plastic casing and test by releasing a single puff into the air and replace the mouth piece cover

Dry powder inhaler

- Wipe the mouth piece of your dry powder inhaler with a dry cloth at least once a week
- Do not use water as the powder is sensitive to moisture

It is important to monitor and record the effectiveness of the inhaler and report any changes in its effectiveness.

E Application of Compression Hosiery

Following the assessment of need and appropriate recording in the Medication plan of care, care workers will assist in the application of compression hosiery.

Carers will only assist in the application of compression hosiery:

- When they have received appropriate training and been assessed as competent by the appropriate professional.
- The carer must not assist with the application of compression hosiery without the proper instruction from the office.
- To ensure maximum effect, compression hosiery should be applied before the Client gets out of bed and removed last thing at night.

Compression hosiery is prescribed to Client to:

- Prevent deep vein thrombosis, a complication of mobility
- To prevent occurrence or re-occurrence of leg ulcers
- To manage oedema (swelling) as a result of disease or injury, e.g. for a Client with heart failure whose legs swell, or following treatment for burns.

Before removal or application of the hosiery the carer should explain the procedure.

The carer should check the medication plan of care for specific instructions about the times of removal/application and any special instruction related to the type of hosiery used.

Hosiery Removal

- The carer should remove all jewellery they are wearing on their hands to avoid ladders and unintentional injury
- Gently but firmly grip the top edge of the hosiery and pull it away from the body towards the end of the limb
- If at any time the Client complains of pain, the carer should stop and check no skin damage is occurring before they resume the procedure. If skin damage occurs contact the Clients surgery immediately for advice.

When the hosiery has been removed, the carer should gently wash and dry the Clients skin using warm water and soap. Skin covered by hosiery can become very dry; if a cream has been prescribed then this should be applied; if no cream has been prescribed then the Clients surgery should be contacted to seek advice.

If the hosiery is to be reapplied immediately following skin cleansing it is advisable to apply a light dusting of powder to the skin to aid application. If an application aid has been provided this should be used according to the manufacturer's instruction.

Application of Hosiery

The carer applying the hosiery should:

- Ensure the hosiery is clean and wrinkle free, with no tears or frays
- Explain the procedure to the Clients
- Run their hand inside the stocking down to the heel and pinch the heel with finger and thumb
- Turn the stocking inside out leaving the foot part tucked in
- Pull the foot part gently over the Clients toes and ease over the foot taking care to check the toes and heel are correctly positioned and wrinkle free
- Gather up remaining stocking and take it over the foot and lower leg. Working in sections from the ankle pull the stocking up the leg in short folds of about 2 inches (5cm) at a time without forcing and keeping it wrinkle free
- When the stocking is fully extended on the leg, take the top back down to the calf hold the top stocking up the leg again to ensure it remains in place
- If applying thigh length hosiery secure with a suspender belt.

If the Clients experiences pain at any time then the carer should cease the application and check if any skin damage has occurred. If this is the case contact the Clients surgery for further advice and remove the hosiery.

Hosiery should be washed at 40 degrees and hung to dry.

(UNDER NO CIRCUMSTANCES SHOULD THEY BE IRONED)

Clients should always wear hosiery on both legs.

Hosiery should be replaced every three months or earlier if they become damaged or worn.

F Administration of medicines via an enteral feeding tube

Before a carer can administer medication via an enteral feeding tube they will receive Level 3 training from a health professional. This will be recorded, dated and signed off by the health professional only when the carer is deemed competent to administer medication to the Client. The training will also include the recognition of adverse or side effects and actions to take in the event of an emergency.

Enteral feeding tubes are designed to provide access to the lumen of the stomach or jejunum. They are designed to bypass dysfunction and obstruction, reduce discomfort or remove the need for Clients to actively eat. The lumen of a narrow enteral tube has the potential to occlude and once occluded can be difficult to unblock. It is therefore important when caring for an Clients with an enteral feeding tube to know the type of material the tube is made of, the type of tube and the abbreviation used should be standardised for example 'nasogastric tube' (NG). It is important to know where the tip of the enteral feeding tube lies and therefore the site for medication administration. The position of the tip may affect the type of feed that can be used and the absorption of some medications.

Procedure for medication administration via an enteral feeding tube

Before administering a medication

- wash hands and wear gloves
- re-secure and check any tape holding the enteral feeding tube in position if loose
- close any ports on the enteral tube to ensure there is an airtight seal
- check if a connector to join the syringe to the tube is required, such as a PEG tube connector
- check the position of the tube to confirm the gastric placement of the nasogastric tube
- the position of a PEG or surgical/radiological jejunostomy can be assessed by checking that the length of tube outside the body remains constant and the suture remains intact

- confirm that the Client is not experiencing undue pain or discomfort
- check that the enteral feeding tube is patent by flushing with 30-50ml of water using a 50ml oral, enteral or catheter-tipped syringe
- do not use syringes designed for intravenous use
- oral, enteral and catheter-tipped syringes are not compatible with intravenous devices and their use reduces the risk of the medication being accidentally administered via the intravenous route
- if the tube is blocked, attempt to unblock it without using excessive force, if unsuccessful seek specialist advice

Administering the medication

- check the Clients identity and explain what is to be done and obtain consent
- check prescription for the medication dose, route and site of administration according to medication plan and MAR
- draw the required dose of the liquid medication into an appropriate syringe and place the syringe in a clean receiver
- tablet-crushing must only be considered with consultation with GP and or pharmacist
- if crushing the tablet is prescribed by GP a tablet-crushing syringe or pestle and mortar should be used
- crushed tablets can be added to 30ml of water and dissolved
- prepare a flush of water in a syringe and label if necessary
- place it in the receiver with the medicines to be administered
- tubes should be flushed before, during (if the suspension is thick, for example lactulose) and after medication administration to prevent interactions between the medications, tube or feed
- in some cases, for example in children or in Clients with renal and cardiac disease, these volumes may need to be revised to meet the Clients prescribed fluid restriction
- attach the syringe to a port on the enteral feeding tube, ensure there is an airtight connection between the syringe and enteral tube and administer the flush and medications
- flush immediately with an appropriate amount of water and leave the connector clean and dry
- monitor the Clients for any adverse effects
- complete any records such as medication plan or MAR
- wash hands and dispose of any waste in appropriate container

Further Information

Leaflets published by the British Association for Parenteral and Enteral Nutrition are available to carers. www.bapen.org.uk

<http://www.evidence.nhs.uk/search?q=medication+via+peg+tubes>

G Levels of Medication - Support and Administration

Level 1: General Support, also called Assisting with Medicine

General support is given when the person takes responsibility for their own medication and particularly when they contract the support through Direct Payments. In these circumstances the carer will always be working under the direction of the person receiving the care.

The support given may include some of the following:

- Requesting repeat prescriptions from the GP
- Collecting medicines from the community pharmacy/dispensing GP surgery
- Disposing of unwanted medicines safely by return to the supplying pharmacy/dispensing GP practice (when requested by the person)
- An occasional reminder or prompt from the carer to the Client to take their medicines. (A persistent need for reminders may indicate that the client does not have the ability to take responsibility for their own medicines and should prompt review of the Clients plan)
- Manipulation of a container; for example opening a bottle of liquid medication or popping tablets out of a blister pack at the request of the person, and when the carer has not been required to select the medication.

General support needs should be identified at the care assessment stage and recorded in the Clients care plan. Ongoing records will also be required in the continuation notes when care needs are reviewed.

Adults can retain independence by using compliance aids. These should be considered if packs and bottles are difficult to open, or if the person has difficulty remembering whether they taken medicines.

The compliance aid will be filled and labelled by the community pharmacist or dispensing GP. The person may qualify for a free service from a community pharmacist if they meet criteria under the *Disability Discrimination Act*.

Constantia Care will not take responsibility for the filling of the compliance aid unless trained and competence-assessed to do so by an appropriate person e.g. district nurse, pharmacist. The level 3 criteria applies in these circumstances.

Level 2: Administering Medication

The care assessment stage may identify that the Clients is unable to take responsibility for their medicines and needs assistance. This can be due to impaired cognitive awareness or result from physical disability.

The Client must agree to have the carer administer medication and consent should be documented in the care plan. If the Client is unable to communicate informed consent, and there is no responsible person the prescriber must formally indicate that the treatment is in the best interest of the Clients.

Administration of medication may include some or all of the following actions:

- When the carer selects and prepares medicines for immediate administration, including selection from a monitored dosage system or compliance aid
- When the carer selects and measures a dose of liquid medication for the Clients to take
- When the carer applies a medicated cream/ointment, inserts drops to ear, nose or eye, and administers inhaled medication
- When the carer puts out medication for the Client to take themselves at a later (prescribed) time to enable their independence

The need for assistance with medication should be identified at the care assessment stage and recorded in the care plan, with ongoing records in the notes updated when care needs are reviewed. Constantia Care has in place training to ensure that only competent and confident carers are assigned to Clients who require assistance. The Carer has the right to

refuse to administer medication where they themselves feel they have not received adequate training and do not feel competent to do so.

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

Clients discharged from hospital may have medication that differs from those in the home prior to admission. The Carer must be taken to ensure checks are in place to provide clear instructions as to which medicines are to be administered. Additional support should be in place for carers when this occurs.

Level 3: Administering Medication by Specialised Techniques

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

- Rectal administration, e.g. suppositories, diazepam (for epileptic seizure)
- Insulin via injection
- Administration through a Percutaneous Endoscopic Gastronomy (PEG)

If the task is to be delegated to a carer, the healthcare professional must train the carer and be satisfied they are competent to carry out the task.

Constantia Care procedures include that carers can refuse to assist with the administration of medication by specialist techniques if they do not feel competent to do so.

Constantia Care will consider the request only in the following circumstances:

- Where an inappropriate admission to care would have to be considered
- Where the ability to maintain the Client at home is undermined by a lack of appropriate funding which allows community nursing support
- Where the Client is in the later stages of end of life management and has made clear their wishes to remain at home.

In the above circumstances Constantia Care will strive to maintain the Client with true regard to their wishes, whilst seeking to ensure that the Client will be cared for in an appropriate manner by carers that are fully trained and competent to do so.

If the decision is taken that the task to be delegated to the carer the HEALTHCARE PROFESSIONAL must train the carer(s) and be satisfied they are competent to carry out the task, this must be recorded on the Level 3 Training Record and signed off by the HEALTHCARE PROFESSIONAL involved in the training. Any additional support appropriate to the circumstances must be available by the Health Services involved.

Carers who feel that they are not competent to assist with the administration of medication by specialised techniques can refuse to assist.

Any Level 3 Support must be authorised by the Manager and a Level 3 Training Record must be completed by and in place after training by the appropriate healthcare professional.

H Health-Related Activities

In the interests of the Client, carers may from time to time be asked to assist in health-related activities which can include:

- Massage techniques
- Exercise regimes
- Mobility-related assistance
- Monitoring and recording of particular conditions (diabetes, epilepsy etc.)

This area of activity must be clearly assessed and recorded during the care assessment. Specialist training must be undertaken and carers must be competent and confident in their own abilities to undertake the tasks required. The appropriate healthcare professional must

“sign off” the training, and the competency of the carer and the information should be recorded on the Level 3 carers training record. Health-related activities will be undertaken only with the express agreement of the manager, and when the appropriate care assessment has been completed and recorded in the Medication Care plan. Reviews should take place and care plans updated as required.

All carers should be able to refuse to undertake tasks which they themselves feel they are not competent to do.

I Monitoring and Auditing

The function of monitoring and auditing needs to be a planned and systematic process that is embedded throughout this Constantia Care.

“**Monitor**” means to check, observe, identify task or system performance.

“**Audit**” means to evaluate, examine, critically analyse conformance to set standards by reviewing the objective evidence from statements, records, files and any formal monitoring systems which are in place.

Medication monitoring is part of the observed practice of carers which is recorded, dated and signed off and is usually delivered via a spot check. The spot check findings are then followed through using the error sheets, and advice and guidance to carers. This includes any training and further monitoring as required.

Auditing of medication is a part of Constantia Care’s quality audit process. Auditing of all medication documentation including MAR charts is done regularly, and solutions implemented with immediate effect where any shortfalls are identified.

Peer auditing forms the core of the audit regime and carers are constantly reminded of the importance of signatures, dates and appropriate record keeping.

J Medication MAR Sheet Procedure

Medication Administration Record or MAR Sheet is the form which you initial every time you administer medication; as and when you are convinced the medication has actually been consumed.

NOTE: The MAR sheet is pre-populated by the Constantia Care office and supplied to every client’s home each month. This covers the number of days in that month.

In the event that the new MAR charts do not arrive on time the carer must note the medication given on the daily report in the medication section and when it does arrive copy the details of medication given onto the new MAR sheet.

Constantia Care is currently introducing the online Care Plan system; this process will be completed by the end of July 2018. Therefore there are currently there are two MAR sheet systems in use: One on computer and one on paper.

In the unlikely event that you do not have a pre-populated MAR sheet available at the clients home, because it is a new position and the medication is only advised when the client leaves Hospital or a Care Home you will need to know how to populate the sheet prior to giving medication.

This also applies if the online system goes down for any reason; complete the paper version and sign for medication given on paper. Once the computer system is up and running again O will be placed in the missing days and an explanation of where the meds have been signed for will be done in the allocated box.

The procedure is as follows:

Preparing the MAR sheet prior to administering the first dosage:

Write in your **Clients name** and **Date of Birth**; your Clients **Doctors name** and **the Surgery number**; any **known allergies**. **Allergies ONLY** which you will find noted very clearly in your Clients Care Plan; then **the month** in which they will be given plus the year.

Your Clients medication will either have been delivered by the Pharmacist or you will have collected it. This is dependent on how it has been set up by the family or the previous carer who handed over to you. You will be advised on this when you start in a new position.

Then comes the inclusion of the medication onto the MAR sheet; this information comes from the label on the box or the labels in the blister pack; dependant on how the medication has been supplied.

- Which medicines are prescribed for the Client
- What they are for
- What the dose is & by which route
- When they must be given
- Any special information, such as giving the medicines with food

Note: you write **ONLY ONE** lot of medication in each block and you include the strength, type and purpose of the medication.

For example: Diclofenac, 100mg, Tablet for Gout. **See Sample MAR Sheet**

Under Directions: you would include which route it is taken and how often.

Then enter the times it is to be given under the allocated time column.

To complete the chart ready for use enter the dates in the date row.

You are now ready to give medication

Giving Medication

Clients will differ dramatically on how they like to have their medication administered. Prepare everything you need prior to informing your client it is time for their medication.

Give the medication and when you are sure it has been swallowed initial in the appropriate box.

If medication is Refused, please indicate the reason by using the appropriate symbol and give an explanation in the area allocated. Please make sure to Date and Sign. See examples on Sample MAR sheet.

ONLY USE BLACK INK AT ALL TIMES AS THIS IS A LEGAL DOCUMENT

RECORD OF COVERT ADMINISTRATION

Clients name

Date of birth

NHS/ Ref number

Date form completed

<p>Has a Mental capacity assessment been performed to establish if the Client lacks the mental capacity about taking their prescribed medication?</p> <ul style="list-style-type: none"> • Assessment to ascertain whether they are capable of making decisions about their medication • Assessment of mental capacity to consent should be subject to continuous review • What support does the person need to take their medication 	<p>YES / NO (delete as appropriate)</p> <p>Surgery name - in capital</p> <p>Prescribers name – in capitals</p> <p>Date of Assessment</p> <p>Decision recorded</p>
<p>Is there a person that holds decision making power such as Lasting Power of Attorney for health and welfare decisions or a court deputy that relates specifically to their medication?</p> <p>Medication may only be administered covertly if that person is able to make a decision in the clients best interests with the clinician agreeing the plan to have the medication covertly.</p>	<p>YES / NO (delete as appropriate)</p>
<p>List the medication being considered for covert administration</p>	
<p>Why is this medication necessary?</p>	
<p>What alternatives (such as less restrictive alternatives) have been considered?</p>	

(Other ways to manage, or administer treatment)		
Why were these alternatives not pursued?		
Why is covert the least restrictive way to treat the Client? (Give reasons)		
Client view of the proposed treatment, if known?		
Has the Client expressed views in the past that are relevant to present treatment? If YES, what were those views?	YES / NO (delete as appropriate)	
Name all the members of the people and teams involved in the decision to administer medication covertly (For example, healthcare professionals, family, carers etc.) Name of pharmacist consulted to give advice on the administration of the medication – in capitals	Name	Designation
Were all those involved in the decision in agreement with the proposed use of covert medication? If NO, they must be informed of their right to challenge treatment	YES / NO (delete as appropriate) If NO, person / reason	

	Date informed	
Which carer will be administering the medication? Ensure carer have received appropriate training and guidance on the covert administration of the specified medication which can be evidenced.	Name	Designation
How will the medication be administered? (e.g., mixed in yoghurt)		
How will this be recorded on the MAR chart?		
When will this need for covert administration be reviewed? (Six months' maximum)	Date of first review Date of next review Date in six months	
Constantia Care copy Pharmacy copy Any additional notes? If in any doubt, refer to the Manager.		

This policy has been reviewed by the Registered Manager.

Signed: Morag Collier

Date: 20/02/2018

Review Date: 20/08/2018

MEETING NEEDS

Constantia Care Ltd

Policy Statement

These are the procedures that are of most importance to our Clients; they are core to the delivery of quality care services. Any survey of Clients' priorities of quality care places the consistency and reliability of carers as their first priority. These procedures set out how we would deliver good quality services which would meet the needs of our Clients.

The Policy

Our Workforce

It is a responsibility of management to ensure that this organisation employs staff in sufficient numbers and with appropriate skills to respond effectively to the needs of the Clients for whom we provide services. The Registered Manager therefore should keep under review the size and composition of Constantia Cares workforce and correlate this with the profile of needs presented by current and predicted Clients. Where there is a poor match, necessary action on recruitment or training, or in other personnel areas, should be initiated.

Skills and Experience of Individual Carers

Constantia Care wishes to provide as wide a range of skills as possible to meet the needs and preferences of Clients. Line managers should therefore maintain a review of the capabilities of each of the carers for whom they are responsible. The objective should be to add to the carers' skills and experience through balanced and varied workloads, incorporating new sorts of work if possible, and through appropriate training and supervision, so that they are able to make as broad a contribution to the work of the of Constantia Care as possible.

Matching Carers to Clients

When Constantia Care accepts a referral and agrees to provide a service, the responsible manager needs to ensure that the new work is allocated to a carer with the appropriate skills and experience to meet the needs and preferences of the new Client. This is of course subject to other workload pressures, but for every new case we should seek a match between the Client and the carer that is as good as possible.

Meeting the Special Needs of Individual Clients

The process of matching a carer to the specific needs and preferences of a Client becomes even more important where a Client has specific needs arising from dementia, mental health problems, sensory impairment, physical disabilities, learning disabilities or substance misuse problems, or where our service is for intermediate care or respite care. In any of these instances, the manager responsible for case allocation must ensure that the carer allocated to the Client has the appropriate skills and experience, and is prepared carefully for the new work. Use might be made of knowledge possessed by other carers for briefing a carer new to such a situation, and managers should use the opportunities of internal training and group supervision sessions to facilitate this sort of sharing.

Meeting the Needs of Clients from Minority Groups

Similar care must be taken in selecting a carer to take on the care of a new Client from an ethnic, social, cultural or religious minority. Constantia Care cannot and would not wish to guarantee that a Client would invariably be assisted by a carer from the same group, but we should make use of the personal knowledge gained from a carer's membership of a minority group where this is appropriate. A carer's ability to understand the language of choice of a Client may be particularly helpful. Where a carer is to become responsible for the care of a member of a minority with which he or she has not previously had much experience, the carer should be carefully briefed so as to be able to provide appropriate services with tact.

Some matters such as diets, toileting procedures and religious observance may be of particular sensitivity.

Intermediate and Respite Care

When this organisation is asked to provide a short term service either as, or contributing to, a respite care or intermediate care service, special steps need to be taken to ensure that the allocated carer understands and is capable of responding to the particular demands and pressures of these forms of service.

Listening to Clients

We have a responsibility at all times to ascertain and take into account the wishes and feelings of Clients. Carers who pick up any views about the service from a Client with whom they are working should pass these on to their supervisor, who should consider the implications both for that particular Client and for the service in general. All carers should encourage and help Clients to make decisions about their care. We will comply with any special local arrangements for self-assessment by Clients.

Clients' Right to Choice

We have a responsibility to provide Clients with full information about services and offer opportunities for choice wherever possible.

If a Client expresses a wish for a change of carer, this should be similarly reported and explored by the supervisor.

If it appears that Constantia Care is not able to meet the needs or preferences of a newly referred Client, the manager should give consideration to advising on an alternative source of service, either by referring the Client to the social services department or by directly suggesting another organisation. If a situation arises wherein an existing Client develops needs or preferences that the current carer is not able to meet, then the manager or supervisor should consider whether an alternative carer would be more suitable and to arrange this if appropriate. If, exceptionally, it appears that we cannot in any way continue to meet the Client's requirements, they should be referred elsewhere and appropriate arrangements made for this organisation's services to be terminated.

If the service we provide is likely to be varied to any significant degree for a Client whose fees are being paid by a social services department, the manager should take steps to consult and obtain authorisation from the responsible social services care manager before implementing any change.

Encouraging Clients' Autonomy

All carers should take steps to ensure that the provision of our service does not undermine a Client's capacity to take decisions about their own care. Carers should take every opportunity to stress to Clients with whom they work that they retain the right to organise their own lives and that our task is to meet their requirements as best as possible. Care co-ordinators should take a similar stance when making Spot Checks. Managers are responsible for ensuring that this position is reflected in all of Constantia Cares literature, and in communications with Clients and others.

Updating Practice

As Constantia Care we are obliged to see that all services are demonstrably based on good practice and reflect the relevant clinical and specialist guidance. The manager is responsible for reviewing new publications, government documents and professional guidance as it appears; for considering its relevance to our work; and, where necessary, for instituting appropriate changes in working practice, instructions to staff and staff training.

Related Policies

Adult Safeguarding
Advance Care Planning
Assessment of Need and Eligibility
Autonomy and Independence
Co-operating with other Providers
Continuity of Care or Carers
Care and Support Planning
Cyber Security
Dignity and Respect
Equality and Diversity
Mental Capacity Act 2005
Nutritional and Hydration Needs
Sensory Impairment

This policy will be reviewed by the registered manager.

Signed: *M Collier*

Date: 20/02/18

Review Date: 20/08/18

MENTAL CAPACITY ACT 2005

Constantia Care Ltd.

Policy Statement

The Mental Capacity Act 2005 and the accompanying Code of Practice is a vital piece of legislation which aims to make a real difference to people's lives. It should empower people to make decision and protect those who lack capacity by providing a flexible framework that places individuals at the very heart of the decision-making process.

Care Act 2014

Throughout this Act, capacity or lack of it determines how adults will be supported and cared for by ensuring that person centred care is core to how services are delivered. Those services must reflect the needs and preferences of the person requiring care and support and where they lack capacity the Code of Practice must be followed. The Care and Support Statutory Guidance updated on May 9th 2016 issued under the Care Act 2014 - Chapter 6.

The Policy

Within Constantia Care the Code of Practice referred to above will be used as the guidance on how to proceed in regard to individuals who may lack capacity. Individuals with capacity will be listened to, their needs and preferences taken into account during all aspect of the Care and Support Planning process. We will act in accordance with the five statutory principles, at all times unless guided otherwise by our local Mental Capacity Assessment team or statutory multi-agency partner.

The five statutory principles are:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under this Act, for or on behalf of a person who lacks capacity, must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Throughout the Code of Practice a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

To summarise:

- Every adult has the right to make their own decisions if they have the capacity to do so. Family carers and health care or social care staff must assume that a person has the capacity to make decisions, unless it can be established that the person does not have the capacity
- People should receive support to help them make their own decisions. Before concluding that individuals lack capacity to make a particular decision it is important to take all possible steps to take all possible steps to try to help them reach a decision themselves.

- People have the right to make decisions that others might think are unwise. A person who makes a decision that others think is unwise should not automatically be labelled as lacking the capacity to make a decision.
- Any act done for, or any decision made on behalf of, someone who lacks capacity must be in their best interests.
- Any act done for, or any decision made on behalf of, someone who lacks capacity should be an option that is less restrictive of their basic rights and freedoms, as long as it is in their best interests.

These basic tenets must be understood, respected and incorporated into the organisation's practice, at every level, by all members of staff. Anyone who claims that an individual lacks capacity should be able to provide proof. They need to show, that, on the balance of probabilities, the individual lacks capacity to make a particular decision, at the time it needs to be made. This means being able to show that it is more likely than not that the person lacks capacity to make the decision in question.

What is the test of capacity?

To help determine if a person lacks capacity to make a particular decision, the Act sets out a two stage test of capacity, which must be undertaken using the appropriate forms **used by the Barnet Mental Health Team or relevant local Mental Health Team.**

Stage 1: Does the person have an impairment of, or a disturbance in the functioning of their mind or brain. IF the person does not have such an impairment or disturbance, they will not lack capacity under the Act.

Examples of impairment or disturbance include:

- Conditions associated with some forms of mental illness.
- Dementia
- Significant learning disabilities.
- The long-term effects of brain damage.
- Physical or mental conditions that cause confusion, drowsiness or loss of consciousness
- Delirium
- Concussion following a head injury, and
- The symptoms of alcohol or drug use

Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

For a person to lack capacity to make a decision, the Act says their impairment or disturbance must affect their ability to make the specific decision when they need to. But first people must be given all practical and appropriate support to help them make the decision for themselves. (Principle 2)

Stage 2 can only apply if all practical and appropriate support to help the person make the decision has failed.

“Inability to make a decision”

A person is unable to make a decision if they cannot:

- Understand information about the decision to be made (the Act calls this “relevant information”).
- Retain that information in their mind.
- Use or weigh that information as part of the decision-making process, or
- Communicate their decision (by talking, sign language or any other means).

Assessing ability to make a decision

Does the person have a general understanding of what decision they need to make and why they need to make it.

Does the person have a general understanding of the likely consequence of making or not making the decision?

Is the person able to understand, retain and use and weigh up information relevant to this decision?

Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as speech and language therapist) be helpful?

The member of staff who carries out the initial assessment will be trained and competent to do so. All care or support staff will be trained and competent in MCA 2005 as different people will be involved in assessing someone's capacity to make different decisions at different times on day to day basis. Any assessor will have the skills and ability to communicate effectively with the person, where necessary they should get professional help to communicate with the person.

When assessing capacity the following points are considering.

- Start by assuming the person has capacity to make the specific decision. Is there anything to prove otherwise?
- Does the person have previous diagnosis or disability or mental disorder? Does the condition now affect their capacity to make this decision? If there have been no previous diagnoses, it may be best to get a medical opinion
- Make every effort to communicate with the person to explain what is happening.
- Make every effort to try to help the person make the decision in question.
- See if there is a way to explain or present information about the decision in a way that makes it easier to understand. If the person has a choice, do they have information about all the options?
- Can the decision be delayed to take time to help the person make the decision, or to give the person time to regain the capacity to make the decision for themselves?
- Does the person understand what decision they need to make and why they need to make it?
- Can they understand information about the decision? Can they retain it, use it and weigh it to make the decision?
- Be aware that the fact that a person agrees with you or assents to what is proposed does not necessarily mean that they have capacity to make the decision.
-

Anyone accessing someone's capacity will not assume that a person lacks capacity simply because they have a particular diagnosis or condition. There must be proof.

The following questions will be asked.

- Does the person have a general understanding of what they need to make and what they need to make it.
- Do they understand the likely consequences of making or not making the decision?
- Can they understand and process the information about the decision? Can they use it to help them make a decision.

Complex decisions

When assessing someone's capacity in making a complex decision, we will get a professional opinion when necessary. This maybe the G.P a specialist, speech a language therapist and in some cases a multi-disciplinary team.

Record of a person's capacity to consent to the provision of service

Records of assessment will be kept as individual plans and be part of the care plan review. Care staff will keep records in the daily notes of the steps they take when carrying out an assessment for the individual.

Professional records

When professionals carry out an assessment of a person's capacity to consent or make a particular decision the relevant professional records are kept in the Client's plan.

Challenging a "finding of lack of capacity"

When a situation arises that a Client responsible person challenges the result of the assessment of capacity, the first step is to raise the matter with the person who carried out the assessment. If the Client has been assessed to lack capacity they should have support from family, friends or an advocate

- The assessor must give the reason why they believe the person lacks capacity to make the decision
- Provide objective evidence to support their belief
- The assessor must show they have applied the principles of the Mental Capacity Act.
- If possible a second opinion from an independent professional or expert in assessing competence should be sought.
- If the disagreement cannot be resolved the person who is challenging the assessment may be able to apply to the Court of Protection.

Best interest decision

One of the key principles of the MCA 2005 is that any decision made on behalf of a person who lacks capacity must be done or made, in that persons best interests.

This organisation follows these rules:

- For most day to day actions or decisions the decision maker will be the carer most directly involved in Client care as recorded in care plan
- Where a decision involves the provision of medical treatment, the G.P or other health care staffs are the decision makes. All decisions are recorded in care plan.
- Where nursing or paid care is provided, the nurse or paid carer will be the decision makers.
- If a Lasting Power of Attorney has been made or a deputy has been appointed under a Court order, the attorney or deputy will be the decision-maker, for decisions within the scope of their authority
- Whenever possible, the person who lacks capacity will be involved in the decision-making process.

A record is kept in the Client file and includes:

- How the decision about the person best interest was made
- What the reason for reaching the decision were
- Who was consulted to help work out best interests
- What particular factors were taken in to account

For major decision based on best interests of a person who lacks capacity the responsible person is also given a record of the decision.

FACTORS which may indicate that a person may regain capacity in the future:

- The cause of the lack of capacity can be treated, either by medication or some other form of treatment or therapy
- The lack of capacity is likely to decrease in time (for example, where it is caused by the effect of medication or alcohol, or following a sudden shock)
- A person with learning disabilities may learn new skills or be subject to new experience which increase their understanding and ability to make certain decisions

- The person may have a condition which causes capacity to come and go at various times (such as more forms of mental illness) so it may be possible to arrange for the decision to be made during a time when they do have capacity.
- A person previously unable to communicate may learn a new form of communication

Advocacy

Constantia Care will encourage the Client or responsible person to use an advocate if:

- the person who lacks capacity has no close family or friends to take an interest in their welfare, and they do not qualify for an independent Mental Capacity Advocate
- family members disagree about the person's best interests
- family members and professionals disagree about the person's best interests
- there is a conflict of interest for people who have been consulted in the best interests assessment (for example, the sale of family property where the person lives)
- the person who lacks capacity is already in contact with an advocate
- the proposed course of action may lead to the use of restraint or other restriction on the person who lacks capacity
- there is a concern about the protection of a vulnerable adult

Advance decision

If the Client has made an Advance Decision to refuse treatment while they still have capacity to do so and before they need that particular treatment this Advance Decision is kept in their file and health care staff must be informed and they must respect this decision if it is valid and applies to proposed treatment.

Restraint

This organisation understands that someone is using restraint if they:

- use force or threaten to use force to make someone do something that they are resisting.
- restricts a person's freedom of movement, whether they are resting or not

Restraint can be physical, medical and mechanical.

Constantia Care is aware that:

An action intended to restrain a Client who lacks capacity will not attract protection from liability unless: the person taking action must reasonably believe that restraint is necessary to prevent harm to the Client who lacks capacity the amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.

Additional staff must refer to and follow the organisation's Restraint Policy.

Related Policies

Advocacy
 Adult Safeguarding
 Dignity and Respect
 Deprivation of Liberty Safeguards
 Meeting Needs
 Restraint

Training Statement

This policy must be continually updated until clarity of the Cheshire West Judgement, via a Supreme Court Review is completed.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

MISSING PERSONS POLICY

OUTCOME 4, REGULATION 9 (Care and welfare of people who use services)

Constantia Care Ltd.

Policy Statement

It is common for some of the clients who Constantia Care provides care for to be frail, infirm or limited in their mobility. Some may also be confused or easily disoriented and therefore become easily lost. For these reasons, a client going “missing” from their home while under the care of a staff member from Constantia Care, would be an obvious cause for concern as to the client’s safety and will be considered as a potential emergency situation.

Constantia Care adheres fully to Outcome 4, Regulation 9 of the Care Quality Commission Guidance about compliance, Essential standards of Quality and Safety, which relates to the degree to which clients are protected from abuse, neglect and self-harm.

Aim of the Policy

This policy is intended to set out the values, principles and policies underpinning Constantia Care’s approach to the discovery that a client is missing.

Preventing Missing Persons Incidents

Staff from Constantia Care will always remain vigilant, and be aware of exactly where clients are at any given time. Clients who are prone to wandering, or who may be at risk of getting lost by reason of their mental state, will have this identified during risk assessment and a suitable entry made in their plan of care.

Such clients will be kept under observation as appropriate to the level of risk identified.

Situations where a missing person’s report will be made include the following:

- where a client has not returned from or has got lost during an arranged activity or walk
- where a client cannot be found in their house or grounds and no prior arrangements have been made to explain their absence

If it becomes clear that a client may be missing, it is vital that all the members of staff in Constantia Care work as a team and follow a clearly defined procedure.

Missing Persons Procedure

Immediately they suspect that a client may be missing, staff at the client’s home or place of care will:

- Initiate an immediate search of the building and its immediate surrounds
- Contact relatives, friends, neighbours or other obvious places where the client may have gone or has been known to go in the past.

If the client cannot be found during the initial search, then the member of staff will immediately raise the alarm by informing their line manager at the office by phone.

They will pass on all relevant information, such as the full details of the client (it is very important to correctly identify the client) and full details of the incident, including when and where the client was last seen, who by and what the client was wearing.

The member of staff will then remain at the client’s home or place of care in case the client returns.

Upon receiving a missing person's report the line manager will do the following.

- Make immediate efforts to contact the client's relatives or carers, if not already done, to inform them of the situation, to gather information and to get advice.
- Contact the police and give full details about the client, including when and where they were last seen, who by, what they were wearing and any special risk factors involved. Contact telephone numbers will be given and the line manager will remain at the office to co-ordinate Constantia Cares response and to maintain communications.
- Co-operate fully with any police search.

Where the police are involved then Constantia Care's registered owners will be informed as soon as possible, as will members of the missing client's family if they have not already been contacted. Families will be requested to telephone the office or police if the client contacts them, and relatives will be kept informed at each stage of the search.

The line manager will, at the earliest opportunity, fill out an incident form and ensure that a full note of events has been made in the client's notes by the member of staff at the client's home. Times of actions and decisions will be noted as accurately as possible. On conclusion of the incident, staff involved will be asked to check the incident form for accuracy and to sign it.

Once the client has been found, it is essential that all the parties who were advised of the emergency are contacted again and informed that the search has been concluded, including the member of staff at the client's home and the police.

At all stages the line manager will be sensitive to the needs of members of staff involved, who may well be upset by the emergency incident, and will provide or arrange any support required, including bringing in extra staff to help or sending someone to "sit" with the staff involved, and checking staff are OK before they go home.

If at any stage the duty manager is unsure of what to do then the registered owner will be contacted immediately for advice.

Procedure to Follow After a Missing Persons Incident

Upon conclusion of a 'missing persons' incident Constantia Care will mount a full enquiry and investigate the incident thoroughly. Investigations will be led by Constantia Care's registered manager who will also be responsible for implementing any improvements that are indicated. Under Outcome 20 of the Essential Standards of Quality and Safety issued by CQC a notification will be completed and submitted on line.

Training

The registered manager is responsible for organising and co-ordination training. All staff will be trained in the Missing Persons procedure and to know their role in the event of a search.

This policy will be reviewed by the registered manager

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

MONITORING AND ACCOUNTABILITY

OUTCOME 12, REGULATION 21 (Requirements Relating to Workers)

Constantia Care Ltd.

Purpose of this Document

This policy makes clear Constantia Care's expectations with regard to the completing of work sheets used to record the making of a call or visit to a client's home, and the accountability of staff with regards to their conduct using social networking sites.

The policy includes how Constantia Care monitors staff working patterns and the actions that it takes if it discovers that staff have been falsifying records, for example, by recording that they have made a visit when for some reason it has not been made.

The need for such a policy has arisen because of a (hopefully small) number of publicised incidents in which domiciliary care workers have been known to have falsified time or work sheets. In addition, networking sites have become a popular social pastime and this policy sets out how Constantia Care Ltd. expects its staff to conduct themselves whilst using those sites.

Scope with regard to Timesheets, Visits and Journeys

The policy applies to all care staff who have a schedule of visits and who need to record accurately the fact that:

1. They have made the visit
2. The duration of the visit, and
3. Journey times between visits.

Policy Statement

Constantia Care provides its care staff with a schedule of visits, which provides for some flexibility in that each set of work tasks always needs to be completed fully and to the satisfaction of the client. This can sometimes result in the schedule being disrupted and delayed.

Constantia Care also operates on the basis that there needs to be a certain level of trust placed in staff to carry out their work satisfactorily and it encourages transparency and honesty in the use of time. It expects staff to communicate any difficulties being experienced say in travelling and in obtaining entry to a client's home.

Constantia Care's policies on *Missing Persons, Home Security and Key Holding* address the main contingencies in which visits might not be completed as scheduled or result in delays, which can disrupt the rest of the worker's schedule.

In all of these instances the care worker is expected to contact their supervisor, line manager or office at the earliest opportunity and to discuss appropriate ways of proceeding.

The Use of Time Sheets

The time or work sheets that Constantia Care asks a care worker to complete on a daily basis provide a tool to enable Constantia Care to exercise its accountability for the service that it provides to its users and to its commissioners.

To complete the time sheet, Constantia Care requires the care worker to record the time of arrival at a house and of departure, obtaining the client's signature or that of someone else in the household wherever possible. If this is not possible then the space will be left blank. Constantia Care will try to obtain specimen copies of "authorised" signatures from clients or representatives in advance to help with the checking.

The line manager will collect time sheets on a weekly basis and carry out a check to assess the visits have been made as planned and to take note of any issues indicated by the records. The manager might make spot checks by telephoning a sample of clients to make sure they have received the visits as planned and to discuss any quality issues arising.

When making their supervisory visits to clients' homes to comply with care standard 21.3, the manager will also check care plans and records held in the home to verify that the visits have taken place as planned. Managers will also use review meetings as a monitoring vehicle.

Constantia Care expects that its care staff will be able to account for any significant discrepancies or departures from the agreed schedules. It will use staff meetings and supervision to discuss any workload difficulties that might be experienced.

However, it does expect honesty and transparency and will take disciplinary measures if it discovers that there has been deliberate falsifying of time sheets and care workers have not been carrying out their agreed work schedules. The outcome could result in a worker's dismissal.

Also if it has been proved that care workers by their misconduct — for example, not making calls when they have recorded them — have caused harm or possible harm to clients, Constantia Care will be legally required to refer them for possible inclusion on the Protection of Vulnerable Adults list, which would bar them from future care work. In some cases, Constantia Care might need to refer the matter to the police if it considers the care worker might have committed a criminal offence.

Scope of Policy with regards to Social Networking Sites Use

There are various numbers of these sites including

- Facebook
- Twitter
- Myspace
- Flickr
- YouTube

Policy

Constantia Care Ltd. expects all staff to be familiar with the General Social Care Council's Code of Practice, particularly in regards to the upholding of public trust and confidence in social care services. It is important for staff to remember that these are social sites and that anything regarding work will not be on any of these forums.

Where staff need to discuss any matter regarding work, this will be kept within the workplace and discussed in the first place with their line manager. If this does not resolve the issue, the staff grievance procedure is available. It is vital that staff do not involve clients, their families or representatives on these sites as confidentiality and the Data Protection Act could be breached. Flickr in particular can be easily misused. Pictures or videos of clients must remain private e.g. Birthday Party photos etc.

Where any misuse of these sites has been brought to the attention of Constantia Care Ltd. the disciplinary procedures will come into play where appropriate.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

MOVING AND HANDLING POLICY

OUTCOME 11, REGULATION 16 (Safety, Availability and Suitability of Equipment)

Constantia Care Ltd.

Policy Statement

Constantia Care recognises its responsibility to ensure that all reasonable precautions are taken to provide and maintain working conditions that are safe, healthy and compliant with all statutory requirements and codes of practice.

Constantia Care fully complies with Outcome 11, Regulation 16 of the Care Quality Commission Guidance about compliance, Essential standards of Quality and Safety, which both relate to the degree to which the registered manager of an organisation ensures that clients and staff are protected from health and safety hazards in Constantia Care.

Manual handling is also covered specifically by the following legislation:

1. The *Health and Safety at Work Act 1974*
2. The *Management of Health and Safety at Work Regulations 1999*
3. The *Manual Handling Operations Regulations 1992*
4. The *Lifting Operations and Lifting Equipment Regulations 1998*.

The *Manual Handling Operations Regulations 1992* were the end result of a European directive, issued in 1990, and are firmly based on a “minimal handling” approach to manual handling. Under the Regulations, employers are required to avoid the need for employees to undertake any manual handling operations which involve a risk of their being injured and where such activities cannot be immediately eliminated a “suitable and sufficient assessment” of all such operations is mandatory. Having carried out this assessment, employers must take appropriate steps to reduce the risk of injury to the lowest level reasonably practicable.

Aim of the Policy

This policy is intended to set out the values, principles and policies underpinning Constantia Care’s approach to manual handling.

Manual Handling at Work Policy

Constantia Care recognises its responsibility under the *Health and Safety at Work, etc Act 1974* and the *Management of Health and Safety at Work Regulations 1999* (MHSWR) to ensure that all reasonable precautions are taken to provide and maintain working conditions that are safe, healthy and compliant with all statutory requirements and codes of practice. Employees, clients and contractors are expected to abide by safety rules and to have regard to the safety of others.

Constantia Care understands manual handling as the transporting or supporting of loads by hand or by bodily force without mechanical help. This includes activities such as lifting, carrying, shoving, pushing, pulling, nudging and sliding heavy objects. It especially covers the lifting or moving of clients by staff.

Constantia Care is committed to ensuring the health, safety and welfare of its staff, so far as is reasonably practicable, and of all other persons who may be affected by our activities including clients, their visitors and contractors.

As all of these manual handling activities obviously carry the risk of injury if they are not performed carefully, Constantia Care will take the following steps to ensure that its statutory duties to protect staff and clients are met at all times.

1. Each employee will be given such information, instruction and training as is necessary to enable safe manual handling.
2. All processes and systems of work will be designed to take account of manual handling.
3. All processes and systems of work involving manual handling will be assessed and properly supervised at all times.

Risk assessments

All potential lifts or manual handling tasks will be fully assessed first using the following process.

1. A moving and handling risk assessment will be undertaken, by a member of staff who is trained for the purpose, whenever staff are required to help a client with any manual handling task, as required under the *Manual Handling Operations Regulations 1992*. This will be performed in any new care situation and before the care or support worker commences work. The results will be included in the risk management plan.
2. Two people fully trained in safe handling techniques and the equipment to be used will always be involved in the provision of care when the need is identified from the manual handling risk assessment.
3. Company staff will always consider each manual handling task for risk of injury. If the activity involves occasional lifting of small, regular-shaped, lightweight items, the risk can be deemed to be negligible. If however the task involves repeated movement of a heavier item, or one that is an irregular shape, then the risk is increased and will be identified as a potential risk.
4. If a risk is identified, care staff will next consider whether there is a way to eliminate the need for manual handling altogether. For instance, can equipment be used instead?
5. If the manual handling task cannot be eliminated completely, the specific risks involved must next be assessed. This is done in a similar way to any other health and safety risk assessment but the assessment does not need to be recorded provided it is easy to repeat.
6. Where a specific risk of injury is identified and manual handling is unavoidable, then measures to reduce the risk must be introduced. Examples of these are the use of mechanical aids, changing the task to minimise the risk or altering the working environment to make manual handling less awkward.
7. Any measures taken to ensure manual handling safety must be in proportion to the risk and the cost-benefit involved.

Note: Staff will never, in any circumstances, attempt to lift a client or a weight where they believe that there is a significant risk of injury involved.

Constantia Care's policy will, so far as is reasonably practicable, be to:

1. Provide and maintain lifting equipment such that health and safety is not compromised
2. Provide the information, instruction, training and supervision required to ensure the health and safety, at work, of employees and others
3. Control and maintain the place of work in a safe condition
4. In the event of any accident or incident (such as a near miss) involving injury to anybody on work premises to make a full investigation and to comply with statutory requirements relating to the reporting of such incidents.

Duties on Company Staff and Employees

The *Manual Handling Operations Regulations 1992* set out an obligation upon employees to make full use of systems of work laid down for their safety in manual handling operations. This is in addition to their obligations under other health and safety legislation including making proper use of equipment provided for their safety. To conform with the *Manual*

Handling Operations Regulations 1992, Constantia Care requires its staff to adopt the following three-stage model.

1. Staff will avoid hazardous manual handling as far as is reasonably practical.
2. Where hazardous manual handling cannot be avoided, staff will assess the risk first.
3. Depending on the result of the assessment, staff will reduce the risk involved to the lowest level reasonably practicable.

The successful implementation of this policy requires total commitment from all employees.

Each individual has a legal obligation to take reasonable care for their own health and safety, and for the safety of other people who may be affected by their acts or omissions.

It is also the policy of Constantia Care that, under s.7 of the *Health and Safety at Work, etc Act 1974*, it is the duty of every employee at work:

1. To take reasonable care of their own health and safety and those of any other person who may be affected by their acts or omissions at work
2. As regards any duty or requirement imposed on their employer by or under any of the relevant statutory provisions, to co-operate with the employer, so far as is necessary, to enable that duty or requirement to be complied with.

In addition, no person at Constantia Care shall intentionally or recklessly interfere with or misuse anything provided in the interests of health, safety and welfare in pursuance of any statutory provisions.

Staff injured at work

Manual handling accidents are covered by the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995* (RIDDOR). According to RIDDOR, all manual handling accidents and injuries will be recorded and also reported to the HSE, especially if they result in staff being off work for three days or more or involve faulty equipment (see Accident Reporting Policy). All staff injured at work will be given appropriate support and any staff who have suffered a manual handling injury will see their GP as soon as possible. Any necessary alterations to a member of staff's job after an accident will be made in line with current *Disability Discrimination Act 1995* guidelines.

Lifting equipment

Any Moving and Handling equipment provided will be maintained in a safe condition to use and be subject to regular visual inspections by the manufacturers. Lifting equipment (people) must be inspected 6 monthly by a suitably qualified person. Records of all such equipment and their maintenance schedules are kept in the office. In Constantia Care, **John Collier** is responsible for ensuring that equipment is maintained adequately.

Training

Everyone in Constantia Care will be given adequate training and information on manual handling risks and how to avoid them. Such training will focus on specific tasks and equipment as well as on the more general information required to carry out safe manual handling. All staff will be trained to assess whether or not a load is too heavy to carry.

All new staff are encouraged to read the policies on health and safety and manual handling as part of their induction process. All staff are expected to attend annual manual handling refresher training. In addition, all staff will be appropriately trained to perform their duties safely and competently and those staff who need to use specialist equipment will be fully trained and supervised while they are developing their competency.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

MRSA POLICY

OUTCOME 8, REGULATION 12 (Cleanliness and infection control)

Constantia Care Ltd.

Policy Statement

Constantia Care believes that adherence to strict guidelines on infection control is of paramount importance in ensuring the safety of both clients and staff. Constantia Care adheres fully to Outcome 8, Regulation 12 of the Care Quality Commission Guidance about compliance, Essential standards of Quality and Safety, which relates to the degree to which staff and clients are protected by Constantia Care's policies and procedures.

Aim of the Policy

The aim of Constantia Care is to prevent the spread of MRSA amongst clients and staff.

Goals

The goals of Constantia Care are to ensure that:

- Clients, their families and staff working for Constantia Care are as safe as possible from MRSA
- All staff in Constantia Care are aware of the causes of the spread of MRSA and are trained to avoid these
- Clients who are colonised with MRSA receive the highest quality of care and are not discriminated against.

Legal Considerations and Statutory Guidance

Constantia Care will adhere to the following infection control legislation:

- The *Health & Safety at Work, etc Act 1974* and the *Public Health Infectious Diseases Regulations 1988* which place a duty on Constantia Care to prevent the spread of infection
- The *Control of Substances Hazardous to Health Regulations 2002 (COSHH)* which place a duty upon employers to control dangerous substances in the workplace
- The *Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)* which place a duty on Constantia Care to report outbreaks of certain diseases as well as accidents such as needle-stick accidents.

Policy Background

MRSA, or *Methicillin Resistant Staphylococcus Aureus*, is a variant of *Staphylococcus Aureus*, a type of bacterium carried normally by about a third of the population. In most people *Staphylococcus Aureus* causes no harm.

However, when the skin is broken or where a patient is otherwise unwell the bacteria can cause boils or pneumonia and can prevent wounds from healing properly. MRSA behaves in much the same way as its more common relative but, while *Staphylococcus Aureus* is readily treatable with modern antibiotics, MRSA has a high resistance to antibiotics which makes MRSA infections much harder to treat.

Many people carry MRSA in the same way that they carry *Staphylococcus Aureus* without it causing any harm to themselves or others. These people are said to be 'colonised' with MRSA rather than 'infected' as they are not ill and there are no visible signs that they are carrying MRSA. However, when MRSA does cause an infection this can be very dangerous, even life threatening, and is especially problematic in elderly, vulnerable patients who are debilitated.

In healthcare settings, MRSA is spread by hand from person to person, unwittingly by healthcare employees who do not wash their hands sufficiently between person contacts. It can also become established in clinical areas, on equipment and in such things as bedding and clothes and extremely vigorous cleaning and infection control techniques are required to eradicate it or halt its growth.

Policy on Preventing MRSA

In healthcare organisations MRSA carriers will not be a hazard to staff and, according to Department of Health guidelines, the implementation of sound infection control techniques, especially rigorous attention to hand washing, are sufficient to control the spread of the bacteria.

Therefore, in Constantia Care:

- All staff will comply with Constantia Care's infection control policies and procedures and adhere to best practice in infection control at all times
- All staff will adhere to Constantia Care's Handwashing Policy at all times, ensuring that their hands are thoroughly washed and dried on arrival and before leaving a client's home, between seeing each and every client where direct contact is involved, after handling any body fluids or waste or soiled items, after handling specimens, after using the toilet and before handling foodstuffs; Constantia Care believes that, consistent with modern infection control evidence and knowledge, hand washing is the single most important method of preventing the spread of infection whether a client is a known carrier of MRSA or not
- All staff will adhere to Constantia Care's Protective Clothing Policy and disposable gloves and aprons will always be worn when attending to dressings, performing aseptic techniques, dealing with blood and body fluids or when assisting with bodily care; gloves and aprons will be changed and disposed of after each procedure or contact and always between contacts with different clients
- Cuts, sores and wounds on staff and clients will be covered with suitable impermeable dressings
- Blood and body fluid spills will be dealt with immediately according to Constantia Care's Infection Control Policy
- Clinical waste will be disposed of according to Constantia Care's Infection Control Policy
- Sharps will be disposed of into proper sharps containers
- Equipment (such as commodes) will be cleaned thoroughly with detergent and hot water after use
- Clients and staff will not need routine screening for MRSA unless there is a clinical reason for such screening to be performed (for example, a wound getting worse or new sores appearing) and in such cases screening will be requested by a GP or by the local consultant in communicable disease control
- If a client's wound gets worse or does not respond to treatment then the client's GP will be advised immediately
- MRSA risks will be included in COSHH assessments and any appropriate control measures taken to reduce identified risks.

If a client is identified as colonised with MRSA:

- They will not be isolated (according to Department of Health guidelines the isolation of colonised clients in nursing organisations is not necessary and may adversely affect the clients' quality of life)
- They may receive visitors and go out, for example to see their family or friends, and will not be discouraged from normal social contact
- Friends or family need not take any special precautions when visiting
- Domiciliary staff with eczema or psoriasis will not perform intimate nursing care on clients with MRSA.

When arranging care for a new client or when transferring clients to and from hospital:

- The relevant care manager will always ask in the initial assessment of a potential client if there is any record that the applicant is colonised or infected with MRSA and this will be entered into the plan of care
- Colonisation with MRSA will never be reason for refusing a service to a potential client, for preventing discharge from hospital or for any other form of discrimination
- Carers will always inform a hospital if a client that they care for who is admitted hospital is known to be infected with or colonised with MRSA
- Clients with MRSA will not normally require special treatment after discharge from hospital but if a specialised course of treatment needs to be completed, the hospital will be asked to provide all the necessary details and agree in advance in the discharge plan and check that Constantia Care is agreeable
- Domiciliary s will seek and follow expert infection control advice from the consultant in communicable disease control and/or community infection control nurse in any case where support is required and for any client with MRSA who has a post-operative wound or a drip or catheter.

Contact details for the local Consultant in Communicable Disease Control (CCDC), Communicable Disease Team or Communicable Disease Control Nurse are as follows:
Public Health Team – Liz Brookes; liz.brookes@barnetnhs.uk

Reporting

MRSA is not a notifiable infection under the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)* which oblige Constantia Care to report the outbreak of notifiable diseases to the Health and Safety Executive. The presence of MRSA in a client can only be ascertained by the laboratory investigation of swabs and any positive result will be notified to the client's GP. Domiciliary care managers will liaise with the relevant GP if a positive result is received and will work with all relevant members of the healthcare team to revise the client's plan of care and to ensure that everybody involved in the care of the client is informed.

Training

All new staff will be encouraged to read Constantia Care's policies on Infection Control as part of their induction process. In house training sessions covering basic information about infection control will be conducted at least annually and clinical staff and those with special responsibilities for infection control and risk assessment will also be supported in doing additional advanced training on infection control as required.

Further Information

Information sources used in the preparation of this policy include:

The Health and Social Care Act 2008 Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance

MRSA — *What nursing and residential organisations need to know?* Department of Health guidance.

Hospital Infection Control: Guidance on the Control of Infection in Hospitals, HSG(95)10 — available free from the Health Publications Unit.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

NOTIFICATION POLICY

OUTCOME 20, REGULATION 18 (Notification of other incidents)

Constantia Care Ltd.

Policy statement

This policy is intended to set out the values, principles and policies underpinning Constantia Care's approach to its notification requirements. These requirements are set out in the Health and Social Care Act (2008) Registration Regulations (2009). Although this outcome and regulation do not form part of the Key 16 outcomes it warrants a policy on its own because of the complexity and importance of Outcome 20.

Aim of Policy

The aim of the policy is to comply with outcome 20 and to ensure that all relevant notifications are completed in the appropriate format and timescale as required by the Care Quality Commission.

Statutory Notifications

The Care Quality Commission regularly updates and amends the electronic system of notifications. These notifications and their purpose are made clear in the Guidance issued by the Care Quality Commission. See Statutory Notification Guidance for Registered providers and managers of;

Adult Social Care
Independent Health Care
Primary Dental Care
Independent Ambulances

In Constantia Care a regular check of the Care Quality Commission website will be undertaken in order to ensure that we are fully compliant and up to date with all Statutory Notification requirements and guidance.

Training

All staff involved in the completion of the Statutory Notification records will be trained and made aware of the importance of the documents and their timely return to the Care Quality Commission. It will be noted however that Outcome 20 makes clear the responsibilities of the Registered Manager in relation to the Statutory Notification process.

This policy will be reviewed annually by the registered manager

Signed: *Morag Collier*
Date: 30/01/18
Date of Review: 30/06/18

NUTRITIONAL AND HYDRATION NEEDS

Constantia Care Ltd

Policy Statement

Constantia Care believes that the provision of a healthy, nutritious and balanced diet for its Clients is of vital importance. Constantia Care also believes that, with respect to food provided within the service or brought into the service, there is a duty to ensure that all Carers and Clients should be kept as safe as possible from food poisoning, and food-related illness, by the adoption of high standards of food hygiene and food preparation

The Policy

This policy is intended to:

- ensure that Clients benefit from being prepared food that is of high quality, well-presented and prepared, and which is nutritionally sound
- ensure that those with special dietary needs are supported
- protect carers and Clients from food-related illness

Constantia Care believes that every Client has the right to choose from a varied and nutritious diet that provides for all their dietary needs, and which offers health, choice and pleasure. To accomplish this, each Client will be asked for their individual food preferences as well as their cultural, religious or health needs. Clients or their family will always be involved when planning menus and meal alternatives.

In this service:

- All food will be prepared, cooked, stored and presented in accordance with the high standards required by the *Food Safety Act 1990*, the *Food Safety (General Food Hygiene) Regulations 1995*, the *Food Safety (Temperature Control) Regulations 1995*, and the *Food Hygiene Regulations 2006*.
- Food allergens can be life threatening and this organisation will work with the Client to ensure all food allergens are recorded in the care plan and carers are aware and when preparing food check that there are no foods in the preparation of meals to which the Client is allergic. We also make our carers and Clients aware of and ensure they know how to respond to any allergic reaction. The most common symptoms of an allergic reaction includes:

Body part affected	Physical reaction
Eyes	Sore, red and/or itchy
Nose	Runny and/or blocked
Lips	Swelling of the lips
Throat	Coughing, dry, itchy and swollen throat
Chest	Coughing, wheezing and shortness of breath
Gut	Nausea and feeling bloated, diarrhoea and/or vomiting
Skin	Itchy and/or a rash

- Any reaction can be life threatening and medical assistance will be sought immediately and all emergency procedures followed for that Client.
- Methods of cooking will be agreed upon by the Client and the care organisation.

- Each Client will be encouraged and supported to eat three full meals each day, at least one of which will be cooked. However, if the Client prefers smaller, more frequent snacks this will be catered for in the service provided.
- When Clients are unable to prepare their own drinks both hot and cold drinks will be made and left for the Client to access throughout their day and during mealtimes.
- Religious, personal or cultural special needs will be recorded in the Care Plan and will be fully catered for as required by the Client.
- Menus will be created by carers with Clients and their family, if appropriate, so that the required shopping can be purchased.
- In agreement with the Client, menus may be changed regularly to stimulate appetite and discussion.
- Special therapeutic diets will be recorded in the care plan and provided when these are advised and discussed by healthcare or dietetic carers with the Client
- In a live-in setting it is important not to rush the mealtimes, but instead to create a relaxed atmosphere in which Clients are given plenty of time to eat and enjoy their food.
- Food will be presented in a manner that is attractive and appealing.
- If a Client neither wants to nor eats their meal then an alternative or a meal replacement may be offered, if appropriate; these changes must be recorded in the Daily Observation
- Carers will help all Clients to be as independent in feeding themselves as possible and will work to ensure their dignity while they are doing so. Eating difficulties will be identified within each Client's Care Plan and a plan of assistance agreed, both with the Client and with their carers.
- The service will make whatever reasonable arrangements are necessary for a Client to be able to feed themselves with dignity and ease, including the provision of special eating aids and special food preparation; assistance with feeding will be offered in a sensitive and dignified manner. Provision of finger foods.
- The nutritional model followed will be based around the "Balance of Good Health, Eat Well Plate" guidance. www.food.gov.uk

The model has eight key principles, which are as follows:

- Food should be enjoyed
- A variety of different foods should be eaten
- The right amount should be eaten to maintain a healthy weight
- Plenty of foods rich in starch and fibre should be included in the diet
- Foods that contain a lot of fat should be avoided, and sugary foods and drinks should not be eaten or drunk too often
- Vitamins and minerals in food are critical
- Alcohol consumption should be within sensible limits
- Menus should take into account any ethnic or cultural dietary needs of Clients and should be sensitive to religious and cultural beliefs surrounding food.

For live-in care providers this is an area where motivation and encouragement of the Client is central to the service delivery, where it is identified that the Client is making unhealthy choices.

Nutritional Screening

Nutritional Screening is undertaken by this organisation to identify those at risk of malnutrition, or to identify obesity. Screening is undertaken by a member of staff trained to understand the process, who liaises closely with other professionals such as dieticians, speech & language therapists or the Healthy Living nurse.

The five step Malnutrition Universal Screening Tool (MUST) is used.

Records are kept in the Client's Care Plan.

Observation of weight and associated issues

On a day to day basis carers are best placed to observe the wellbeing of the Client in relation to any issues regarding nutrition and hydration. Where weight gain or loss is observed carers must ensure that a proper recording of such a situation takes place appropriate guidance should be sought which includes the views of the Client and how they could improve the situation. This is particularly important in a situation where there is a health issue e.g. diabetes. It is therefore important that carers check that food has indeed been eaten.

While any Client receiving our service could be considered to be at risk of undernutrition, certain other groups also pose a definite risk.

These include:

- people with existing acute and long-term conditions such as chronic obstructive pulmonary disease
- people with long-term, progressive conditions such as dementia and cancer
- people who have been discharged from hospital recently
- older people in general

As part of the initial nutritional and hydration assessment/screening the Client's consent is gained to measure and record their weight. If it is not possible to weigh the Client then the following information concerning their weight is documented

- the Client is asked about their latest recorded weight
- if they have noticed any weight gain or loss
- relatives are asked about the Client's weight
- a visual assessment is carried out to determine if the Client looks thin e.g. loose rings on fingers

If the Client is under the care of a health professional for weight loss or obesity, then the health professional will identify the frequency for the need to weigh the Client.

Related Policies

Adult Safeguarding

Assessment of Needs

Care and Support Planning

Consent

Food Hygiene

Meeting Needs

Prevention of Pressure Ulcers

GUIDENCE

NICE guidelines [CG32]: Nutrition support in adults: Oral nutrition support, enteral tube feeding and parenteral nutrition (Published February 2006 Updated August 2017).

NICE Quality Statement [QS24] Nutrition Support in Adults (Published 2012)

Statement 1. People in care settings are screened for the risk of malnutrition using a validated screening tool.

Statement 2. People who are malnourished or at risk of malnutrition have a management care plan that aims to meet their nutritional requirements.

Statement 3. All people who are screened for the risk of malnutrition have their screening results and nutrition support goals (if applicable) documented and communicated in writing within and between settings.

Statement 4. People managing their own artificial nutrition support and/or their carers are trained to manage their nutrition delivery system and monitor their wellbeing.

Statement 5. People receiving nutrition support are offered a review of the indications, route, risks, benefits and goals of nutrition support at planned intervals.

<https://www.nice.org.uk/guidance/QS24/chapter/List-of-quality-statements>

TRAINING

All new carers will be asked to read this policy as part of their induction process. All carers will undertake training in nutrition, the provision of a healthy balanced diet, food handling, in aiding Clients with eating difficulties and the importance of accurate recording of the Clients weight.

This policy will be reviewed by the registered manager.

Morag Collier

Signed: *Morag Collier*

Date: 20/02/18

Review Date: 20/08/18

Oral Health

Constantia Care Ltd.

Policy Statement

As Constantia Care we recognise the importance of good oral health including dental health and daily mouth care. Our aim is to encourage our clients to maintain and improve their oral hygiene and encourage timely access to dental treatment.

We have a nominated “Oral Health Care Champion”/ member of staff who liaises with dental and oral professionals to ensure all clients are receiving the correct support and care and also support staff in this area.

As Constantia Care we follow NICE Guidelines NG48 and access resources such as the “Oral Health Toolkit” <https://www.nice.org.uk/guidance/ng48/resources> and carry out an oral health assessment using the tool available from the above mentioned website. This acts as a risk assessment flagging up any issues regarding oral health

The Policy

We assess the oral care needs of all clients as soon as they start receiving our service. Clients, relevant persons and where consented to by the client, family and friends are involved in the initial assessment. This informs the plan of care for continued oral hygiene support as consented to by the client.

The assessment includes;

- how the client usually manages their daily mouth care (for example, tooth brushing and type of toothbrush, removing and caring for dentures including partial dentures and identifying any support required)
- taking regard to any cultural or ethnic preferences in regards to oral hygiene
- If they have dentures, including partial dentures, whether they are marked or unmarked. If unmarked, we can arrange for marking if they wish
- obtaining the name and address of their dentist or any dental service they have had contact with, and where and how long ago they saw a dentist or received dental treatment
- recording if there has been no contact or they do not have a dentist, and help them find one and support the client to make an appointment
- this is recorded in the care plan and the date and time of any forthcoming appointments documented
- results of any dental assessments and appointments are recorded in the care plan along with any mouth or dental care requirements
- reviews are carried out with the care plan reviews or if oral health needs change

Daily mouth care

We ensure care staff provide clients with daily support to meet their mouth care needs and preferences, as set out in their care plan after their assessment.

This includes encouraging and supporting clients to:

- brush their natural teeth at least twice a day with fluoride toothpaste
- providing daily oral care for full or partial dentures (such as brushing, removing food debris and removing dentures overnight)
- use their choice of cleaning products for dentures if possible
- using their choice of toothbrush, either manual or electric/battery powered
- daily use of mouth care products prescribed by dental clinicians (for example, this may include a high fluoride toothpaste or a prescribed mouth rinse as per their MAR)

- daily use of any over-the-counter products preferred by clients if possible, such as particular mouth rinses or toothpastes; or sugar-free gum, (gum containing xylitol helps promote dental health)
- Observing and reporting any soreness, bleeding, pain or marks while carrying out oral hygiene

Supporting Staff Knowledge

Information on specific oral health needs are given by an appropriate health professional and recorded in individual care plans.

Prescribed mouth care products are as per MAR

Training on general oral health is given to all staff, this includes;

- understanding the importance of clients' oral health and the potential effect on their general health, wellbeing and dignity
- understanding the potential impact of untreated dental pain or mouth infection on the behaviour, and general health and wellbeing of people who cannot articulate their pain or distress or ask for help (this includes, for example, clients with dementia or communication difficulties)
- knowing how and when to reassess clients' oral health
- knowing how to deliver daily mouth care
- how to support people who are lacking capacity with oral health care tasks e.g. the brushing of their teeth
- understanding the role of diet, alcohol and tobacco in promoting good oral health
- knowing how and when to report any oral health concerns for clients, and how to respond to a client's changing needs and circumstances (for example, some clients, may over time lose their manual dexterity)
- understanding the importance of denture marking and how to arrange this for clients, with their permission (there are many advantages to denture marking most importantly the ability to identify and the return of lost or misplaced dentures, which is essential for our clients)
- ensuring care staff know how to respond if a client does not want daily mouth care or to have their dentures removed
- recognising and reporting adverse symptoms

As Constantia Care we work with and access information from local Health Watch Teams and Dental Public Health information to support us to meet the oral health needs of all clients, especially those with complex needs. We have also created local partnerships or links with general dental practice and community dental services including special care dentistry. This enables the sharing of good practice and the identification of any gaps in the service to our clients. It also enables us to provide routine or specialist preventive care and arrange their treatment as necessary, in line with local arrangements on

Contact Details

- The contact details of the individual clients' Dentist or NHS Dentist are documented in their care plan should they have one.

Training: Oral health is covered during induction and training is received by staff throughout their employment.

Related Policies

Assessment of Need

Care Planning

Consent

Co-operating with other Providers

Dignity and Respect

Equality and Diversity

Mental Capacity

This Policy will be reviewed by the Registered Manager

Signature: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

OUT OF HOURS EMERGENCY ON CALL COVER POLICY

OUTCOME 4, REGULATION 9 (Care And Welfare of People who use Services)

Constantia Care Ltd.

Policy Statement

The out of hours duty is a requirement within the service specification for social services contracts and is linked to the care and welfare of people who use services, in that it provides a mechanism to ensure that while staff are at work, there is a safe and tried method of contact between the staff and Constantia Care.

This ensures the safeguarding of both staff and clients. It is important that those who undertake the duty of the out of hours contact are clear about their role and what they need to do in certain circumstances. This policy outlines their responsibilities and procedures to be followed under certain circumstances. It also gives guidance where staff need to refer to the out of hours social services team.

Guidelines

The out of hours duty is to ensure a response to a situation and where necessary to implement an action. The situation will be one of an emergency nature, not that of a situation which can be dealt with within normal working hours. Staff and clients will use it in the following circumstances:

- To report staff sickness
- To seek advice in an emergency
- To relay urgent information
- To convey information which is required first thing the next morning

Definitions

In order for the criteria to be applied, everyone has to share the same understanding of what we mean by emergency, priority, urgent etc. The important thing to remember is that the definitions are not set in stone, and that common sense coupled with the relevant information will enable the out of hours duty worker to make the best decision given the information.

So what constitutes an emergency or an urgent or crisis situation? Perceptions are often not the same as facts. Factual information gathering is the prerequisite for an appropriate response, along with the ability to stay calm and ask the right questions in order to gain the full picture of the situation.

An Emergency

This is a situation that requires an immediate response, and is usually a life or limb scenario, involving the emergency services as required e.g. Police, ambulance, fire service or coastguard. These four services are available via the emergency 999 number.

Crisis

These situations often look worse than they are, and can be things like an unexpected fall, a sudden deterioration in health, an unplanned hospital discharge, or a carer who is, for whatever reason, unable to continue in their caring duties. This can be particularly difficult where the carer is in a 24 hour live in situation.

Urgent

These situations do not require immediate response, but do require forward planning. For instance, an urgent situation can be one where a family member is unable to turn up for a pre booked appointment, such as lunch or a hospital trip. You have time to forward plan, because the situation is not imminent, you are notified and given time to deal with it.

Priority

You urgent situation now becomes a priority for the next day dependent upon how much notice you've been given about the situation, and how many hours and days you have to respond.

Other situations need to be dealt with in a polite but firm manner and referred to the office during normal opening ours e.g. calls from staff Re time sheets or pay queries, changes to programme for the days ahead etc.

Clients need also to be reminded of what is appropriate for the out of hours.

All of these need to be "Signposted" to normal working office hours. The more you deal with these sort of situations, the more you are signalling that it is alright for your time to be taken up with queries that are not out of hours duties situations.

Please remember that social services out of hours teams have your duty number in order that they can gain access to providers who can in turn assist them with evening discharges from hospital, client falls etc. This includes situations in which they would send in a provider to prevent a hospital admission.

Out of Hours Procedures

You will need:

- The phone, including charger if a mobile is used
- Client information
- A list of helpful numbers
- Staff rotas and client visit sheets

It is important that you record all telephone activity on the out of hours record, so that, will any investigations or queries be instigated, there are records to show our response. The out of hours duty starts when the office closes, and you need to ensure, as a company, that all clients, staff and social services out of hours teams have your duty number.

Clients

Remember the out of hours cover is an emergency response cover, politely but firmly hold this line. Record all details on your telephone record, and your actions in regard to any situation that you have responded to. If the client is admitted to hospital, respite care, or residential care, remember to inform the next of kin and the social services if they are a social services funded client.

Staff

This is the same situation, always signpost all queries that can be dealt with during normal working office hours, to the next day. You cannot assist with things such as pay queries, because you do not have the information, nor on out of hours duty do you have the time to find the information. Remember, the phone is the only method that other emergency services, and social services out of hours team can contact you.

Scenarios

Listed below are general scenarios which occur during out of hours cover duty, the scenarios and the advice on how they will be handled, is guidance only. All staff who are on duty will know how to contact the out of hours duty cover, and be aware of what they need to report. Duty cover will always be available for staff advice in situations where they are not sure how to proceed.

Scenario 1 – Falls

All falls that are reported by staff will be dealt with in the same way. If there is an injury, paramedics will be called to check them over and to ensure that nothing is broken. Even if they are able to get themselves up, they are often left shaken and distressed, so always check if they want the paramedics or next of kin called, and record if they have declined. If they are unable to get themselves up from the floor, please check that staff have followed the correct moving and handling procedures, remember, we do not get anyone up from the floor. The paramedics will be called to assist the client from the floor. Record all of this activity and ensure that all is well before the carer leaves the clients home. Where there is no reply from a next of kin, ensure that this is a priority for the next morning.

Scenario 2 – A No reply

Clients sometimes forget to tell us that family are coming to take them out for an evening meal. Evening visits made by carers who cannot access are to be dealt with in the following way. When the carer calls in to report a no reply, please ensure that the carer has checked with neighbours, looked in windows and doors, and ascertained that the client is not there. Where they find that the client is on the floor, or perhaps sitting in the chair, they need to have shouted through the letterbox and tried to question the client calmly and quietly to find out as much as possible before deciding on a course of action. If there is still no response, the following steps need to be taken.

Where the client is visible but there is no response, call the paramedics straight away, they will then take charge of the situation and deal with it appropriately.

Where the client does not appear to be there, you need to try and ascertain the following.

- Has there been an admittance to hospital?
- If they are mobile, is it possible that a relative has taken them out on an unscheduled visit?
- If they are confused or have a mental health diagnosis, are they prone to wandering?

This is the type of client where you need to do some investigation surrounding the situation. Ask the carer to check with neighbours to see if they have seen anyone arrive such as an ambulance or GP. Leave no more than 1 hour to try to find out where they could be. If this is a social services client, inform the out of hours service who will deal with the situation and make the appropriate responses, they will make all the decisions, but may be in contact with you for further information regarding the client.

At this point the duty cover may wish to involve the registered manager in order that they take the appropriate steps. If the client is a self funder, then the responsibility lies with you to ascertain the whereabouts of the client, in which case, the missing persons policy comes into place.

The key phrase is

“This is an emergency contact number, so can I please ask that you ring the office in the morning where they will be happy to deal with your enquiry.”

Remember, the duty phone needs to be as clear as possible for real emergencies to be dealt with.

Note: The Social service out of hours system is staffed by a team of qualified social workers, including mental health specialists. This team is also a very good source of advice for the out of hours duty cover. Will you report anything to this team, it is fully logged and a faxed

report is sent to the appropriate local office with the details pertinent to that client e.g. had a fall, admitted to hospital etc. It is important that you inform social service duty team because they can stop visits that are planned for the next day, remember you may not be the only provider of service to that particular client.

For staff, the message has to be got across that this is not a carer information line, they have a responsibility to ensure they are equipped with all the relevant information to enable them to complete their work, and only where appropriate for advice or information that may need to be shared will they contact the out of hours duty cover. This document is intended as a guide and will not be viewed as a prescriptive remedy for all situations. Common sense and a clear channel of support are what is required for a successful model of the out of hours duty cover service.

List of Helpful Numbers Relevant to your Local Area and Local Emergency services such as hospitals etc will be part of the out of hours information and updated regularly

Morag Collier

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

OVERSEAS WORKERS POLICY

OUTCOME 12, REGULATION 21 (Requirements Relating to Workers)

Constantia Care Ltd.

Policy Statement

This policy is intended to set out the values, principles and policies underpinning Constantia Care's approach to the recruitment of foreign workers. Constantia Care understands that all foreign nationals, other than European Union (EU) citizens and citizens of certain Commonwealth countries, are subject to immigration control in the UK and will normally require a work permit. Some may also need an entry visa.

Citizens of the EU are more or less free to move from one Member State to another and to find work; the restrictions imposed by the national immigration law of individual Member States does not apply to them.

Constantia Care also understands that employing foreign nationals who are not permitted to work in the UK is a criminal offence under s.8 of the *Asylum and Immigration Act 1996* and can lead to a fine of up to £5000 per person illegally employed.

Policy

Constantia Care is committed to equality of opportunity in its recruitment, selection and employment practices. To prevent discrimination Constantia Care treats all applicants in the same way and verifies the eligibility of all new staff to work in the UK in accordance with its recruitment policy.

In order to comply with the *Asylum and Immigration Act 1996* Constantia Care will:

- Never discriminate against any candidate who may "look or sound" foreign
- Treat all job applicants in the same way and during the recruitment process check documents which prove the individual's entitlement to live and work in the UK, such as:
 - A current passport from the country of citizenship, with a valid visa if the passport is not from one of the exempt countries (eg. EU Member States, Gibraltar, Commonwealth countries with right of abode from a grandparent's birth in the UK)
 - A certificate of registration or naturalisation as a British citizen
 - A birth certificate issued in the UK, the Republic of Ireland, the Channel Islands or the Isle of Man
 - A document issued by a previous employer, the Inland Revenue, the Contributions Company, the Employment Service or the Benefits Company which states the National Insurance number of the person named
 - A valid work permit
- Accept only original copies of these documents (as photocopies may be tampered with)
- Keep copies of all documents with other recruitment files.

Constantia Care can obtain up-to-date guidance and application forms from the Immigration & Nationality Directorate of the Home Office or from its website at www.ind.homeoffice.gov.uk

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/05/18

PATERNITY RIGHTS POLICY

OUTCOME 14, REGULATION 23 (Supporting Workers)

Constantia Care Ltd.

This policy has been developed to provide you with guidance as to your entitlements and the procedure to follow if requesting paternity leave.

No employee will be treated less favourably, suffer detriment or be dismissed because they request or take paternity leave. However, the misuse of paternity leave — such as the use of leave for reasons other than to care for the child or support the mother, or failure to follow the correct procedure — may result in disciplinary action being taken against you.

Procedure

- Paternity leave is the right to take paid leave to care for a child or support the mother.
- In order to qualify for paternity leave in birth situations you must:
 - Be the child's biological father, and have, or expect to have, the main responsibility for the child's upbringing
 - Be the spouse or partner of the mother, and have, or expect to have, the main responsibility for the child's upbringing.
- In order to qualify for paternity leave in adoptive situations you must:
 - Be married to, or the partner of the adopter, and have, or expect to have, the main responsibility for the child's upbringing.
- In both birth and adoptive situations you must:
 - Have formally informed your manager of your intention to take statutory paternity leave
 - Have provided documentary evidence supporting your right to take statutory paternity leave, if requested by your manager.
- Paternity leave is for a maximum of two weeks. You may take the leave in a block of one or two consecutive weeks. Leave must be taken within 56 days of the birth of the child or, in the case of adoption, within eight weeks of the placement.
- Additional paternity leave. This will be available only if your partner has unused maternity or adoption leave and it can now be shared between both parents. From 2015 new plans will allow couples to share all their maternity or adoption leave 8 weeks before it starts. Further details will be released by the government.
- In order to take statutory paternity leave after the birth of a child, you must inform your manager of your intention to take leave by the end of the 15th week before the mother's expected week of childbirth (EWC). You must specify:
 - The week in which the baby is expected to be born
 - Whether you intend to take one or two weeks' leave
 - The date on which you intend to start your leave.
- In order to take statutory paternity leave after the adoption of a child, you must notify your manager of your intention to take leave no later than seven days after the date on which you received notification from the adoption company of the match with the child. If the child was adopted from abroad you must let your employer know the date on which you received notification of the placement and the date on which the child is expected to enter the UK.
- Statutory paternity leave may not be taken before the birth or adoption of a child.
- If you fall ill before starting your period of paternity leave, you should postpone it. The 56-day period within which you should take your leave is not extended under these circumstances.
- You may be entitled to Statutory Paternity Pay (SPP). Your manager will let you know whether you are. Should you not qualify for SPP you may be able to get Income

Support while on paternity leave. Your local Social Security Office will be able to give advise.

- You are entitled to return to the same job as before, on the same terms and conditions of employment, unless a redundancy situation arises. It is presumed that you will return to work after a period of paternity leave.
- If you cannot return to work at the end of your paternity leave because of illness, you should follow the normal procedures for sickness absence.
- If you do not wish to return to work you are required to give your manager notice in accordance with your contractual notice period.
- On some occasions it may be necessary for your manager to defer your paternity leave. This may occur if, in discussion with your manager, there is a strong organisational reason for deferral. The reasons may include:
 - A significant number of employees applying for paternity leave at the same time
 - Your role is such that your absence at a particular time may unduly harm the organisation.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

PERSONAL BUDGETS

Constantia Care Ltd.

Policy Statement

Constantia Care is committed to working with Adults regardless of the funding arrangements in place for their service. We will, where appropriate, assist with any types of funding mechanism and this includes a personal budget.

Care Act 2014

The Act sets out, in detail, how personal budgets are to be extended to include carers, how health personal budgets can be included, explains what they can be used for, and importantly, what services are excluded from use of these budgets. "Personal budgets are a key part of Government's aspirations for a person – centred care and support system. Independent research shows that where implemented well, personal budgets can improve outcomes and deliver better value for money."

It is the role of the Local Authority to assess and determine the personal budget, the amount to be paid including any contribution from the Client.

The local authority should allow choice of how the budget should be managed e.g. direct payments, local authority managed arrangements or a third party managing the budget on the Clients behalf an individual Service Fund (ISF) or a combination of these approaches.

Personal Budget Exclusions

Intermediate care and re-enablement services should usually be free, as a universal service under the Act. These services should be part of the care planning process but not included for personal budget purposes.

Future development

Our role, as a provider of services, is to be as flexible and open to developing services which can meet the needs of personal budget holders.

We will need to develop and build the systems to enable these flexible services such as itemised invoicing in order to be transparent and contribute to the audit requirements for Personal Budget holders.

Related Policies

Direct Payment

Self Funders

Statutory Guidance Care Act 2014 (updated May 2016) Chapter 11

Training Statement

All office based staff will be made aware and updated, as local authority guidance is made available to providers during 2015.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

PERSONAL SAFETY POLICY

OUTCOME 10, REGULATION 15 (Safety and Suitability of Premises)

Constantia Care Ltd.

Policy Statement

Constantia Care believes that its staff will be safe at work and will not be exposed to undue or unreasonable risk. In particular, Constantia Care is committed to implementing measures that increase the personal safety and security of staff wherever possible, along with safety of their personal property, and which ensure an effective response to personal safety and security incidents.

Constantia Care also seeks to encourage clients, staff and others to have care and concern for the safe keeping of equipment and property and the personal safety of all.

Constantia Care adheres fully to Outcome10, Regulation 15 of the Care Quality Commission Guidance about compliance, Essential standards of Quality and Safety, which relates to the degree to which staff and clients are protected by Constantia Cares policies and procedures.

This policy applies to all organisation staff without exception.

Aim of the Policy

This policy is intended to set out the values, principles and policies underpinning Constantia Cares approach to ensuring that staff working for Constantia Care are as safe as is reasonably practical while at work or when travelling to and from work.

Responsibilities of Constantia Care

Constantia Care will:

- Seek to ensure that it can respond effectively to all personal safety and security incidents, including incidents involving violence or threats of violence to staff, through the preparation of plans, management of incidents and appropriate follow up and recovery actions, as deemed necessary
- Seek to ensure that the personal safety of staff is always considered a factor when planning individual care plans with clients, especially with regard to staff travelling to and from a home care site; and, wherever possible, arrangements that involve staff travelling to and from houses alone during the hours of darkness and in isolated areas or in known high crime areas, will be avoided
- Be responsible for crime prevention/loss reduction measures, including assessing threats to personal safety of staff and investigating and initiating follow up actions in response to any reported incidents
- Provide staff with a personal alarm where necessary; raise awareness of personal safety and security issues by offering training and advice to staff and clients on personal safety and security.

Responsibilities of Staff

Constantia Care Ltd. believes that personal security is also the responsibility of every member of staff. Constantia Care expects every member of staff to accept that responsibility and to:

- Act and behave in a way so as to ensure their own safety and security at all times
- Act and behave in a way so as to ensure the safety and security of clients and property in the areas in which they are working
- Report all personal safety and security incidents, including violence or threats of violence to themselves, and suspicious activities or incidents
- Always leave information of their whereabouts with the office and with a friend/relative and to advise the office of any changes to their whereabouts

- Never leave equipment visible in their cars, especially things like mobile phones, laptop computers, etc.; staff will only carry equipment that is strictly necessary for the visit they are making and will lock it away in the boot
- Always try to park in a well-lit, open location, or walk to a client's home, along well-lit and populated routes.

All staff are strongly encouraged to carry a personal mobile phone and to ensure that an up to date contact number for it is left with the main office in case they need to be contacted. Staff carrying mobile phones will ensure that the battery is fully charged before leaving for work. A spare mobile phone is kept in the office for emergency use.

Constantia Care's Offices

Security is also considered an issue in Constantia Care's offices, especially for staff working alone there. Constantia Care's security lead, will conduct or arrange to conduct regular risk assessment checks around the offices specifically designed to pick up on security issues.

Checks will be carried out on a monthly basis and will include:

- Alarms
- Security lights
- Window and door locks

Staff will always be aware of who is in the building at all times. Any designated staff working at the office beyond their standard "going home" time will check who is still in the building before they leave.

Staff will enter the office building by using a key or via the keypad controlled entrance from the car park. Codes for the keypad will be kept secret by staff and never disclosed to anyone else. Keypad numbers will only be made known to staff on a "need to know" basis and will be changed every **12** months. Staff will never leave the outside door open.

Visitors are able to announce that they have arrived by using the entrance intercom system. Office staff will answer the intercom politely and check the identity of the caller before allowing them in. Staff who are working alone in the offices will be sure that they know the identity of a caller before allowing them in, otherwise they will refuse entry and ask the visitor to return when other staff are around.

Note: Constantia Care pursues a zero tolerance policy towards aggression and violence directed against staff (see separate policy on Dealing with Aggressive or Potentially Violent Clients).

Training

The registered manager is responsible for organising and co-ordinating training.

All staff will be trained to recognise the early warning signs of potential aggression and in de-escalating potentially violent situations. Office staff, line managers and supervisors will also be trained to know what to do in response to a complaint of violence made by a member of staff. Dealing with Aggressive or Potentially Violent Clients will be included in the induction training for all new staff. In house training sessions will be conducted at least annually and all relevant staff will attend. These sessions will cover the drill of how staff will act in an emergency situation.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/05/18

POSITION OF TRUST

Constantia Care Ltd

Policy Statement

Broadly speaking, a relationship built on trust can be described as one in which one party is in a position of power or influence over the other by the virtue of their work or the nature of their activity. It is vital that those in positions of trust understand the power this may give them over those they care for and the responsibility they must exercise as a consequence of their relationship.

Responsibility of Carer

It is important that Carers recognise that power is an important factor in working professional relationships and that such power must be balanced in order that it does not become abusive. The Sexual Offences Act 2000 prohibits a person in a position of trust from having sexual relations with someone who cannot consent, which include minors and “very vulnerable people”..

Abuse of Power

The act of using one’s position of power in an abusive way can take many forms such as improper use of authority by someone who holds public office.

An abuse of power is different from usurpation of power, which is the exercise of a power which the offender does not actually have.

Introduction

This policy concerns people who work with or care for adults at risk in a paid or voluntary capacity and who could be exposed to allegations of adult abuse or neglect. These individuals are known as “People in Positions of Trust” (PiPoT)

Principles

The following principles are in place and should be followed for all cases where concern, suspicion or allegations arise in connection with a person working with adults at risk who has:

- Behaved in a way that has harmed or may have harmed an adult at risk
- Possibly committed a criminal offence against or related to an adult at risk
- Otherwise behaved towards a vulnerable adult in a way that indicates she/he is unsuitable to work with adults at risk
- Behaved in a way that has harmed children or may have harmed children which means their ability to provide a service to people at risk must be reviewed
- May be subject to abuse themselves which means their ability to provide a service to adults at risk must be reviewed.
- Has behaved in a way which questions a person’s ability to continue providing a service to an adult at risk e.g. a conviction for grievous bodily harm

The above principles apply to current or historical allegations. Any information sharing must follow the principles of the Data Protection Act 1998 and the organisations own Information Sharing Protocols. Information should only be shared with those entitled to see it and consent should be sought where necessary from the appropriate person.

Where a PiPoT concern is identified, the organisations policies and procedures should be followed in respect of Adult Safeguarding protocols. If the allegations identify an Adult Safeguarding incident, the Adult Safeguarding team will instigate the PiPoT process.

Please note:

Where an allegation involves children, within an Adult setting, then refer to the appropriate policy - Safeguarding Children in an Adult Setting and inform the Local Authority Designated Officer (L.A.D.O).

If the concerns do not meet safeguarding thresholds, then a check must be made of the scope criteria applied to ensure the concerns are reported to the Adult Safeguarding team.

Related Policies

Adult Safeguarding

Codes of Conduct

Cyber Security

Disclosure and Barring Service

Whistleblowing

Safeguarding children in an adult setting

Please also refer to the Carers Handbook

Training Statement

All staff and carers need to be aware of this policy and in particular any changes to their circumstances which need to be shared because of its nature and potential impact on this policy.

This Policy will be reviewed by the Registered Manager

Signature: *Morag Collier*

Date: 20/02/18

Review Date: 20/08/18

PREVENTION OF PRESSURE SORES

OUTCOME4 REGULATION 9 (Care and welfare of people who use services)

Constantia Care Ltd

Policy Statement

Since the main type of client being cared for are elderly, whether with or without mental illness, pressure sore prevention is a continual challenge.

Pressure sores are multi factorial in origin and as such require a thorough assessment prior to the commencement of the service to determine the risks of the client developing pressure sores. Should a pressure sore exist on commencement of the service, the GP/District Nurse/Tissue Viability Nurse must be informed and consulted regarding the treatment to be given.

Development of Pressure Sores

Sometimes, in spite of all efforts to prevent them, pressure sores will occur. The wound will require assessment for grading its severity in order to provide the most effective management and treatment. Pressure sores are graded according to their severity and have been classified by several people i.e. Torrance and Lothian, Stirling.

Grade 0

Blanching Hyperaemia

The skin flushes red and blanches on finger application. The skin is not broken and the redness is resolved at the next inspection.

This is a normal reaction to pressure.

Grade 1

Non-blanching Hyperaemia

Persistent redness or discoloration, indicating damage to the microcirculation. The skin appears undamaged but does not blanch on pressure.

This type of sore will recover once the pressure is removed. If it does break down this is usually because the damage has already occurred at a deeper level.

Grade 2

Area of partial thickness skin loss, involving the epidermis and / or dermis.

The wound presents as graze, abrasion or blister (intact or broken)

People with Oedema are prone to these types of sores as the skin has lost its elasticity and has a reduced blood supply, reduced collagen and reduced nutrients.

Incontinence is often found in people with grade two sores as their skin has become macerated and excoriated. These types of sores may be caused by friction and commonly occur on heels and elbows.

Grade 3

Full thickness skin loss with damage to the subcutaneous tissue, but not the muscle. The wound may be covered with eschar (scab), which after removal may reveal a crater and undermining of the surrounding tissue.

Ischemic changes occur as a result of poor tissue perfusion caused by stretching of the underlying blood vessels.

Because of the changes in the interstitial fluid damage progresses to surrounding tissues, pressure intensifies due to the build up of metabolic waste as blood supply and lymph drainage are affected.

Grade 4

Full thickness skin loss with extensive destruction of the superficial and subcutaneous tissues, muscle, bone and supporting structures.

Pressure is highest at the point of contact between the soft tissue and the bony prominence. Pressure and shear forces distort and stretch blood capillaries and underlying tissue, resulting in a large area of necrosis and undermining.

The cause of a sore can be recognised by the shape of the wound. A round or oval shaped sore is caused by shearing force.

Policy Aim

The aims of preventative procedures are as follows:

- a) To identify those clients who are at risk from developing pressure sores
- b) To work with nursing staff to promote prevention or in treating pressure sores
- c) To compile individualised care/support plans, incorporating the rationale to prevent the formation of pressure sores
- d) To encourage the clients co-operation in the objectives of prevention
- e) To encourage healing where a pressure sore is established
- f) To monitor the incidence of pressure sores
- g) To continually reassess/review clients "at risk"

"Pressure sores will not be seen as an inevitable consequence ill health or hospitalisation 95% of all pressure sores are preventable (Hibbs 1988)"

Pressure Sore Risk Assessment (PSRA)

Many clients will be somewhat "at risk" from developing pressure sores.

It is, therefore, inevitable that the use of a recognised assessment tool is incorporated into the initial and subsequent care planning process.

The initial calculation and score will be ascertained if possible, either before commencement of the service or within 24 hours; this reading to be comprehensive and thorough.

There are two assessment tools in current usage within Constantia Care; Norton and Waterloo. The assessment tool is not a substitute for sound clinical judgement it is an adjunct and a means of helping to identify those clients at risk and informing the district nurse as soon as possible.

The staff will contact the Constantia Care 24hour help line for advice & instruction if they are concerned about any pressure area; the local District nurse to be contacted as soon as possible. Any pressure equipment advised will be obtained and the NOK informed. All information will be documented; dated and signed.

Predisposing Factors to Pressure Sore Formation

The following may be contributory factors to pressure sore formation:

- a) Undue or prolonged pressure
- b) Friction
- c) Shearing forces e.g. poor fitting shoes
- d) Repeated forces
- e) Incontinence
- f) Poor nourishment/ dehydration
- g) Chronic illness e.g. vascular disease and diabetes
- h) Simple moving and/or washing
- i) Rubbing together of skin surfaces
- j) Immobility/reduced mobility
- k) Impaired circulation e.g. related to smoking/ blood disorders i.e. anaemia
- l) Shock
- m) Age
- n) Decreased consciousness/mental awareness
- o) Reduced sensation e.g. multiple sclerosis
- p) Medications e.g. steroids sedatives
- q) Pain

Planning for the prevention of and/or care of pressure sores.

Assessment

As discussed previously, skin inspection and documentation using a recognised scoring system is vital. Record the presence of or potential for a pressure sore in the care plan and report to the manager/District Nurse/Tissue Viability Nurse.

The District Nurse/ Tissue Viability Nurse will advise how the following will be carried out in relation to individual client.

Diet

Nutrition is an essential factor in pressure sore prevention and treatment. The following aspects will need consideration:

- a) A good fluid intake unless otherwise indicated.
- b) Sufficient calories to meet energy requirements - increased when wounds present.
- c) Sufficient protein intake, additional vitamins and extra fibre can be useful.
- d) Food supplements/ fortification of food will be used for Clients whose appetite is poor. Consultation with the GP and family may be useful in this instance

Movement

Movement is the body's defence against pressure. Repositioning may be required more frequently depending on the condition of the client. This applies to all clients who spend much of their time in bed or in their chair unable to move themselves.

All staff must attend annual moving and handling training.

Care of the Skin

Skin integrity will be maintained where possible. The skin only needs washing when absolutely necessary. Frequent washing will remove the skin's natural oils which create the skin's own barrier to infection. A mild soap can be used to minimise the change of pH in the skin. The skin must be dried by patting.

Only specific **prescribed** emollients and creams may be used. These will only be used where necessary, and sparingly, as they can interfere with the effectiveness of incontinence products.

All creams and emollients' must be documented on the clients MAR.

Contenance Planning

It is essential that thorough assessment is undertaken by qualified professionals for the client who is incontinent to ensure that a comprehensive programme is formulated so that pressure sore formation is kept to a minimum, and that skin integrity is maintained.

Aids.

These will be recommended by the district nurse or occupational therapist.

Pressure relief aids will:

- a) Provide a surface which conforms to body weight
- b) Reduce frictional sores

Evaluation.

This must be done according to criteria identified within the Plan of Care, and incorporating the same assessment tool used in the initial assessment.

Involving the Tissue Viability Nurse/District Nurse/OT at all stages and the GP as required.

CQC Notifications.

When a pressure sore of Grade 3 or above develops **after the person has started to use the service** a Notification must be sent to CQC as required under Outcome 20 Regulation 18

Training.

All staff will be given appropriate training in relation to Prevention of Pressure Sores and associated subjects such as Nutrition and Moving and Handling.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

PROFESSIONAL BOUNDARIES

OUTCOME 7, REGULATION 11

Constantia Care Ltd.

Policy Statement

Constantia Care believes that staff need to observe professional boundaries in their relationships with clients and their relatives, friends, visitors and representatives and that behaviour outside those boundaries will be regarded as abusive and a reason for disciplinary action. We recognise that it is often difficult to draw precise lines defining appropriate behaviour, so we encourage staff to be transparent in their dealings with clients and others and to discuss with managers any ambiguities which arise. The starting point is that the needs of clients will be at the centre of our care practice; any relationship which might threaten that objective will be questioned.

Aim of the Policy

The aim of this policy is to lay down the principles and values underlying our approach to professional boundaries in relationships with clients and their relatives, friends, visitors and representatives.

The Parties Involved

Staff

This policy applies to all staff of Constantia Care, including temporary staff and volunteers, not only those who have regular contact with client in a care-giving capacity.

Clients

The term client is used in this policy to include current clients, past clients and anyone whose contact with Constantia Care is concerned with their being or having been a user or potential user of services.

People associated with clients

This policy includes relationships with people directly associated with clients in a personal capacity — their relatives, friends, visitors and representatives.

Professional Boundaries

Professional relationships must be distinguished from personal relationships. Although we believe that staff can quite properly gain satisfaction from developing and sustaining relationships with clients, the key consideration will always be the needs of the client rather than the personal or mutual satisfactions which characterise personal relationships. Staff must therefore on occasions hold back from allowing a relationship to develop a dimension or to a degree which they personally would find satisfying; in the interests of ensuring that the needs of the client remain paramount.

Any member of staff who feels that a relationship is developing which might be judged inappropriate, will discuss the situation with their manager. The action to be taken may include varying the staff member's duties in order to limit contact with that person, discussing the situation frankly with the person in order to re-establish appropriate boundaries, or in extreme circumstances controlling an individual's contacts with Constantia Care.

Professional Codes of Practice

All staff will be familiar with and comply with the code of conduct and practice of the General Social Care Council (GSCC), copies of which are supplied to all staff. Nursing and other professional staff will in addition comply with the standards of conduct and practice set by their own regulatory bodies. Breaches of any of these codes by staff will be reported, and Constantia Care will cooperate with any action taken by a regulatory body.

Action Outside the Work Situation

Although we do not in general seek to regulate the private behaviour of staff, we recognise that on occasions an individual's behaviour away from work may call into question their suitability to work in social care services. It is the responsibility of all staff therefore to behave, both at work and outside, in ways which uphold their own credibility and Constantia Care's reputation.

Training

All staff will be encouraged to read this policy and related policies as part of their induction process and will be provided with training on professional boundaries.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

PROTECTIVE CLOTHING AND EQUIPMENT POLICY

OUTCOME 11, REGULATION 16 (Safety, Availability and suitability of Equipment)

Constantia Care Ltd.

Infection control is the name given to a wide range of policies, procedures and techniques intended to prevent the spread of infectious diseases amongst staff and service users. All of the staff working in Constantia Care are at risk of infection or of spreading infection, especially if their role brings them into contact with blood or bodily fluids like urine, faeces, vomit or sputum.

Such substances may well contain pathogens that can be spread if staff do not take adequate precautions. Disposable gloves and protective clothing such as aprons offer staff some protection from being contaminated with an infection and then passing it on to somebody else.

Policy Statement

Constantia Care Ltd. believes that adherence to strict guidelines on infection control is of paramount importance in ensuring the safety of both service users and staff. It also believes that good, basic hygiene is the most powerful weapon against infection, particularly with respect to hand washing.

Constantia Care Ltd. adheres fully to Outcome 11, regulation 16 of the Care Quality Commission Guidance about compliance, Essential standards of Quality and Safety, which relates to the degree to which staff and service users are protected by Constantia Care's policies and procedures.

This policy is cross referenced to Outcome 8 Regulation 12 Cleanliness and Infection Control and the Code of Practice for Health and Adult Social Care on the Prevention and Control of Infection and Related Guidance

Aim

The aim of Constantia Care is to prevent the spread of infection amongst staff, service users and the local community.

Goals

The goals of Constantia Care are to ensure that:

1. Service users, their families and staff are as safe as possible from acquiring infections through work-based activities
2. All staff at Constantia Care are aware of and put into operation basic principles of infection control.

Infection Control Procedures

In Constantia Care:

1. All staff will adhere to Constantia Care's protective clothing policy and use the disposable gloves and disposable aprons which are provided for staff who are at risk of coming into direct contact with body fluids or who are performing personal care tasks
2. Staff will treat every spillage of body fluids or body waste as quickly as possible and as potentially infectious, they will wear protective gloves and aprons and use the disposable wipes provided wherever possible.

Protective Clothing Procedures

The hands or clothes of staff are likely to be the most common means of transmission of infection unless basic precautions are taken. This involves careful hand washing between contacts and the correct use of protective clothing such as disposable gloves (sterile and non-sterile) and disposable aprons. It is therefore the policy of Constantia Care that disposable gloves and disposable aprons are provided for all staff who are at risk of coming into direct contact with body fluids.

Gloves will be worn at all times during personal care or cleaning procedures and disposed of immediately after the procedure or contact is finished. Gloves will always be changed between service users. On no account will staff attempt to wash and reuse gloves. Plastic disposable aprons are also provided for use by care staff. Aprons will be used in procedures where body fluids may be involved or there is risk to clothing from substances such as bleach.

The responsibility for ordering and ensuring that supplies of gloves and aprons are readily available and accessible lies with the administrator. Individual domiciliary care staff are responsible for contacting the main office to order fresh supplies, which they will do before they run out or their stock becomes too low

Latex allergies

It is known that some people can develop allergic reactions to the latex within disposable gloves. Any member of staff who suspects that they might be suffering from an allergic reaction to the latex gloves provided will stop using them immediately and inform their line manager or supervisor. They will then consult their GP.

Training

All new staff will be encouraged to read the policies on infection control, and protective clothing as part of their induction process. In house training sessions will be conducted at least annually and all relevant staff will attend.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/07/14

Review Date: 30/06/18

QUALITY POLICY

OUTCOME 16, REGULATION 10 (Assessing and Monitoring the Quality of Service Provision)

Constantia Care Ltd.

Policy Statement

This policy is intended to set out the values, principles and policies underpinning Constantia Care's approach to maintaining and improving quality and high standards.

Aim of the Policy

Constantia Care places a strong emphasis on providing the highest quality service possible for all of its clients. It works on the basis that no matter how good its present services, there is always room for improvement.

Constantia Care adheres fully to Outcome 16, Regulation 10 of the Care Quality Commission Guidance about compliance, Essential standards of Quality and Safety, which relates to the extent to which quality standards are set and maintained and the service is run in the best interests of its clients.

Constantia Care believes that having the highest quality care is the absolute right of all of our clients. The continuing aim of Constantia Care is to provide a professional and efficient service to meet all of the requirements of its clients and the long term goal is to obtain the highest possible level of satisfaction from clients and relatives.

Where possible client's views will be sought, collated and used to inform the services we provide.

All Clients of this Company Will

- Expect the highest quality care possible
- Be given a say in the running of Constantia Care through routine evaluations of each care episode and a larger survey of client opinion carried out on an annual basis. This survey is confidential but the results are published and distributed to all clients and purchasers. Comments and feedback are also sought from clients' relatives, carers, friends, advocates and other stakeholders
- Be free to complain about any aspect of the running of the services provided and to have their complaints welcomed and acted upon promptly. To this end the company operates a robust complaints procedure. (See the company's Complaints Policy and Procedures for details on how this works.)

Procedures

All staff including senior managers are expected to demonstrate their commitment, understanding and adherence to delivering the highest standards of quality care services to all of our clients in all aspects of their day to day roles and to discharge their responsibilities accordingly.

In particular:

- The owner and management team bear the responsibility for establishing, maintaining and implementing a quality management system for the company. This system helps to set standards and to make changes to achieve the standards and the process is reviewed regularly
- Every employee is responsible for the quality of their work and is trained to perform their duties to our specified quality standards

- Contractors employed for specific functions are required to meet our specified standards
- Constantia Care has an annual development plan for quality improvement drawn up as part of its business plan and which is based upon feedback from clients, staff and relatives. The plan is costed, focusing upon specific measurable standards and includes named staff as responsible for each aspect
- The company is consistently listening to its clients and stakeholders and conducts annual user satisfaction and feedback surveys using a standardised questionnaire and follow up interviews with a random sample of its clients, representatives and stakeholders. The findings are analysed and incorporated into its development plan
- Constantia Care Ltd's managers monitor closely the quality of its staff's work by regular supervision, which includes direct observation of people's care practice and occasional unannounced visits to clients' homes when staff are expected to be there
- The company has a timetable for regularly self assessing its activities against each of the domiciliary care standards, information from which informs its improvement and annual development plans.

Personnel

The registered manager is responsible for quality in the company

The **Administrator** is responsible for preparing and distributing the annual questionnaires and collating the results.

Audits

At least one quality audit is conducted on an annual basis. All data collected during the audit is treated as confidential. Regular ongoing surveys are conducted including during the review process. All views are recorded and acted upon.

Training

The owner and management team are committed to the idea that in order to provide a quality service, Constantia Care requires high quality staff who are suitably trained, supervised and supported.

In particular we are committed to ensuring that:

1. All new staff read, understand and become committed to the policy on quality as part of their induction training
2. Each member of staff has a personal development plan in which their training needs are identified and a plan made as to how such needs will be met. (See the company's policy on Development and Training.)

The company's management undertake to ensure through instruction, practical example and training that quality is the aim of all members of staff and that each employee has a proper understanding of the importance of the quality system and its direct relevance to the success of the business.

Additional Guidance

To encourage clients to participate in any type of client forum or quality assurance group, the Social Care Institute for Excellence (SCIE) issue a guide to get started. Guide 17 available at: <http://www.scie.org.uk/publications/guides/guide17/index.asp>

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

RADICALISATION (STAFF AND CLIENTS)

Constantia Care Ltd.

Policy Statement

The *Counter-Terrorism and Security Act 2015* became law in February 2015. It introduced a raft of measures, some of which are still being debated in Parliament. The terrorism threat to the UK is considerable, and the government has acted to ensure that the intelligence agencies have the powers they need to keep us safe; it has issued statutory guidance to all relevant specified authorities.

Policy

Schedule 6 List

This list, which is regularly reviewed, includes all local authorities; anyone on the list is known as a 'specified authority'. It also includes prison, health- and social care, education, and police personnel at an identified level, for instance a chief officer of police. The Act creates a general duty of 'due regard' on all 'specified authorities'.

Local authorities must have 'due regard' to local circumstances; give appropriate weight on the need to 'prevent' people being drawn into terrorism (see below); and consider all other factors relevant to how they carry out their usual functions.

The Prevent Strategy

This includes clarification of the Prevent strategy first identified in 2011, which is a part of CONTEST: the government's counter-terrorism strategy.

The CONTEST strategy is made up of four 'workstreams', each comprising a set of objectives:

- **Pursue:** to stop terrorist attacks
- **Prevent:** to stop people becoming terrorists or supporting terrorism
- **Protect:** to strengthen our protection against a terrorist attack
- **Prepare:** to mitigate the impact of terrorist attack.

This policy is intended to make staff aware of their role and responsibilities in regard to the Prevent area of work, as required by the new legislation.

Prevent Strategy Objectives

The Prevent strategy aims to perform the following:

- Respond to the ideological challenge of terrorism and the threat posed by those who promote it
- Prevent people from being drawn into terrorism and ensure they are given the appropriate advice and support
- Work with sectors and institutions where there are risks of radicalisation that we need to address.

Since the 2011 Prevent strategy, the government has defined extremism as "a vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs"; also included in their definition are "any calls for the death of members of the armed forces".

The Prevent strategy was explicitly changed in 2011 to counter all forms of terrorism, including non-violent extremism, that create an atmosphere conducive to terrorism or that popularise views which can then be exploited by terrorists. The changes also made clear that preventing people becoming terrorists or supporting terrorism requires challenging extremist

ideas where they are used to legitimise terrorism and are shared by terrorist groups. The strategy also means intervening to stop people moving from extremist (albeit legal) groups into terrorist-related activity.

Prevent work is intended to deal with all kinds of terrorist threats to the UK. Currently, the most significant threats are from terrorists' functions in Syria and Iraq, including Al Qa'ida associate groups, ISIS (also Daesh), and so forth; however, right-wing extremists also pose a threat to our safety and security. In fulfilling the Prevent duty, all specified authorities are expected to participate fully in work to prevent people being drawn into terrorism.

Specified authorities in Schedule 6 of the Act are those judged to have a role in protecting vulnerable people and/or our national interest and security.

The Statutory Guidance

Three themes run through the 'risk-based approach' to the Prevent duty (i.e., an awareness of the risk of radicalisation; see below):

1. Effective Leadership

For all specified authorities, the expectation is that those in leadership positions will

- Establish or use existing mechanisms for understanding the risks of radicalisation
- Ensure staff understand the risk and build the capabilities to deal with it
- Communicate and promote the importance of the duty
- Ensure staff implement the duty effectively.

2. Working in Partnership

Prevent work depends on effective partnership. To demonstrate effective compliance with the duty, the specified authorities must demonstrate evidence of productive co-operation, in particular with local Prevent co-ordinators, the police and local authorities, and co-ordination through existing multi-agency forums, for example Community Safety Partnerships regime.

3. Capabilities

Frontline staff who engage with the public should understand what radicalisation means and why people may be vulnerable to being drawn into terrorism as a consequence of it. They need to be aware of what we mean by the term 'extremism' and the relationship between extremism and terrorism.

Staff need to know what measures are available to stop people becoming drawn into terrorism and how to challenge the extremist ideology that can be associated with it. They need to understand how to obtain support for people who may be being exploited by radicalising influences.

All specified authorities subject to the duty will need to ensure they provide appropriate training for staff involved in the implementation of this duty; such training is now widely available.

Risk-Based Approach

This means, as a starting point, an awareness and understanding of the risk of radicalisation in their local area, institution, or body. This risk will vary greatly and can change rapidly, but no local area, institution, or body will be risk-free; the type and scale of activity that will address the risk will vary but all of the specified authorities will need to give "due regard" to it.

Local authorities are expected to provide appropriate training to frontline staff, including those whom it contracts for services.

As outlined above, three themes run throughout the sector-specific guidance: leadership, working in partnership, and capabilities.

Sharing Information

In addition to those overarching themes, sharing information is paramount. To ensure the rights of individuals are fully protected, it is important that agreements exist at a local level (usually via the local authority).

When sharing information in this context, consideration of the following is important:

- Necessity and proportionality
- Consent
- Power to share
- Legislative requirements e.g. *Data Protection Act*, common law, duty of confidentiality.

Monitoring and Enforcement

All specified authorities must comply with this duty; they must maintain appropriate records, in order to show compliance with their responsibilities, and provide reports when requested.

Central Support and Monitoring

The Home Office (HO) oversees Prevent activity in local areas which have been identified as priorities for this programme; they will provide central monitoring for the new duty. The HO shares the management of local Prevent co-ordinator teams with local authorities. The HO will draw together data about implementation of Prevent from local and regional Prevent co-ordinators from all specified authorities; monitor and assess the delivery of Prevent; maintain contact with relevant departments (escalating issues where appropriate); and support the Prevent Oversight Board, chaired by the Minister for Immigration and Security, which may agree on further steps to support implementation of the duty.

Where non-compliance of the duty is identified, the Board can make recommendations to the Secretary of State to use their powers of direction.

Inspection Regime in Individual Sectors

Central support and monitoring will be supported by existing inspection regimes in specific sectors. Not every specified authority has a suitable inspection, and in some areas it may be necessary to create or enhance existing regimes. Specific arrangements are in place to work with the Welsh government to provide support to Welsh inspection regimes.

This will mean, for instance, that for specified authorities within health- and social care the inspection regime which will support the Prevent strategy will be the CQC, NHS England, and Monitor, to name but a few.

Sector-Specific Guidance

All of the above information relates to all of the sectors identified below. In addition, each of those sectors has its own sector-specific guidance.

Those sectors are

- Local authorities
- The health sector
- Prisons and probation
- The police.

As providers of services to local authorities and/or the health sector, it is vital to understand Prevent and any role we may play within it via our contractual arrangements. Staff are at the frontline of contact with the local community and need to be aware of Prevent and understand their role in relation to the strategy.

Remember, not all local authorities will have a Prevent coordinator; it depends on the risk level of your locality. Prevent coordinators are located within the local police authority and accessed via the 101 number.

Channel

What is it?

A multi-agency early intervention process designed to safeguard vulnerable people from being drawn into violent extremist or terrorist behaviour; it works in a similar way to SABs.

Who does it work with?

Individuals of any age who are at risk of being exploited by extremists or terrorist ideologues. It provides support for tackling any form of radicalisation or personal vulnerabilities.

The Channel Panel

Each panel is chaired by a local authority and brings together a range of multi-agency partners to collectively assess the risk; they can decide whether a support package is needed.

Raising a concern

If staff believe that someone vulnerable is being exploited or radicalised then the established safeguarding procedures within the company should be used to escalate concerns; this can then raise concerns with Channel, if appropriate.

There is separate guidance for further education colleges and children's services.

Training Statement

Local authorities are expected to provide appropriate training to frontline staff, including those whom it contracts for its services.

Related Policies

Safeguarding

This policy will be reviewed by the registered manager.

Signed: Morag Collier

Date: 30/01/18

Review Date: 30/06/18

RANGE OF ACTIVITIES & THE LIMITS TO RESPONSIBILITY PROCEDURE OUTCOME 1, REGULATION 17 (Respecting and Involving People who use Services)

Constantia Care Ltd.

Policy Statement

At Constantia Care Ltd. our ethos is to try to deliver a range of services which meets the needs of each individual service user. If however Constantia Care sometimes not able to meet all of these needs; when this occurs Constantia Care will advise where to go for the appropriate service to the best of our ability.

Set out below is a summary of the range of service which Constantia Care deliver this is not an exhaustive list. Constantia Care will always try to accommodate the needs of our service users. It summarises the procedures within Constantia Care Ltd. for defining the range of services Constantia Care provide and the limits of our responsibility.

Aim of the Policy

Management is responsible for keeping under review the range of services Constantia Care provide and this may change in the light of variations in levels of needs, changes in the practice of local authorities and other social policy developments. Currently our range of services, are as set out below.

Service user groups

Constantia Care are able to consider providing a live-in care service for any member of the following service user groups:

- Older people
- People with physical disabilities
- People with sensory loss, including those with dual sensory impairment
- People with dementia
- People with learning disabilities
- Personal or family carers.

Short-term care

Constantia Care welcome referrals from or on behalf of people who require respite, intermediate or any other short-term care.

Minority groups

Constantia Care welcome referrals from or on behalf of people from ethnic, social, cultural or religious minority groups. Constantia Care will discuss a potential service user's special needs and preferences at the time of our agreeing to provide a service and will seek to meet requirements as closely as possible or to refer on to appropriate sources of help elsewhere.

Timing of services

Constantia Care are able to provide services at any time required.

Constantia Care is a 24 hour live-care agency, our carers work a 12 hour day with a two hour break. Carers are flexible to the schedule of services users and are on call, within reason. More than 3 calls for 4 consecutive nights require a further assessment for waking night care to be placed.

Working with an existing carer

Our workers are happy to work alongside an existing carer, family member or friend. Constantia Care will explore this issue at the time of making a care needs assessment or pre admission assessment and before starting to provide a service so that the position is clear to all concerned.

Insurance

Our staff are covered by Employers' and public liability insurance both of which are to the minimum amount of £10 million.

Geographical area covered

The service is delivered nationwide to the UK.

Limits to Our Service**Local authority funding**

If a service user's fees are paid by the local authority, Constantia Care cannot significantly change the service provided without consultation with the relevant care manager. This will usually result in a review of the service which will be undertaken by Social Services and Constantia Care Ltd.

Limits of responsibility

Constantia Care Ltd. tries to deliver to its service users a range of services to meet their needs. Any limit to these services will be fully discussed and agreed on the care needs assessment or pre admission visit.

Summary

Constantia Care Ltd. is in the business of helping people who need care. Constantia Care are constantly reviewing our services and are always willing to discuss the particular needs of an individual. If at all possible Constantia Care will try to provide a service which meets their needs and preferences.

This policy will be reviewed by the registered manager

Signed: *Morag Collier*

Date 30/01/18

Review Date 30/06/18

RECORD KEEPING

Constantia Care Ltd

Policy Statement

Constantia Care believes that all records required for the protection of service users, and for the effective and efficient running of the organisation, should be maintained accurately and be up to date; that service users should have access to their records and information about them; and that all individual records and organisation records should be kept in a confidential and secure fashion.

The Policy

This policy is intended to set out the values, principles and methods underpinning this organisation's approach to record keeping, data protection and access to records.

CONTEMPORANEOUS NOTES

- Investigations into cases of alleged or actual abuse or neglect may in some cases lead to criminal and civil proceedings of one kind or another. For example, investigators may be called as witnesses for the police in criminal proceedings or on behalf of regulatory bodies regarding criminal and civil proceedings against registered providers.
- Notes taken in the course of investigations for one purpose may be important in the context of giving evidence in legal proceedings. Notes taken at the time of meetings with individuals, telephone calls, visits to premises and so on are referred to as 'contemporaneous' notes.
- The value of contemporaneous notes is greatly enhanced evidentially if they are taken in a certain way. For them to be admissible in evidence in criminal proceedings they would have to conform to Rules of Evidence and statutory Codes of Practice set out in the Police and Criminal Evidence Act 1984.
- Notebooks should be regarded as an official document.
The notes recorded in them should be: -
 - Factual – write nothing you would be unhappy to read out in court;
 - Made in ink at the time of an event or as soon after as is reasonable and practical;
 - Dated;
 - Original and not copied from elsewhere.
- As memory is fallible, such notes may be the only place from where evidence can be recalled and substantiated, so the following points should be observed:
 - No erasures;
 - No leaves to be torn out;
 - No blank spaces to be left;
 - No overwriting;
 - No writing between lines;
 - No separate pieces of paper;
 - Amendments to be initialled;
 - Notebooks to be retained.
- This guidance does not constitute full adherence to the law and statutory Codes of Practice for the keeping of contemporaneous notes but will assist if staff are called to give evidence in legal proceedings.

Record-keeping

- With the client's consent, records should include
 - Assistance with medication including time and dosage
 - Financial transactions undertaken on behalf of the service user
 - Details of any changes in the service user's or carer's circumstances, health, physical condition or care needs
 - Any accident, however minor, to the service user and/or care or support worker
 - Any other untoward incidents
 - Any other information that would assist the next health or social care worker to ensure consistency in the provision of care.
 -
- All records required for the protection of service users and for the effective and efficient running of the organisation should be maintained in an up-to-date and accurate fashion by all staff.
- Service users have access to their records and information about them held by the organisation; they are also given opportunities to help maintain their personal records at initial assessment, reviews and other occasions.
- Individual records and organisation records are kept in a secure fashion; are up to date and in good order; and are constructed, maintained and used in accordance with the *Data Protection Act 1998* and other statutory requirements.
- Ensure that all files or written information of a confidential nature are stored in a secure manner in a locked filing cabinet and are only accessed by staff who have a need and a right to access them
- Ensure that all files or written information of a confidential nature are not left in a place where they can be read by unauthorised staff or others
- Check regularly on the accuracy of data being entered into computers
- Always use the passwords provided to access the computer system and not abuse them by passing them on to people who should not have them
- Use computer screen blanking to ensure that personal data is not left on screen when not in use.
- All essential records and data relating to service users
- All essential records and personnel data
- Interview/recruitment records (records of interviews of applicants for posts who are subsequently employed for three years, and six months for applicants for posts who are not subsequently employed)
- All paperwork and computer records relating to complaints
- All paperwork and computer records relating to accounts and financial transactions.

Access to Records

The organisation believes that access to information, and security and privacy of data, is an absolute right of every service user; furthermore, it believes that service users are entitled to see a copy of all personal information held about them, and to correct any error or omission therein. Any 'brown envelope' data should be clearly labelled and include the post holders who have the right to access the information.

Storage and Disposal of Records

Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) (Regulations 2010) laid down the requirements for record keeping and storage. These requirements are still in place.

Wherever they are relevant to the service, the following records are kept and for the periods of time stated: he

- Risk assessments; retain the last risk assessment until a new one replaces it
- Purchasing excluding medical devices and medical equipment; 18 months
- General operating policies and procedures; retain the current version and previous version for three years
- Any incidents, events or occurrences that require notification to the Care Quality Commission; three years
- Use of restraint or the deprivation of liberty; three years
- Detention; three years
- Maintenance of the premises; three years
- Maintenance of equipment; three years
- Electrical testing; three years
- Fire safety; three years
- Water safety; three years
- Medical gas safety, storage and transport; three years
- Money or valuables deposited for safe keeping; three years
- Staff employment; three years following date of last entry
- Duty rosters; four years after the year to which they relate
- Purchasing of medical devices and medical equipment; 11 years
- Final annual accounts; 30 years
- Social care records for adults are kept or disposed of in accordance with the Data Protection Act 1998 and three years from last date of entry
- The social care records for children are kept or disposed of in accordance with the Data Protection Act 1998 and 80 years from last date of entry

Archiving records and documents.

Archived paper records are kept securely in a locked and secure filing cabinet in the office. Archived paper records of over a year are secured in the storage facility.

Electronic documents are archived in the shared folder which has firewall protection.

The information is backed up every day in cloud storage, protected by a firewall and maintained by Fone and Mobile services.

Destruction of Confidential Records

It is the responsibility of all staff to ensure information they are handling is destroyed effectively, securely and in accordance with this policy and procedure.

All manual records that have reached their destruction date should be destroyed using one of the following methods:

Internal Shredding: Cross Cut Shredder

Paper records are destroyed using a shredding device designed to cross cut material to ensure shredding cannot be reconstructed. Staff shredding their own records are responsible for ensuring records are destroyed adequately and in such a way that protects the security of the information contained within them.

Use of External Confidential Waste Disposal Company

The confidential waste disposal company will supply waste disposal containers or bags which are stored until the required amount of waste meets the criteria agreed by the waste disposal company.

IT Equipment/Electronic Media

All queries regarding the destruction of IT equipment and electronic media must be referred to the organisations IT Department or our IT Consultant Derek Ridgewell.

Related Policies

Accessible Information and Communication

Access to Records and Files

Adult Safeguarding

Confidentiality

Consent

Cyber Security

Data Protection

Service users Records

Training Statement

All new staff will be encouraged to read the policies on data protection, record keeping and confidentiality as part of their induction process. Training in the correct method for entering information in clients' records will be given to all carers. The nominated data user/data controller for the organisation will be trained appropriately in the requirements of the *Data Protection Act 1998*.

This policy will be reviewed by the Registered Manager.
Morag Collier

Signed: *Morag Collier*

Date: 20/02/18

Review Date: 20/08/18

RECRUITMENT AND SELECTION

Constantia Care Ltd.

Policy Statement

Constantia Care recruitment and selection procedure aims to ensure that the most suitable candidate is chosen for the job, and that all applicants receive fair and equitable treatment both during the recruitment and selection processes. These processes will adhere to relevant employment law practice, guidance issued by the Care Quality Commission (CQC) and Department of Health (DoH).

We are also mindful of the changes within the *Equality Act 2010* and of the guidance issued by Government Equalities Office with respect to health questionnaires and health questions allowed during the interview process. Safe recruitment and selection is acknowledged as our first line of defence in the safeguarding our Client.

The Policy

This policy is intended to set out the values, principles and policies underpinning this organisation's approach to recruitment and selection of its staff. All staff involved in the recruitment process must adhere to this policy. Failure to do so could result in disciplinary action.

It is important to recognise that the recruitment and selection of staff is directly linked to the safeguarding of the people using services. It is essential that the process allows the right people to be recruited and that it filters out those who are unsuitable to work within a regulated activity.

It is therefore important that the following principles are adhered to:

- all legal and regulatory requirements regarding Regulation 19 are met
- all potential applicants are aware of the employer's obligations to the welfare and safeguarding of clients
- the organisation is satisfied that each applicant has demonstrated their suitability for the post
- every stage of the recruitment and selection process is completed to the highest standard and in particular relation to references, that these are checked, validated and where necessary added to with a supporting third reference
- the organisation is satisfied of the applicant's identity, qualifications and where necessary, revalidation processes are checked

The above principles should be in place and anyone involved in the recruitment and selection process must be fully aware of these principles

Job Posting

Constantia Care provides employees with an opportunity to indicate their interest in open positions and to advance within the company according to their skills and experience. Generally, notices of all regular, full and part-time job openings are posted, though the company reserves the right to not post a particular opening, for succession planning purposes.

To be eligible to apply for a posted job, an employee must be performing competently in their present position and have held it long enough to make a significant contribution.

Constantia Care encourages employees to talk with their supervisors about their career plans and supervisors are encouraged to support employees' efforts to gain experience and advance within the organisation.

An applicant's supervisor may be contacted to account for an employee's performance, skills, and other factors relevant to any application they might make. Any staffing limitations or other circumstances that might affect a prospective transfer may also be discussed.

Job Advertisement

Alongside the internal posting of any vacancies, jobs can be advertised in local newspapers, job centres and other media means. This is to ensure that the organisation benefits from as wide a pool of prospective employees as possible.

Personnel Selection

All applicants are sent an application pack that contains the following: the applicants guide, application form, person specification, and availability sheet. Only applications made using the proper form and received by the advertised deadline are considered.

Applicants are short-listed by comparing their application form with the person specification for the job. All short-listed candidates are offered an interview and given details of the company, the position for which they have applied, and the terms and conditions of employment. Where possible, we strive to have a gender-balanced panel.

Equal Opportunities Policy

Constantia Care practices an equal opportunities policy and wishes to recruit and employ those people who are best suited for the vacancies for which they have applied, regardless of sex, sexual orientation, religion and belief, race, disability, maternity and pregnancy, age, Gender Reassignment, marriage and civil partnership. To monitor the equal opportunities' policy all applications (and their ultimate selection or rejection) are thoroughly reviewed.

We require all employees and applicants to complete an equalities monitoring form. This organisation complies fully with the *Equality Act 2010* including the guidance issued by the Government Equalities Office (GEO)

(<https://www.gov.uk/government/organisations/government-equalities-office>), giving specific exclusions in regard to pre-employment health questions

Checks and References

These are undertaken by the company and fulfil the requirements of Schedule 3 of the *Health and Social Care Act 2008 (Regulation 2014)*.

This includes the following:

- A minimum of 2 references,* one of which must be from their current or last previous employer, where possible;
- Where verbal references are sought these will be recorded and held on file until receipt of written references; any discrepancies will be investigated and recorded;
- Documentary evidence of relevant qualifications, full employment history and satisfactory information about their ability to work within a Regulated Activity;
- A "Right to work! Check.
- A DBS at enhanced level, which must include all original identification documentation as set out on the form;
- Any immigration documentation, if appropriate, where a work permit is in place;
- Verification of reason for leaving previous employment;
- Identity documents verified
- Photograph of employee

Please Note:

Applicant with a DBS who are part of the update service can be checked immediately on the DBS website by the manager.

* Where a reference does not give sufficient information as requested we will seek a third referee.

Administrative and Support Staff

Administrative and other staff who are not in regular direct contact with Clients are expected to have a DBS Standard disclosure. The DBS are continually updating the list of those who are and are not eligible for a DBS on their website.

Employment of Staff from Overseas

Staff recruited from overseas will, in addition to all the above checks, be subject to immigration legislation requirements.

Procedures where DBS Checks are not 'Available at Time of Starting'

In cases where it is proving impossible for newly appointed care staff from the home country or overseas to obtain an enhanced DBS disclosure the company follows the regulations and CQC guidance by:

- Arranging for new staff to have a structured induction programme in which they carry out their work under supervision at all times
- Closely monitoring the appointee's work settings
- Informing the Clients of the position regarding lack of confirming information
- Terminating the employment if the DBS disclosure is unsatisfactory on receipt.
-

Job Interviews

Job interviews provide an opportunity for the organisation to acquire the information it needs about applicants in order to decide who is most suitable for the position in question.

Interviews are conducted after applicants have been shortlisted.

Every attempt is made to ensure that interviews are conducted under conditions that are conducive to interviewees being able to demonstrate themselves at their best. Interviewers, for their part, ensure that they have all the appropriate documentation before the start of the interview.

The assessments made by interviewers are formally recorded on an interview assessment form.

Health questions are asked at interviews where the applicant is required to be fit and mentally able to undertake the tasks, and where those tasks are an intrinsic part of the job.

All interviewers are familiar with the guidance issued by the GEO

(<https://www.gov.uk/government/organisations/government-equalities-office>).

Please Note: where Clients form part of the selection process there must be clarity regarding their role. It must be clearly identified from the outset of the process whether their involvement is of a formal or informal nature. Formal participation in the interview process means being part of the recruitment process, including the recording and consideration of their views. Informal participation in the interview process means that their views do not form part of the consideration of the appointment

Valued Based Recruitment

Constantia Care not only acknowledges the importance of safe recruitment but recognise the importance of retention. To support this we use a value-based recruitment tool as part of the recruitment selection process. In addition Skills for Care issue guidance such as Finders Keepers

<http://www.skillsforcare.org.uk/document-library/finding-and-keeping-workers/practical-toolkits/finderskeepers.pdf>

Code of Conduct

All staff are employed in accordance with the Code of Conduct issued by Skills for Care.

Offers of Employment

These are made only on satisfactory completion of all of the above. We are aware of the requirements of the *Disability Discrimination Act 1995* and due diligence will be exercised where reasonable adjustments are a consideration.

NICE Guidelines

Older people with social care needs and multiple long-term conditions [NG 22] Published November 2015

This guideline covers planning and delivery of social care and support for older people who have multiple long-term conditions. It promotes an integrated and person-centred approach to delivering effective health and social care services. .

As Constantia Care we are working towards ensuring these guidelines are implemented, proportionate to our service, using the tools and resources available from NICE in relation to safe recruitment and effective staff training and support.

Related Policies

Adult Safeguarding

Code of Conduct for Workers

Data Protection

Disclosure and Barring Service (DBS)

Equal Opportunities

Monitoring and Accountability

Overseas Workers

Recruitment of Volunteers

Young People and Employment

Training Statement

Managers receive training in interview methods and are made aware of aspects of employment law relating to discrimination, recruitment and selection.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

RECRUITMENT OF VOLUNTEERS OUTCOME 14 REGULATION 23 (Supporting workers).

Constantia Care Ltd

Policy Statement

A volunteer is a person who gives freely of his or her time, skills and experience without expectation of financial reward. Volunteering can take many forms. Some tasks require particular skills whereas others require none. Volunteering may be for a limited time to complete a particular project or may be on an ongoing basis.

Constantia Care Ltd. recognises the immense benefits that volunteers bring to Constantia Care, and the bridges that they build between Constantia Care and the local community. In return Constantia Care hopes to give its volunteers an opportunity to exercise their skills in a chosen environment and to undertake new experiences including appropriate training where required.

Constantia Care Ltd. tries to offer a range of volunteering opportunities and, in accordance with its equal opportunities and diversity policies, to ensure that the opportunity to volunteer is widely available.

A volunteer is not an employee and will not have a contract of employment with Constantia Care Ltd. Constantia Care Ltd will agree a role with the volunteer and there will be an expectation that the volunteer will meet the role's requirements and that Constantia Care Ltd will provide tasks for the volunteer.

However, the volunteer is free to refuse to fulfill the role and Constantia Care is not bound to provide the tasks. It is also expected that both Constantia Care Ltd and the volunteer will give as much notice as possible if unable to meet these expectations.

Aim of policy

Roles suitable for volunteers are identified by the relevant Manager, who will draw up a volunteer outline. This will set out the requirements of the role and the skills or experience needed, as well as induction and any training that is required before the volunteering is undertaken. Volunteers will not be used as substitutes for employees.

Recruitment

A person wishing to become a volunteer will be asked to complete an application form. The selection and recruitment requirements for employed staff will be followed for volunteers to ensure the safeguarding of our service users.

References will be required and will also be required to undergo a Disclosure and Barring Service check and a health assessment as required by the Care Quality Commission in a Regulated Activity. Equality and diversity will be adhered to in all recruitment and selection.

Volunteering agreement

The volunteer will be invited to enter into a volunteering agreement with Constantia Care Ltd

This agreement will identify:

- the volunteer's role;
- the training that the volunteer is expected to undertake;
- the expenses that [Constantia Care Ltd] will pay to the volunteer;
- the insurance cover that will be provided for the volunteer;
- who will supervise the volunteer; and
- The notice that will be given to a volunteer if his or her role is to come to an end.

Training

Constantia Care Ltd will provide an induction and the training required for the role, including safeguarding, health and safety and equal opportunities training. Relevant qualifications will also be encouraged where applicable.

Health and safety

Constantia Care has a responsibility for the health and safety of volunteers. Volunteers will at all times follow health and safety policies and procedures.

Volunteers have a duty to take care of themselves and others who might be affected by their actions. Volunteers will not act outside their authorised area or tasks. Volunteers will report all accidents to their supervisor.

Recompense

Volunteers are unpaid. However, Constantia Care will reimburse volunteers for additional travel and subsistence expenses.

Policies and procedures

Volunteers are expected to comply with all Constantia Care Ltd policies while they are on its premises or undertaking any of their volunteering duties. Their induction will include an explanation of these policies and procedures.

Insurance

Constantia Care will ensure that volunteers are covered for insurance purposes in respect of personal injury. Constantia Care will also ensure that volunteers are provided with professional and public liability insurance. The insurance will not cover unauthorised actions or actions outside the volunteering agreement.

Confidentiality

Volunteers are likely to become aware of confidential information. Volunteers will not disclose this information or use it for their own or another's benefit without the consent of the party concerned. Constantia Care Ltd policies on confidentiality and Data Protection must be adhered to.

Supervision

A supervisor will be appointed to support and manage the volunteer. The supervisor will review the arrangements after three months and thereafter on a regular basis. If the volunteer has any queries or would like to change his or her role this will be discussed with the supervisor.

Dealing with problems

The supervisor will normally try to solve any problems informally, but if this is not possible the volunteer can make a formal complaint formal disciplinary and grievance policy and procedure will come into operation.

If a complaint is made about the volunteer, this will be notified to them in writing and the supervisor will decide whether any action will be taken.

Volunteer drivers

Any volunteers who will be transporting equipment or people using a vehicle provided by Constantia Care Ltd must have a current Disclosure and Barring Service disclosure and a valid clean driving license. They will be covered by Constantia Care Ltd insurance policy. Where the volunteer will be using his or her own vehicle, he or she must provide a copy of the vehicle's insurance policy and, if appropriate, the MOT certificate.

The volunteer must report any accidents to Constantia Care. He or she must also report any motoring offences or police cautions to Constantia Care Ltd. Constantia Care Ltd will not pay any parking fines accumulated by the volunteer.

Volunteer's pack

On commencing his/her volunteer work, the volunteer will be given a pack containing:

- general information about Constantia Care;
- a copy of this volunteering policy;
- a standard volunteering agreement;
- details of where he or she can access [Constantia Care Ltd] policies and procedures;

This policy will be reviewed by the Registered Manager

Signature: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

Volunteer Agreement

Name:

Constantia Care encourages and welcomes volunteers.

This agreement sets out the relationship between a volunteer and Constantia Care Ltd. This agreement is binding in honor only. It is not intended by the parties to be a legally binding agreement nor is it intended to create an employment relationship between us.

Referees and Checks

We require you to provide two referees. We will also require you to be checked by the Disclosure and Barring Service to comply with our statutory requirements with the Care Quality Commission.

What you can expect from us

Constantia Care Ltd will provide you with:

- An introduction to Constantia Care and your volunteering role within it, and an induction and training related to your responsibilities as a volunteer.
- A supervisor who will supervise your volunteering and with whom you can discuss your tasks;
- A review of your volunteering role after three months. This will normally be carried out by your supervisor;
- Personal liability insurance to cover you while you are fulfilling authorized volunteer tasks.
- Reimbursement of your expenses. Constantia Care does not want you to be disadvantaged financially as a result of your volunteering. It will therefore reimburse you any additional expenses or any additional travel costs outside those normally incurred, to be agreed in advance with your supervisor.

All expenses must be submitted, with receipts where possible, to your supervisor.

What we expect from you.

We have agreed that you will be available at **[insert location and working pattern, where applicable]**. If, for any reason, you will not be attending we would be grateful if you could let us know as soon as possible so that a substitute can be found or different arrangements can be made. If we have no tasks for you we will let you know as soon as possible.

Confidentiality

In the course of your volunteering you will come across confidential information. You must respect this confidentiality and not use the information for your own benefit or disclose the

information, except where there is a danger of harm or potential harm to service users, colleagues or self.

Policies

You will follow, Health and Safety, Diversity and Equal Opportunities Policies, Safeguarding and the Code of Conduct for workers in the Health and social care Sector These can be found at www.constantiacare.co.uk

Ideas and problems

You may have ideas for the better performance of your tasks or of ways in which we can meet our objectives as an organisation. Please discuss these with your supervisor.

You may run into problems when performing your tasks. You will discuss any problems with your supervisor.

Your supervisor will discuss with you any issues that they may have with your tasks.

If you would like to change the arrangements for your volunteering or move to a different kind of volunteering, that too will be raised with your supervisor.

Termination

Either you or Constantia Care can terminate this agreement with or without notice at any time.

Signed by Supervisor:

Print Name: Morag Collier

Date:

Review date:

REDUNDANCY AND REDEPLOYMENT

Constantia Care Ltd

Policy Statement

Constantia Care undertakes regular reviews of workforce planning and development across all of its service delivery activities. Such reviews are undertaken for a number of reasons which include the best use of resources which could be a result of reduced public funding.

These reviews can sometimes lead to restructuring or withdrawal of services etc., which may in turn lead to redundancies. In addition, a redundancy situation may occur where there is a loss of contract involving the local authority or NHS.

Whenever it becomes apparent that a redundancy situation may occur, the process will be undertaken in a fair and transparent manner, according to the employment law and guidance applicable at the time. This policy applies to all employees.

Principles

- Where a dismissal is proposed because the requirement for an employee to do a particular kind of work has reduced or ceased (or is expected to reduce or cease), the redundancy dismissal will be genuine.
- All reasonable attempts will be explored to avoid redundancy situation.
- All employees affected and their representative will be informed via a formal consultation process.
- Handling small-scale redundancies. This guidance is for small businesses proposing to make fewer than 20 employees redundant.
- Handling large-scale (collective) redundancies. This guidance applies if it is proposed to make 20 or more employees redundant.

This guidance is produced and regularly updated by the **Advisory Conciliation and Arbitration Service (ACAS)**. They give step-by-step guidance on how to handle the redundancy process. They can be found at: acas.org.uk

Redundancy is a legal process covered by s.139 of the Employment Act 1996 and due attention and diligence to process is imperative.

Redeployment

Where possible and if reasonable, the redundant person may be offered a different position within the organisation as an alternative to a redundancy dismissal – this is known as redeployment. Redeployment is offered before redundancy and legal considerations apply in terms of employment law requirements.

Re-employment

This term describes the re-employment of an individual after redundancy dismissal has been served. It is usual that a period of time lapses before re-employment. In this organisation, a period of 3 months from the date of redundancy dismissal must pass before recommencement of employment in any capacity within the organisation. Full recruitment and selection procedures apply to any such appointments.

Training Statement

Only appropriately trained senior staff will implement this process, following the up to date guidance indicated above, taking all relevant legislative requirements into account.

Related Policies Good Governance, Grievance, Recruitment and selection

Signed: M Collier
Date: 30/01/18

CONSTANTIA CARE

RELATIVES, FRIENDS AND CARERS POLICY

OUTCOME 1, REGULATION 17 (Respecting and Involving people who use Services)

Constantia Care Ltd.

Policy Statement

Constantia Care Ltd. is committed to involving relatives, friends and carers as part of the partnership working which is inevitable when putting together a package of care. However it will be noted that no assumption will be made regarding the sharing of information or the involvement of relatives, friends and carers in the care planning process. Consent to share any written or verbal information must be given expressly by the client and any deviance to this must be recorded in the care plan, assessment of need or pre admission assessment. This ensures staff know exactly who can be involved in the sensitive discussions around the client and their needs.

This document outlines the policy of Constantia Care Ltd. in relation to involving relatives, friends and carers in our dealings with clients.

Aim of the Policy

Constantia Care Ltd. recognises that the services it provides to a client are only one part of the network of care and support on which the client depends. We will always strive therefore to cooperate with and help any relatives, friends and carers whom a client identifies to us. We believe that each client will be able, in ways and at a level they themselves decide, to maintain relationships with relatives, friends, and carers, and that those relatives, friends and carers will be consulted and involved in any aspect of the assessment, care and support of a client that the client wishes. We see relatives, friends and carers as partners in caring for clients and, subject always to the principle that the needs and wishes of the client remain paramount, we value and seek to encourage their involvement in the life and work of Constantia Care. We undertake always to deal courteously with the relatives, friends and carers of clients.

Specific procedures

1. Staff of Constantia Care will only communicate with a relative, friend or carer of a client with the client's express permission. We will always respect the client's right to privacy in their affairs, in particular in relation to information about them held by or known to Constantia Care. Subject to those limitations we will attempt to involve named relatives, friends and carers in all appropriate areas of a client's assessment and care.
2. Before starting to provide services to a client, we will provide both full information on Constantia Care's services and facilities and the contract of service to any relative, friend or carer whom the prospective client identifies to us, with written material in a relevant language, style and format.
3. In carrying out the needs assessment or pre admission assessment of a prospective client, we will consult any appropriate relative, friend or carer, will take fully into account any information they supply about the client and about their relationship to the client, and will respect their privacy and other rights. We will be especially sensitive in situations where our staff visit a prospective client in a property where a relative, friend or carer also resides.
4. If it is appropriate, we will, in the course of carrying out a needs assessment, seek and take into account information about the needs and wishes, as carers or clients in their own right, of any relative, friend or carer of a prospective client.
5. We will be responsive to information provided by relatives, friends and carers during any further assessment or re-assessment of a client's situation carried out during their period of their receiving services.

6. We will take particular care in dealing with the relatives, friends and carers of clients who come from minority cultures, ensuring that our staff are familiar with and respect practices relating to families, kinship and social relationships.
7. We will involve appropriate relatives, friends and carers in drawing up, reviewing and implementing the client plan of the client to whom they are related or connected.
8. We will involve appropriate relatives, friends and carers in all aspects of the day to day care which our staff provide for a client if this is what they and the client wish, will consult them in advance if possible and involve them in the decision about any change of care or support worker, and will keep them fully informed on issues relating to the care provided.
9. We will record the names and contact details of relatives, friends and carers with whom the client wishes us to communicate and establish with them and with the client the circumstances in which they are to be informed or contacted about any significant development.
10. We will take all possible steps to encourage and facilitate contact between clients and their relatives, friends and carers, by helping in arrangements if a client wishes to welcome visitors to their home.
11. We will never act to restrict contact between a client and their relatives, friends and carers except at the request of a client.
12. We will be particularly responsive to the need to involve and cooperate with relatives, friends and carers at times of the increasing infirmity, terminal illness or death of a client, will show sensitivity to any special requests made to us regarding rituals, cultural practices or required methods of care associated with dying and death, and will try to respond to the needs of relatives, friends and carers after the death of a loved one.
13. The relatives, friends and carers of a client who have been named by the client as approved by them will have access to that client's record whenever they require it.
14. We will encourage, enable and empower clients' relatives, friends and carers to make complaints and suggestions about the service and ensure that these are promptly investigated and where appropriate acted on.
15. We will systematically seek the views of clients' relatives, friends and carers on the services Constantia Care provides, using consultation processes and surveys, and will incorporate this material into our quality assurance procedures.
16. We will encourage and assist the formation of groups of relatives, friends and carers both locally and nationally as an aide to expressing views in ways which can lead to improvements in our services.
17. If a client expresses a wish that Constantia Care will have no further contact with a relative, friend or carer, that wish will be respected.
18. If a client expresses a wish to cease to have contact with a relative, friend or carer, we will as far as possible support them in carrying out that decision.
19. If it is apparent or suspected that a client is suffering any form of abuse from a relative, friend or carer, we will take all necessary steps to protect the client, to report to the relevant authorities and to collaborate in any further investigation and action.
20. We will respect the right of a client at any stage to appoint a representative to deal with Constantia Care on their behalf, and we recognise that this may be someone other than the relatives, friends and carers with whom we had previously had contact. We will provide information to clients, relatives, friends and carers about independent advocates who can act on their behalf and about self-advocacy schemes.

This policy will be reviewed by the registered manager

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

RELIGION AND BELIEF POLICY

OUTCOME 1, REGULATION 17 (Respecting and Involving people who use Services)

Constantia Care Ltd.

Policy Statement

Everyone has a very different value and belief system which is almost always viewed in the light of a religion. Constantia Care Ltd. believes in the individual's right to their own values faith religion and belief, no matter what form these may take. This is a particularly sensitive area for the individual and the worker. It is core to the delivery of the service that every client must be free to choose and to follow wherever their value faith religion or belief leads them.

This document outlines the policy of Constantia Care Ltd. in relation to the religion and beliefs of clients. Constantia Care Ltd. believes that every client has the right to freedom of religion and belief and that this includes opportunities and facilities to practice their religion. We will do everything possible to ensure that the way in which our service is delivered does nothing to compromise this right.

Aim of Policy

1. We will ensure that the information about the service which we provide to prospective clients informs them of their rights in respect of their religion and beliefs and of what help we can provide to further that right. We recognise that for some ethnic minorities, religion is inescapably linked with culture and sometimes with language, so we will make every effort to ensure that this information is accessible, comprehensible and expressed sympathetically for all who need to understand it.
2. In the course of making or considering the assessment of the needs of a prospective client, we will seek and record information regarding their religious needs so that we can give assurances that our workers will be able to respond appropriately when they provide care.
3. If we honestly feel that we would not be able to provide appropriate care because of a prospective client's religious needs, we will advise the person and, if necessary, their care manager, relatives and representative, accordingly.
4. In each client's plan of care we will in collaboration with the client set out what involvement if any the organisation expects to have in relation to the client's religious needs.
5. We will brief all relevant staff on each client's religious needs and ensure that they understand the undertaking which the organisation has given and take all necessary steps to fulfil these elements of the care plan.
6. We recognise that contacts with places of worship and fellow believers are for many clients an important element of their continued integration with the community, and if asked to do so we will take steps to make such continued contacts possible and meaningful.
7. The staff who visit a client's home will respect the necessary space and privacy which the client needs to engage in personal religious practice such as prayer, worship, meditation or the reading of scriptures if and when they wish to.
8. If staff are involved with food preparation they will make every possible effort to observe any dietary requirements which are based on a client's religious beliefs and take account of any special requirement of the client in relation to festivals and anniversaries related to their faith.
9. We acknowledge that at the time of dying and death religious belief and practice may assume a particular significance. If our workers are involved at such times we will try to observe any requests for special treatment, ritual, or family and community contacts which are requested, for clients close to death and after and for their friends and relatives.
10. We recognise that for some people the expression of personal and spiritual values takes forms outside a structure of religious belief and practice, and in such instances

we will do everything possible to facilitate that expression in ways appropriate to individuals in order to make possible their maximum personal fulfilment.

11. We know that some people with severe disabilities, communication difficulties, mental disorders or terminal illnesses retain a sense of the importance of their personal faith — we will respect and try to respond to this need in any appropriate way.
12. We will take vigorous steps to ensure that no client is the subject of discrimination because of their religious beliefs or practices. A lack of respect for religious needs on the part of any member of staff will be the subject of disciplinary action.
13. We will seek in the makeup of the staff group to reflect the diversity of faiths and cultures among clients and in the local community as a way of helping our clients to feel accepted and respected. We will not discriminate on grounds of religion against applicants for posts in the organisation, and we will attempt to accommodate staff whose personal religious beliefs require them to be away from work at certain times or on specified days.
14. We see our efforts to promote appropriate responses to clients' religious needs as a part of all our efforts to provide each client with as fulfilling and participative a lifestyle as is possible according to their personal preferences, needs and choices.

Training

All staff members will be given a copy of this policy and encouraged to read it during induction. If any new client presents religious needs with which staff are not familiar, we will take steps to ensure that the relevant staff receive appropriate briefing and training in order to provide good care in this regard.

This policy will be reviewed by the registered manager

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

RESTRAINT

Constantia Care Ltd.

Policy Statement

Constantia Care takes seriously the safeguarding of its clients and staff. This policy clarifies where the use of restraint is considered and the steps that all staff need to take in order to comply with current advice and legislation.

Legal definition

The most relevant legal definition of restraint for care homes in England is that found in the Mental Capacity Act (2005) and its amendments.

Section 6 (4) of the Act states that “someone is using restraint if they:

- use force – or threaten to use force to make someone do something that they are resisting, or
- restrict a person’s freedom of movement, whether they are resisting or not.” (14 Section 10.4)

The definition is deceptively short, but is supported by extensive guidance to assist in its interpretation, and it is, or will be, ultimately interpreted through the decision of the courts in specific cases. The brief outline that follows is not intended as a substitute for the Code of Practice issued with the Mental Capacity Act 2005 but merely to indicate some of its salient features.

It is legal to use restraint only if certain conditions are satisfied:

In an emergency: if a person who lacks capacity to consent has challenging behaviour, or is in the acute stages of illness causing them to act in way which may cause harm to others, staff may, under the common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else.

Any action intended to restrain a person can be legal if the person consents (as long as there has been no coercion), but restraint of a person who lacks capacity to consent has to meet two conditions:

- the person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- the amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm. (Section 6.41; the terms in italics are further elaborated in the Code of Practice, Mental Capacity Act 2005)
- In addition, the person’s lack of capacity cannot be assumed simply because they have some cognitive impairment or illness. The person who is considering undertaking restraint should take reasonable steps to establish whether the individual lacks capacity in relation to the matter in question, and should reasonably believe that it will be in the best interests of the person to use restraint, bearing in mind possible benefits, risks and consequences. There is a process (that is, a set of indicative questions) outlined in the Code of Practice to establish whether someone has capacity to make a particular decision.

The Policy

Implementation of this policy will help services to address important outcomes for clients' choice, rights, independence and inclusion and will contribute to joint working with other agencies. The safety of staff during physical interventions is of equal importance to the best interests of clients, and both take priority over the care of property, which can be replaced.

Defining Physical Intervention

In this document, the term 'physical intervention' refers to a range of physical actions used as techniques for responding to challenging behaviour, and which involve some degree of direct physical force to limit or restrict movement or mobility; this can include the removal of an aid to mobility that is normally used by that person.

There are three main types of physical intervention:

- Direct physical contact between a member of a staff and a patient. Examples include holding another person by the arm to stop self-harm; using manual guidance to stop a person wandering into the road; or two people each holding a person and guiding him or her to a seat, if agitated;
- The use of barriers to limit freedom of movement, for example placing door catches beyond the reach of clients;
- Materials or equipment which restricts or prevents movement. Examples include using a splint to limit the movement of an arm or leg. (mechanical)
-

Physical intervention implies the restriction of a person's movement that involves resistance. It is therefore different from forms of physical contact such as manual prompting, physical guidance or simply support. Over time, the term 'restraint' has acquired a number of negative connotations. It is also a term that is closely linked with a particular kind of approach to the management of aggressive and violent behaviour, 'Control and Restraint', or 'C and R'. For this reason, this document uses the more neutral term 'physical intervention', to indicate a continuum between touching, holding and restraint, and the link with other approaches of de-escalation to be used in conjunction with physical interventions at all times.

Hence the use of physical intervention needs to be consistent with the Guidance issued by the Department of Health April 2014. Positive and Proactive Care: reducing the need for restrictive interventions. <https://www.gov.uk/government/publications>.

From this document the following principles are defined.

Principles

[Paragraph 58] The safe and ethical use of all forms of restrictive interventions.

The legal and ethical basis for organisations to allow their staff to use restrictive interventions as a last resort is founded **on eight overarching principles**

- Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.
- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken.
- The nature of the techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.
- Any restriction should be imposed for no longer than absolutely necessary.
- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.
- Restrictive interventions should only be used as a last resort.
- People who use services, carers and advocate involvement is essential when reviewing plans and restrictive interventions.

- **Key principles**

Key principle	What it means	What it looks like in practice
Participation	Enabling participation of all key people and stakeholders	Consulting with the person, staff and other stakeholders; involving the person, carers and support staff in developing risk assessments and behaviour support plans where possible; using advance statements where appropriate; identifying and reducing barriers to the person exercising their rights.
Accountability	Ensuring clear accountability, identifying who has legal duties and practical responsibility for a human rights based approach	Clearly outlining responsibilities under the Mental Health Act and the Mental Capacity Act (where relevant); ensuring staff are aware of their obligations to respect human rights and are measuring outcomes, including quality of life, against agreed standards.
Non-discriminatory	Avoiding discrimination, paying attention to groups who are vulnerable to rights violations	Using person-centred planning approaches that do not discriminate on the basis of religion or belief, race or culture, gender, sexual preference, disability, mental health; making sure staff are sensitive to culture and diversity and how interventions may affect rights.
Empowerment	Empowering staff and people who use services with the knowledge and skills to realise rights	Raising awareness of rights for people who use services, carers and staff through education and use of accessible resources; explaining how human rights are engaged by restrictive interventions;
Legality	Complying with relevant legislation including human rights obligations, particularly the Human Rights Act	Identifying the human rights implications in both the challenges a person presents and responses to those challenges; considering the principles of fairness, respect, equality, dignity and autonomy.

National Policy and Legal Context

The use of physical interventions involves important legal and ethical considerations, which need to be fully understood by the organisation. Any physical intervention must employ the minimum level of force, for the least amount of time needed. Furthermore, it cannot be used solely to force compliance with staff instructions.

The use of any degree of force is unlawful if the particular circumstances do not warrant it. Therefore, physical force could not be justified to prevent a patient from committing a trivial misdemeanour, or in a situation that clearly could be resolved without force. The degree of force employed must be in proportion to the circumstances of the incident and the seriousness of the behaviour or the consequences it is intended to prevent. The degree of force and the duration of its application should always be the minimum needed to achieve the desired result; frequently the role of staff is to allow the patience and time required to achieve this minimum.

Justification also includes the right of every citizen to 'self defence', which applies for all situations for all staff and clients. In order to be justifiable in court, the use of force must be appropriate to the circumstances.

It is an offence to lock an adult in a room without a court order (even if they are not aware that they are locked in). The exception is the use of a locked room as a temporary measure while seeking assistance, which would provide legal justification; however, there are instances where an adult could be at risk due to lack of awareness of danger, which could provide a reason for restriction to a room or area. Such use needs to be part of a care plan and risk assessment, not an *ad hoc* solution. To the extent that seclusion involves restricting a person's freedom of movement, it can be considered a form of physical intervention.

Justification (as a legal defence) for using physical interventions needs to address these questions:

- Is there clarity about how the intervention helps the patient concerned?
- Are there any conflicts of interest where staff experience fewer demands or less stress when physical interventions are used?
- What steps have been taken to reduce the likelihood that the physical intervention will be used in the future?
- Is the justification for this patient specifically, or for 'all' in the group?
-

Under Health and Safety legislation, employers are responsible for the health, safety and welfare of employees, in addition to the health and safety of persons not in employment, including clients and visitors. This requires employers to assess risks to both employees and clients arising from work activities, including the use of physical interventions. Employers need to establish and monitor safe systems of work, and to ensure that employees are suitably trained. Use of physical intervention may give rise to an action in civil law for damages if it results in injury, including psychological trauma, to the person concerned, making proper training and use of physical interventions imperative.

Providers of health and social care services owe a duty of care towards clients, which requires that reasonable measures to prevent harm are taken. Hence, in some circumstances, it may be appropriate to employ certain kinds of physical intervention to prevent a significant risk of harm. Physical interventions ought only to be used when other strategies have been tried and found to be unsuccessful, or when the risks of not employing an emergency intervention are outweighed by the risks of using one. The physical intervention needs to use the minimum force to prevent injury or to avert serious damage to property, and be applied for the minimum amount of time.

Use of physical interventions needs to be consistent with the *Human Rights Act 1998* and its Articles.

These are based on the presumption that every person is entitled to

- Respect for his or her private life
- The right not to be subjected to inhuman or degrading treatment
- The right to liberty and security
- The right not to be discriminated against in his or her enjoyment of those rights.

Physical interventions need to be specific to clients, integrated with other less intrusive approaches, and clearly part of a person-centred plan of care reducing risk, when needed; they must not become a standard way of coping, or as a substitute for training in people-related skills.

Chemical restraint

Chemical restraint refers to: “The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness”.

Chemical restraint will be used only for person who is highly aroused, agitated, interactive, and aggressive, is making serious threats or gesture towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour. Chemical restraint will only ever be delivered in accordance with acknowledged, evidence-based best practice guidance and prescribed by a medical professional for example GP, doctor or prescribing RN or CPN. The prescribers will provide information to us regarding any physical monitoring that may be required as well as the medication to be used and the route of medication. The use of medication to manage acutely disturbed behaviour must be a very short-term strategy designed solely to reduce immediate risk; this is distinct from treating any underlying mental illness. The associated term “rapid tranquillisation” refers to intramuscular injections and oral medication. Oral medication should always be considering first. Where rapid tranquillisation in the form of an intramuscular injection is required, the prescriber should indicate the preferred injection site having taken full account of the need to avoid face down restraint.

Constantia Cares policy aim is to follow the summary of action laid out in Guidance issued by the Depart of Health April 2014. Positive and Proactive Care: reducing the need for restrictive interventions to ensure that the quality of life of a patient is enhanced and that their needs are better met which will reduce the need for restrictive interventions , and that staff and those who provide support are protected.

- All services where restrictive interventions are used must have an identified **board level** for increasing positive behaviour support planning and reducing restrictive interventions.
- All services where restrictive interventions may be used should have **restrictive intervention reduction programmes** in place. Such programmes must be based on the principles of effective leadership, data informed practice, workforce development, the use of specific restrictive intervention reduction tools, patient empowerment and a commitment to effective models of post incident review.
- In those services where people can reasonably be predicted to be at risk of being exposed to restrictive interventions, individualised support plans must incorporate the key elements of **behaviour support plans**. This will include how needs will be met and environment structured to reduce the incidents of behaviour of concern. They must also detail how early warning signs of behaviour escalation can be recognised and responded to together with plans for the safe application of restrictive interventions if a crisis develops.
- Plans for the use of physical or mechanical restraint **must not include the deliberate application of pain** in an attempt to force compliance with instructions, painful holds or stimuli cannot be justified unless there is an immediate threat to life.
- Where behaviour support plans, or equivalent which incorporate the key components, are used, reviews of their quality of design and application should be included within a service provider’s **internal audit** programmes.
- Appropriate governance structures and transparent policies around the use of restrictive interventions must be established within a context of positive and proactive working.
- The choice of any restrictive intervention that has to be used must always represent the **least restrictive option** to meet the immediate need.
- Wherever possible, people who use services, family carers, advocates and other relevant representatives should be **engaged in all aspect** of planning their care including how to respond to crisis situations, post-incident debriefings, rigorous

reporting arrangements for staff and collation of data regarding the use of restrictive interventions.

- Provider organisations must use a process whereby there is **board level (or equivalent) authorisation** and approval of the restrictive interventions taught to their staff and used in practice.
- Organisation that provide care and support to people who are at risk of being exposed to restrictive interventions must have clear organisational policies which reflect current legislation, case law and evidence of best practice. Accessible versions of the policies should be available to those who use the services,
- Services must publish a **public, annually updated, accessible report on the use of restrictive interventions** which outlines the training strategy, techniques used (how often) and reasons why, whether any significant injuries resulted, and details of ongoing strategies for bringing about reductions in the use of restrictive interventions.
- Service **commissioners** must be informed about restrictive interventions used for those for whom they have responsibility.
- There must be **clear and accurate recording** of the use of restrictive interventions to evaluate services progress against their restrictive intervention reduction programmes.
- Service provides must ensure that **post-incident reviews and debriefs** are planned so that lessons are learned when incidents occur where restrictive interventions have had to be used.
- All staff who may be required to use restrictive interventions must have high quality, specialised training.
- Service commissioners must assure themselves that the **service has the necessary competencies** to provide effective support for the people they are funding.

In addition to the above guidance CQC have issued brief guides for inspectors with regard to restraint and inspections which providers will find useful. You will find this under “brief guides for inspection teams” on their website

<http://www.cqc.org.uk/content/brief-guides-inspection-teams>

From the above guidance definitions of restraint are outlined below

- **Physical restraint:** any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person.
- **Prone restraint:** (a type of physical restraint) holding a person chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person is faced down or has their face to the side. It includes being placed on a mattress faced down while in holds; administration of depot medication while in holds prone, and being placed prone onto any surface.
- **Chemical restraint** (This brief guide does not cover the use of chemical restraint. Refer to brief guide on cycle active medicines for people with learning disabilities): The use of medication which is prescribed and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness
- **Mechanical restraint:** this is the use of a device (e.g belt or cuff) to prevent, restrict or subdue movement of a person’s body or part of the body, for the primary purpose of behavioural control.

A self-assessment tool “Reducing Restrictive Practices Checklist” has been published to help organisations ensure that the use of coercive and restrictive practice is minimised and the misuse and abuse of restraint is prevented. Published by Restraint Reduction Network in 2016 <http://restraintreductionnetwork.org/wp-content/uploads/2016/11/Reducing-Restrictive-Practices-Checklist.pdf>

Constantia Care will always take advice and guidance from multi-agency partners to ensure a consistent and planned approach in any situation that requires physical intervention.

Related Policies

Adult Safeguarding
Care and Support Planning
Challenging Behaviour, Violence and Aggression
Deprivation of Liberty Safeguards
Mental Capacity Act 2005
Moving and Handling
Safe Use of Bedrails

Training Statement

All staff will undertake training as required to comply with this policy

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

RISK ASSESSMENT

Constantia Care Ltd

Policy Statement

Constantia Care recognises its responsibility to ensure that all reasonable precautions are taken to provide and maintain working conditions that are safe, healthy and compliant with all statutory requirements and codes of organisation, including the statutory duty for employers to conduct regular health and safety risk assessments.

Constantia Care is committed to ensuring the health, safety and welfare of its staff, so far as is reasonably practicable, and of all other persons who may be affected by our activities including clients, their relatives and visitors.

Positive Risk Taking

Constantia Care is committed to incorporating Positive Risk-taking into its assessments and plans of care. We recognise that clients have a right to take decisions about their lives and there is a balance to be found between participation in everyday activities, the duty of care to both workers and clients and our legal responsibilities.

The Policy

This policy is intended to set out the values, principles and ethos underpinning this organisation's approach to risk assessment and health and safety.

Risk Assessment Policy

The following points constitute the policy of this organisation:

- A risk assessment should be undertaken, by a trained and qualified person, of the potential risks to clients and staff associated with delivering any agreed package of care before the staff member commences work; where appropriate, this should include risks associated with assisting with medication and other health-related activities, and it should be updated annually or more frequently, if necessary;
- The risk assessment should also determine the risks entailed by clients maintaining their independence and daily living within the home;
- The manner in which the risk assessment is undertaken should be appropriate to the needs of the individual client; their views, and those of their relatives or advocates, should be taken into account;
- A separate moving and handling risk assessment should be undertaken, by a member of staff who is trained for the purpose, whenever staff are required to help a client with any manual handling task, as required under the *Manual Handling Operations Regulations 1992*;
- A comprehensive plan to manage risks (including manual handling and risks to clients) should be drawn up, in consultation with the client, their relatives or representatives; this should be included in the client plan and kept in the home of the client for staff to refer to; a copy should also be placed on the personal file kept in the company office. This risk management plan should be implemented and reviewed annually or more frequently, if necessary;
- Any new risks that arise (including defective appliances, equipment, fixtures or security of the premises) should be reported by staff to their line managers or supervisors, or otherwise identified during regular reviews or the client plan;
- Only staff who are both trained to undertake risk assessments and competent to provide the care should be assigned to emergency situations, and in situations where pressure of time does not allow a risk assessment to be undertaken prior to provision of the care or support;

- Two people fully trained in safe handling techniques and the equipment to be used should always be involved in the provision of care when the need is identified from the manual handling risk assessment;
- The name and contact number of the organisation responsible for providing and maintaining any equipment under the *Manual Handling Operations Regulations 1992* and the *Lifting Operations and Lifting Equipment Regulations 1998* should be recorded on the risk assessment;
- Any manual handling equipment provided should be maintained in a safe working condition and be subject to regular inspections by the manufacturers; records of all such equipment and their maintenance schedules are kept in the central office. In this organisation the live-in carer is responsible for ensuring that equipment is maintained adequately;
- A responsible and competent person will be on call and contactable at all times when staff are on duty;
- Staff should comply with the organisation's staff travelling policy.

NOTE: Most of the equipment in our client's homes are supplied via the OTs and it is their responsibility to service the equipment; however it is the carer's responsibility to advise them when the service is due and ensure they are advised timeously. The equipment must be checked at every Spot Check carried out by the Care Co-ordinator.

Health and Safety Risk Assessments

Constantia Care recognises that risk assessments are a legal requirement under Regulation 3 of the *Management of Health and Safety at Work Regulations 1999* (MHSWR).

Constantia Care believes that risk assessments should identify hazards and resulting risks to employees and other persons who may be affected by work activities.

Constantia Care understands a hazard to be the potential for harm, with risk being the likelihood of that harm actually occurring and the severity of the harm (e.g. slight injury, major injury, death).

Constantia Care will fully implement Regulation 3 of MHSWR which requires employers to:

- Make an assessment of risks to employees
- Make an assessment of risks to others who might be affected by work activities such as clients, contractors, visitors and the public
- Clearly identify the measures needed to protect the persons in points 1 and 2 above
- Review the assessment and make necessary changes if
 - There is any significant change that affects risk (e.g. a new employee, machine or client)
 - There is reason to believe it is no longer valid.
- Where there are five or more employees, keep records of
 - The significant findings of the assessment
 - Any group of employees identified by it as being particularly vulnerable.

Constantia Care will include the following as areas of potential hazard or risk in the office premises or client and their premises:

- Hazardous substances within the scope of the *Control of Substances Hazardous to Health Regulations 2002* (COSHH) (e.g. chemical hazards, drugs, sharps, body fluids, hazardous waste) and others not currently covered by COSHH (e.g. lead, asbestos and substances which are hazardous for reasons other than their toxicity, i.e. those which are flammable, or which enhance combustion, react violently, etc.)
- Manual handling and the moving of clients
- Use of display screen equipment (e.g. computers)
- Electrical hazards

- Work equipment and machinery
- Workplace hazards (e.g. space, clutter, lighting, heating, ventilation, tripping hazards, safe access and egress, and inadequate sanitary facilities, e.g. toilets, drinking water)
- Emergencies (e.g. fire, injuries requiring first aid, dangerous spillages)
- Violence or threats and abuse.
- client Property
- Falls
- Medication
- Pressure areas
- Nutrition
- Lone working

This is not an exhaustive list and any other potential hazard risk relating to specific client will be assessed.

Related Policies

Assessment of Needs and Eligibility
 Care and Support Planning
 Dignity and Respect
 Deprivation of Liberty Safeguards
 Equality and Diversity
 Health and Safety
 Mental Capacity Act 2005

Guidance

Health and Safety Executive <http://www.hse.gov.uk/healthservices/sensible-risk-assessment-care-settings.htm>

NICE guidelines [NG6] Published March 2015 Excess winter deaths and illness and the health risks associated with cold homes.

NICE quality standard [QS117] Published date: March 2016

Preventing excess winter deaths and illness associated with cold homes

This quality standard covers preventing excess winter deaths and health problems associated with cold homes. It includes people of all ages, and takes into account that some people are particularly vulnerable to the effects of the cold, such as people with cardiovascular or mental health conditions, young children and older people.

As Constantia Care we work with others and support our clients to recognise the dangers of “cold homes”

Training Statement

All staff and carers, as part of their induction, cover fire safety and risk assessments as part of the core topics in their training. This is regularly updated, at least annually and where there is any incident or accident or error record this too is covered in the training.

This policy will be reviewed by the Registered Manager

Signed: *Morag Collier*

Date: 20/02/18

Review Date: 20/08/18

SAFEGUARDING CHILDREN IN AN ADULT SETTING

Constantia Care Ltd.

Policy Statement

Constantia Care is aware of its obligations under the *Health and Social Care Act 2008 (Regulated Activities) 2010* to protect and safeguard children who, whilst not patients, sometimes accompany patients, their representatives or families, and are present during delivery of the service.

Please Note: at no time do staff act *in loco parentis* as defined under the *Children Act 1989*.

The Policy

This policy sets out the responsibilities of staff in relation to any allegation of abuse involving children that may be witnessed by staff whilst in the employ of this organisation. We are committed to working in partnership with other multi-agency partners in order that the protection and safeguarding of children is consistent with current policy and guidance.

Defining 'Child Abuse'

'Child abuse' is a term used to describe ways in which either children or young people are harmed, usually by adults but increasingly by their peers. Often these are people they know and trust. It refers to damage done to a child's or young person's physical, mental or emotional health. Children or young people can be abused within or outside of their family, at school, at play and within any environment such as extra-curricular activities, participation with youth organisations and the like. Abusive situations arise when adults or peers misuse their power over children or young people.

Types of Abuse:

Physical	Where children's bodies are hurt or injured
Emotional	This is where children do not receive love and affection. They may be frightened by threats or taunts, or be given responsibilities beyond their capabilities.
Sexual	This is where adults (and sometimes other children) use children to satisfy sexual desires.
Neglect	This is where adults fail to care for children and protect them from danger, seriously impairing their health and development.

Signs of Abuse:

The following signs **MAY** indicate abuse; however, it is important not to jump to conclusions, as there could be other explanations:

Physical	Unexplained or hidden injuries that lack evidence of medical attention, children may also exhibit a "frozen stare" when they are in the vicinity of the abuser (this also applies to all groups of abused children).
Emotional	Often children revert to younger behaviour, nervousness, sudden underachievement, attention-seeking, running away from home, stealing and lying.
Sexual	Often children are pre-occupied with sexual matters, as evidenced by words, play, drawings, display sexually provocative behaviour with adults, disturbed sleep, nightmares, bed wetting, secretive relationships with adults and children, stomach pains with no apparent cause.

Neglect	Appearing ill-cared for and unhappy, being withdrawn or aggressive, or having lingering injuries or health problems.
Self-Harm	Deliberate or systematic abuse of the person, usually covert but signs of a physical nature such as scarring are usually noticed. Alopecia may be present.

Bullying

Bullying is not always easy to define, as it can take many forms and take place over a period of time. The main types are physical (hitting, kicking, theft), verbal (threats, name calling) and emotional (isolating and individual from activities and games); all types can be characterised by:

- Deliberate hostility and aggression towards a victim.
- A victim who is weaker and less powerful than the bully or bullies.
- An outcome that is always painful and distressing for the victim.

Bullying behaviour may also include:

- Other forms of violence.
- Sarcasm, spreading rumours, persistent teasing.
- Tormenting, ridiculing, humiliation.
- Racial taunts, graffiti, gestures.
- Unwanted physical contact or abusive or offensive comments of a sexual nature.

Emotional and verbal bullying is more common than physical violence, it can also be difficult to cope with or to prove.

What to do if you Suspect or Witness Abuse:

The following action should be taken by someone who has concerns about the welfare of a child or young person.

NON ACTION IS NOT AN OPTION.

Child abuse can and does occur outside the family setting, and abuse that takes place within a public setting is rarely an isolated event. It is crucial that people are aware of this possibility and that all allegations are treated seriously and appropriate actions taken.

When staff are providing a service to adults they should ask whether there are children in the family and consider whether the children need help or protection from harm. Children may be at greater risk of harm or in need of additional help in families where the adults have mental health problems, misuse substances or alcohol, are in a violent relationship, have complex needs or learning disabilities

Disclosure

If a child or young person should engage any member of staff in a disclosure information exchange they should do the following:

- React calmly so as not to frighten the child or young person;
- Tell the child or young person that they are not to blame and that they are right to tell someone of their problems;
- Take seriously what the child or young person says;
- Avoid leading the child or young person and keep any questions to the absolute minimum to ensure a clear understanding of what has been said;
- Re-assure the child or young person; however, do not promise confidentiality or outcomes that might not be kept to in the light of further developments;
- Record in full what has been seen and heard as soon as possible;
- Report concerns to the managers / on-call managers out of hours immediately;

The manager will then take advice from the Children's Safeguarding Service. They will make the initial referral to the appropriate agency. All managers will be aware of their roles and responsibilities using the guidance issued by the local authority. Confidentiality should be maintained on a strictly 'need to know' basis, and relevant documents stored in a secure location. Advice will be given to the manager in regards to any actions which are deemed necessary.

It can be more difficult for some children to disclose abuse than for others, e.g. disabled children and vulnerable adults will have to overcome additional barriers. Those working with these groups need to be especially vigilant and give extra thought to how to respond.

Allegations against Staff:

If a member of staff has concerns, or receives a complaint or allegation about another member of staff who has

- behaved in a way that has harmed, or may have harmed, a child;
- possibly committed a criminal offence against, or in relation to a child;
- behaved towards a child or children in a way that indicates they may be unsuitable to work with children;

then you must immediately report to your line manager who will telephone the Children's Safeguarding Service. The Safeguarding and Allegations Officer will advise you on the action to take next

If a concern is raised outside of office hours, and you think a referral to social services is required you should contact the Emergency Duty Team and inform either the Children's Safeguarding Service or Local Authority Designated Officer (LADO) at the first available opportunity during working hours.

The LADO is a specific dedicated role within the local authority where the allegation concerns an employee. They should be used in respect of all cases in which is alleged that an employee has;

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against or related to a child or,
- Behaved towards a child or children in a way that indicates he or she would pose a risk of harm if they worked regularly or closely with children is unsuitable to work with children
-

A staff member is a person whose work brings them into contact with children in their setting. It therefore applies to all adults whether paid or working in a voluntary capacity including supply/ agency workers on or off premises or sites.

Recording of Information, Suspicions or Concerns

Information passed to the Social Services Department or to the police must be as informative as possible, as it may be used in any subsequent legal action; hence there is the necessity for making a factual, detailed record of the following:

- The child or young person's name, address and date of birth.
- The nature of the allegation.
- A description of any visible bruising or other injuries.
- The child's or young person's account, in their own words if possible, of what has happened and how any bruising or other injuries occurred.
- Any observation made by yourself.
- Any times, locations, dates or other relevant information.
- A clear distinction between what is fact, opinion or hearsay.
- Your knowledge of and relationship to the child or young person.

Whenever possible, referrals to Social Services Department should be confirmed in writing within 24 hours and the appropriate Statutory Notification completed and sent to the Care Quality Commission (CQC).

Keep a record of the name and designation of the social services member of staff or police officer to whom concerns were passed, and record the time and date of the call in case any follow-up is needed.

Training Statement

All care or support workers will receive Safeguarding of Children in an Adult Setting training and a copy of the Safeguarding Children in an Adult Setting Policy.

Related Policies

Adult Safeguarding

Duty of Candour

Notifications

Supervision

Training Statement

Employees will be required to attend Safeguarding Awareness training, including prevention, as a minimum offered by the agency; mandatory refresher training will be required annually, or sooner, in accordance with local authorities safeguarding guidance and compliance. Managers are required to attend specific detailed training in line with their responsibilities.

This policy will be reviewed by the Registered Manager and should be read in conjunction with the Adult Safeguarding Policy

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

SEPSIS AWARENESS

Constantia Care Ltd.

Policy Statement

Sepsis can be triggered by an infection in any part of the body. The most common sites of infection leading to sepsis are the lungs, urinary tract, abdomen and pelvis.

There is a greater chance of developing sepsis when in hospital after:

- recent surgery
- having a urinary catheter fitted
- staying in hospital for a long time due to a serious illness

Sources of infection Types of infection associated with sepsis include:

- lung infection (pneumonia)
- appendicitis
- an infection of the thin layer of tissue that lines the inside of the abdomen (peritonitis)
- an infection of the bladder, urethra or kidneys (urinary tract infection)
- an infection of the gallbladder (cholecystitis) or bile ducts (cholangitis)
- skin infections, such as cellulitis – this can be caused by an intravenous catheter that's been inserted through the skin to give fluids or medication
- infections after surgery
- infections of the brain and nervous system – such as meningitis or encephalitis
- flu (in some cases)
- bone infection (osteomyelitis)
- heart infection (endocarditis)

What causes the symptoms of sepsis?

In normal situation your immune system keeps an infection limited to one place. This is known as a localised infection. Your body produces white blood cells, which travel to the site of the infection to destroy the germs causing infection. A series of biological processes occur, such as tissue swelling, which helps fight the infection and prevents it spreading. This process is known as inflammation.

If your immune system is weak or an infection is particularly severe, it can quickly spread through the blood into other parts of the body. This causes the immune system to go into overdrive, and the inflammation affects the entire body. This can cause more problems than the initial infection, as widespread inflammation damages tissue and interferes with blood flow. The interruption in blood flow leads to a dangerous drop in blood pressure, which stops oxygen reaching your organs and tissues.

The Policy

It is important to understand the causes of sepsis along with sources of infection for staff to be able to raise any concerns as soon as possible with a medical professional. We recognise that individuals in our care are amongst those most at risk of developing sepsis.

People at risk

Everybody is potentially at risk of developing sepsis from minor infections. However, some people are more vulnerable, including people who:

- have a medical condition that weakens their immune system – such as HIV or leukaemia
- are receiving medical treatment that weakens their immune system – such as chemotherapy or long-term steroids
- are very young or very old
- are pregnant
- have a long-term health condition – such as diabetes
- have just had surgery, or have wounds or injuries as a result of an accident

- are on mechanical ventilation – where a machine is used to help you breathe
- have infusions or catheters attached to their skin
- are genetically prone to infections

Signs and symptoms of sepsis

- fever, above 103 degrees Fahrenheit / 39.4 degrees Celsius and shaking chills or, alternatively, a very low body temperature
- decreased urination
- rapid pulse. (heartbeat of 90 beats per minute or more)
- rapid breathing. (greater than 20 breaths per minute)
- nausea and vomiting
- diarrhoea
- the high likelihood or confirmed presence of an infection

Septic Shock

Septic shock is a life-threatening condition that happens when blood pressure drops to a dangerously low level after an infection. Any type of bacteria can cause the infection. Fungi such as candida and viruses can also be a cause, although this is rare.

At first the infection can lead to a reaction called sepsis as described above. Left untreated, toxins produced by bacteria can damage the small blood vessels, causing them to leak fluid into the surrounding tissues.

This can affect the heart's ability to pump blood to your organs, which lowers your blood pressure and blood does not reach vital organs, such as the brain and liver. People with a weakened immune system have an increased risk of developing septic shock.

These include:

- new-born babies
- elderly people
- pregnant women
- people with long-term health conditions, such as diabetes, cirrhosis or kidney failure
- people with lowered immune systems, such as those with HIV or AIDS or those receiving chemotherapy

Symptoms of septic shock

Symptoms of septic shock include:

- low blood pressure (hypotension) that makes you feel dizzy when you stand up
- breathing difficulties
- a rapid change in mental state, such as confusion or disorientation
- diarrhoea
- abdominal pain with nausea and vomiting
- heart pumping abnormalities
- cold, clammy and pale skin

Septic shock is a medical emergency; medical help must be summoned immediately if it is thought that the person in your care has septic shock.

Septic shock among the elderly results in death about 20% of the time, costing emotional and financial harm on families and the health care system overall.

Among the elderly, sepsis is most often caused by untreated bedsores, or pressure ulcers. Bedsores occur from remaining in one position for long periods of time, such as in a bed-ridden residents or wheelchair-users. The prolonged pressure on that area, commonly the buttocks, results in injuries to the skin and underlying tissue.

Bedsores often develop quickly, particularly among the elderly whose skin is already fragile, and can be difficult to treat. If the individual has any mobility issues, the risk of bedsores should be noted on their care plan. Furthermore, if staff fail to recognise, inform or

adequately monitor bedsores diagnosis and treatment of sepsis may be delayed. This could lead to sepsis infection, and ultimately septic shock.

Sepsis prognosis

By identifying sepsis early, it is possible to increase an individual's chance of surviving. The longer the symptoms of sepsis go undiagnosed, the less likely a sufferer is of making a recovery.

Training

Staff are made aware of sepsis during their regular Infection Control training

Related Policies

Infection Control

Moving and handling

Prevention of Pressure ulcer

This policy will be reviewed by the Registered Manager

Signature: *Morag Collier*

Date: 30/01/18

Date of Review: 30/06/18

SERVICE IMPROVEMENT PLAN

Constantia Care Ltd.

Policy Statement

As part of our Good Governance Framework, this policy sets out how improvements to our services is achieved by the adoption of robust monitoring and audit systems. It is important for the growth and sustainability of the company that a continual improvement cycle is in place which identifies any deficits so that improvement plans can be implemented.

Planning for improvement

In order to improve, we must first identify the areas for improvement by obtaining feedback from all stakeholders involved in the service. A stakeholder could be:

- The Service user
- Family member or Advocate
- Healthcare Practitioner
- Social Worker
- Local Authority Care Manager
- Care & Support Staff
- Care & Support Management Team
- Care & Support volunteers

The feedback is gathered in 3 distinct ways, all of which relate to different areas of activity.

- Service-user-led feedback
- Professional, multi-agency feedback
- Regulatory framework feedback
-

Service-user-led Feedback

This is core to the delivery of a person-centred quality service and service-users must be involved in the day to day choices of care, be listened to and encouraged to influence and shape their services.

True user involvement must reflect their needs and preferences but more importantly explore their experience of our service and how it met or failed to meet their expectations. We can only improve the quality of service delivery if we are aware of any shortfalls. This means engagement with the service-user, their family or representative on a continual basis. It is often the case that it takes a period of time to build an honest, working professional rapport with a service user but it is vital to build a relationship based on trust and open and honest dialogue.

Sometimes things do not always work as they should, so setting the scene for a positive relationship from the beginning by using clear and open methods of communication is essential to maintain a quality user lead service.

Professional Multi-agency feedback

This is sometimes much more difficult to achieve and developing local networks can be a long and arduous journey. It is vital that multi-agency relationships are built up on the front line and there is a mutual understanding of roles and boundaries which encourages honest and open communication between professionals to ensure defined outcomes and goals are met i.e. that the safety, welfare and independence of the service user is at the core of the service delivery irrespective of the number of providers involved. This important cycle can be difficult and sometimes challenging for staff but by adopting a reflective model of supervision and learning from errors culture will enable staff to view peer or multi-agency partners as a positive learning experience which enhances practice and improves service user's experience.

Regulatory Framework Feedback

This is perhaps the most challenging of all for staff and management. We have a regulatory framework, which in itself can mean more than one visit from various regulators. It is important to be clear about the role and function of each regulator. For providers who offer services across a range of sectors, each sector will have its own Regulator, the Adult Social Care sector generally has the following:

The Care Quality Commission (CQC)

This is the national regulator for England and regulates providers registered under the Health and Social Care Act 2008 (Regulations 2014 and Registration Regulations 2009). This includes Domiciliary, Care and Nursing Homes. G.P. Surgeries, Dentists, Ambulance Services and more.

The Local Authority (L.A.)

This comes in various guises but this regulator is usually found within the Contracts Monitoring section of the Local Authority but will only be relevant where there is a contractual arrangement between a provider and the L.A. It is important to understand that the purpose of this regulator is to monitor the contract terms and specification. Knowledge of both documents is essential in order to meet the monitoring criteria. All L.A.'s devise their own contract terms and specification, so working contractually to different L.A.'s will mean different levels and priorities of the monitoring processes.

Monitoring (Internal)

As part of the Quality Assurance process, monitoring should take place regularly. It is important to distinguish between Monitoring and Auditing. You monitor performance, you audit conformance.

Auditing (Internal)

Regular audits are a vital tool in the continual drive for improvement. This should be systematic and planned activity which is robustly interrogated and actions identified.

Auditing (External)

It is becoming more important to evidence open and transparent ways of working within the Social Care Sector. Work on a Quality Standard is underway between the Care Quality Commission, Monitor, NHS England and L.A.'s so that at least they will all regulate to an agreed quality benchmark. This type of external scrutiny is very positive as new eyes, removed from everyday delivery of the service gives a different view or perspective which is often missed. [Add here any other sources of feedback]

Data Interrogation

All of the aforementioned produce various types of data, often in the format of an action plan. However, surveys, questionnaires etc. which are returned should be scrutinised and the data collated and presented in a suitable format for dissemination into the improvement plan.

The Plan

This is only as relevant as the data upon which it is based. It is therefore important to be "H.O.T." Honest, Open and Transparent. Data and statistics can be skewed to give the best picture, it is important to see the service as it is, not how you think it is.

People Development

People are the building blocks of any quality management process. The only point where true responsibility for quality lies is with the person doing the job or carrying out the administrative process, people must engage with continuous improvement activities. This includes senior management, who must be committed to a culture of continuous improvement and an effective mechanism of recognising individual contributions. A simple thank you goes a long way.

Ownership

Everyone in the organisation needs to “own” a shared understanding of what continuous improvement means. This is why it is important within Health and Social Care, that evidence is collected in respect of the effectiveness of the service delivery and most important of all, its contribution to the Regulator’s rating of the service.

Training Statement

All staff, as part of their induction are aware of the aims and objectives of the business, how business planning impacts and links to the day to day delivery of services, and how they, as individuals, are responsible for their contribution to the ongoing success and improvement of the business.

Related Policies

Audit

Business Planning

Compliance Principles

Good Governance

Notifications

Signed: *Morag Collier*

Date: 30/01/18

Reviewed: 30/06/18

SEXUALITY POLICY

OUTCOME 1, REGULATION 17 (Respecting and Involving People who use Services)

Constantia Care Ltd.

Policy Statement

This document will be read in conjunction with the policy on privacy and dignity. The confidential and sensitive nature of this information means that only those with a specific need to know will be able to access any information regarding a client's sexuality or sexual activities. This information will be recorded separately and held in a file that is accessible only by those who need to know.

This document outlines the policy of Constantia Care in relation to the sexuality and sexual activities of clients.

Aim of the Policy

Constantia Care believes that clients have the right, which is often denied to older people and to people with disabilities, to develop and maintain intimate personal and sexual relationships, to engage in sexual activity which is within the law and does not cause significant offence to others, and to enjoy pleasurable experiences and take appropriate decisions for themselves in this area of their lives.

We recognise, however, that the presence of care staff in the homes of clients and their performing intimate care tasks may threaten the privacy on which this right depends. We believe that our care practice will support the operation of rights associated with sexuality, and that where appropriate we will help to provide the information and guidance to help clients remain safe and healthy.

Care Practice

Aim of the Policy

- Our staff never forget that they are guests in a client's home and that our providing a domiciliary care service will never interfere with clients' right to have visitors at any time and to entertain their visitors in private
- For a client who has a marital, civil or sexual partner who resides with them or visits them, our service is provided in ways which respect their wish to be together in private
- Clients are assured that while a worker is in their home there will be no interruption of privacy for any intimate or personal contacts or sexual activity
- Clients are able to decide whom they see and do not see, and if necessary and requested to do so our staff provide support in these decisions and protection from any personal contacts which are unwelcome or abusive
- A request by a client for assistance in restricting or forbidding entrance to their home by an unwelcome visitor is recorded and as far as possible complied with
- Wherever possible, when intimate care is given, clients' wishes as regards the gender of the worker are respected
- We assist clients' who require access to advice or guidance to ensure that any sexual activity in which they engage is safe and pleasurable
- The sexual orientation and preferences of clients are treated with respect
- Homosexual and lesbian relationships are accorded similar respect to that given to heterosexual activities
- If clients engage in any sexual activity or display which is offensive to a staff member or make a sexual approach to a staff member, the matter is reported to their supervisor who takes prompt and appropriate steps to discuss the matter with the person concerned and to help them contain their behaviour within reasonable limits

- If clients persist in engaging in inappropriate sexual activity or display in the presence of a staff member, the service may be terminated
- All possible efforts are made to protect clients from any forms of sexual abuse
- Any client who, because of a disability, requires assistance in fulfilling their sexual aspirations has the opportunity to discuss their needs with staff, who where possible as part of our care service will arrange for appropriate help to be provided
- Information about clients' personal and sexual relationships and activities is treated confidentially and sensitively and is passed only to those with a specific need to know
- The opportunity is provided for clients to discuss matters relating to their sexual relationships and activities within the care planning process if they wish to, always with due regard to the need to treat these issues with confidentiality and sensitivity
- Particular care and sensitivity are exercised if it is necessary to pass information between staff or to make a written record relating to any matter concerning a client's intimate relationships or sexual activity
- Clients' relatives, friends and representatives are fully informed about the contents of this policy and are provided with appropriate support and guidance if they seek it
- A client requiring advice on sexual matters or personal relationships can raise the matter with any member of the care staff or management with whom they feel comfortable
- Sexual relationships between staff and clients are not allowed

Further advice

Further advice on matters relating to sexuality is available to clients from GP's

Training

All new staff members will be given a copy of this policy and encouraged to read it during induction.

This policy will be reviewed by the registered manager

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

SICKNESS ABSENCE

Constantia Care Ltd.

Policy Statement

The policy statement acknowledges that there are various forms of sickness absence and that each case needs to be treated on its facts. The need to report sickness absence, investigate the cause of absence and identify means of assisting return to work is explained. Sickness absence can vary from short intermittent periods of ill-health to a continuous period of long-term absence and have a number of different causes (for example, injuries, recurring conditions, or a serious illness requiring lengthy treatment).

Constantia Care works to ensure that the reasons for sickness absence are understood in each case and investigated where necessary. In addition, where needed and reasonably practicable, measures will be taken to assist those who have been absent by reason of sickness to return to work. This policy does not form part of any employee's contract of employment and it may be amended at any time. We may also vary the procedures set out in this policy, including any time limits, as appropriate in any case.

This policy covers all employees at all levels and grades, including senior managers, officers, directors, employees, trainees, home care workers, part-time and fixed-term employees and agency staff.

As an organisation we are aware that sickness absence may result from a disability. At each stage of the sickness absence meetings procedure particular consideration will be given to whether there are reasonable adjustments that could be made to the requirements of a job or other aspects of working arrangements that will provide support at work and/or assist a return to work. If an employee considers that they are affected by a disability or any medical condition which affects their ability to undertake their work, they should inform their line manager.

The Policy

This policy is intended to set out the values, principles and guidance underpinning this organisation's approach to Sickness Absence.

Sickness Absence Reporting Procedure

- If taken ill or injured while at work the employee should report or be taken to their line manager and if necessary be given permission to leave work.
- A member of the direct care staff who cannot attend work because they are ill or injured should telephone their line manager as soon as possible or at least two hours before their shift is to begin. If the employee is an office based member of staff they should contact their line manager as early as possible as and no later than 30 minutes after the time when they are normally expected to start work.
-

The following details should be provided:

- The nature of the illness or injury.
- The expected length of time of absence from work.
- Contact details.
- Any outstanding or urgent work that requires attention.

Managers should ensure that:

- Any sickness absence that is notified to them is recorded. **A copy of this record will be filed in the staff file**
- Arrangements are made, where necessary, to cover work and to inform colleagues and clients, while maintaining confidentiality.

- Employees should expect to be contacted during their absence by their line manager who will want to enquire after their health and be advised, if possible, as to their expected return date.

Evidence of Incapacity - Medical Evidence

- For sickness absence of up to seven calendar days a self-certification form which is available from their line manager must be completed.
- For absence of more than a week a certificate from the employee's doctor (a "Statement of Fitness for Work") stating that they are not fit for work and the reason(s) why, must be obtained. This should be forwarded to the line manager as soon as possible. If the absence continues, further medical certificates must be provided to cover the whole period of absence.
- If the doctor provides a certificate stating that the employee "may be fit for work" the line manager must be informed immediately. The organisation will discuss any additional measures that may be needed to facilitate the return to work of the employee, taking account of any doctor's advice. This may take place at a return to work interview. If measures cannot be taken, the employee will remain on sick leave and the organisation will set a date to review the situation.
- Where the organisation is concerned about the reason for absence, or frequent short-term absence, they may require a medical certificate for each absence regardless of duration. In such circumstances, any costs incurred in obtaining such medical certificates for absences of a week or less will be covered by the organisation, on production of a doctor's invoice.

Unauthorised Absence

Cases of unauthorised absence will be dealt with under our Disciplinary Procedure.

Absence that has not been notified according to the sickness absence reporting procedure will be treated as unauthorised absence.

If an employee does not report for work and has not telephoned their line manager to explain the reason for their absence, their line manager will try to contact them, by telephone and in writing if necessary. This must not be treated as a substitute for reporting sickness absence.

Sickness Pay

If the employee is absent from work, they have completed their probationary period and have worked for Constantia Care Ltd for 1 year or more they are entitled to:

- Statutory Sick Pay (SSP) provided the relevant requirements are satisfied. Qualifying days for SSP purposes are DAY 1 to DAY 3.

Keeping in Contact During Sickness Absence

- If an employee is absent on sick leave they will be contacted from time to time by their line manager in order to discuss their wellbeing, expected length of continued absence from work and any work that requires attention. Such contact is intended to provide reassurance and will be kept to a reasonable minimum.
- If an employee has any concerns while absent on sick leave, whether about the reason for their absence or their ability to return to work, they are free to contact their line manager between 9am and 5 pm.

Medical Examinations

- We may, at any time in operating this policy, ask an employee's consent to a medical examination by a doctor nominated by us at our expense.
- The employee will be asked for consent that any report produced in connection with any such examination may be disclosed to us and that we may discuss the contents of the report with our advisers and the relevant doctor.

Return to Work Interviews

- If an employee has been absent on sick leave for any period of time, including a series of one day and part day absences, we will arrange for them to have a return-to-work interview with their line manager or their delegated representative.

- A return-to-work interview enables us to confirm the details of an employee's absence. It also gives them the opportunity to raise any concerns or questions they may have, and to bring any relevant matters to our attention.
- Where their doctor has provided a certificate stating that they "may be fit for work" we will usually hold a return-to-work interview to discuss any additional measures that may be needed to facilitate the return to work, taking account of the doctor's advice.
<http://fitforwork.org/>

Referrals to Fit for Work assessment

For details on when referrals to the Fit for Work assessment can be made in our area please visit: www.gov.uk/government/collections/fit-for-work-guidance

There is an employer's advice line 08000326235. There is also an online "Ask a Question Service". The helpline is an expert and impartial advice service delivered by a team of Occupational Health Professionals

Sickness Absence Meetings

We may apply this procedure whenever we consider it necessary, including, for example, if the employee:

- Has been absent due to illness on three occasions.
- Has discussed matters at a return to work interview that require investigation; and/or
- Has been absent for more than 10 days irrespective if it is the first period of sickness absence.

Unless it is impractical to do so, we will give 7days' written notice of the date, time and place of a sickness absence meeting. We will put any concerns about the sickness absence and the basis for those concerns in writing or otherwise advise why the meeting is being called. A reasonable opportunity for the employee to consider this information before a meeting will be provided.

The meeting will be conducted by their line manager where ever possible and may be attended by any other member of the management staff. The employee may bring a companion with them to the meeting.

The employee must take all reasonable steps to attend a meeting. Failure to do so without good reason may be treated as misconduct. If either the employee or their companion is unable to attend at the time specified they should immediately inform their line manager who will seek to agree an alternative time.

A meeting may be adjourned if the line manager is awaiting receipt of information, needs to gather any further information or give consideration to matters discussed at a previous meeting. Reasonable opportunity to consider any new information obtained before the meeting is reconvened will be given.

Confirmation of any decision made at a meeting, the reasons for it, and of the right of appeal will be given in writing within 5 days of a sickness absence meeting (unless this time scale is not practicable, in which case it will be provided as soon as is practicable).

If, at any time, the line manager considers that the employee has taken or is taking sickness absence when they are not unwell, they may refer matters to be dealt with under the organisations Disciplinary Procedure.

Right to be accompanied at meetings

- The employee may bring a companion to any meeting or appeal meeting under this procedure.
- The companion may be either a trade union representative or a fellow employee. Their identity must be confirmed to the manager conducting the meeting, in good time before it takes place.

Stage 1 First Sickness Absence Meeting.

The purposes of a first sickness absence meeting may include:

- Discussing the reasons for absence.
- Where the employee is on long-term sickness absence, determining how long the absence is likely to last.
- Where the employee has been absent on a number of occasions, determining the likelihood of further absences.
- Considering whether medical advice is required.
- Considering what, if any, measures might improve the health and/or attendance of the employee.
- Agreeing a way forward, action that will be taken and a time-scale for review and/or a further meeting under the sickness absence procedure.

Stage 2 Further Absence Sickness Meetings

- Depending on the matters discussed at the first stage of the sickness absence procedure, a further meeting or meetings may be necessary. Arrangements for meeting will follow the procedure already set out.

The purposes of further meeting(s) may include:

- Discussing the reasons for and impact of the ongoing absence(s).
- Where the employee is on long-term sickness absence, discussing how long the absence is likely to last.
- Where there has been absence on a number of occasions, discussing the likelihood of further absences.
- If it has not been obtained, considering whether medical advice is required. If it has been obtained, considering the advice that has been given and whether further advice is required.
- Considering the employees ability to return to/remain in their job in view both of their capabilities and the organisations business needs and any adjustments that can reasonably be made to the job to enable a return to work.
- Considering possible redeployment opportunities and whether any adjustments can reasonably be made to assist in redeploying.
- Where the employee is able to return from long-term sick leave, whether to their job or a redeployed job if possible, agreeing a return to work programme.
- If it is considered that they are unlikely to be able to return to work from long-term absence, whether there are any benefits for which they should be considered.
- Agreeing a way forward, action that will be taken and a time-scale for review and/or a further meeting(s). This may, depending on steps we have already taken, including warnings that they are at risk of dismissal.

Stage 3 Final Sickness Absence Meeting

- Where the employee has been warned that they are at risk of dismissal, their line manager may invite them to a meeting under the third stage of the sickness absence procedure. Arrangements for this meeting will follow the procedure set out above on the arrangements for and right to be accompanied at sickness absence meetings.

The purposes of the meeting will be:

- To review the meetings that have taken place and matters discussed.
- Where the employee remains on long-term sickness absence to consider whether there have been any changes since the last meeting under stage two of the procedure; either as regards to their possible return to work or opportunities for return or redeployment.
- To consider any further matters that the employee may wish to raise.
- To consider whether there is a reasonable likelihood of the employee returning to work or achieving the desired level of attendance in a reasonable time.
- To consider the possible termination of their employment.
- Termination will normally be with full notice or payment in lieu of notice.

Appeals

The employee may appeal against the outcome of any stage of this procedure and a companion may accompany them to an appeal meeting as stated above.

An appeal should be made in writing, stating the full grounds of appeal, to their line manager within 5 days of days of the date on which the decision was sent to them.

Unless it is not practicable, written notice of an appeal meeting will be given within one week of the meeting. In cases of dismissal the appeal will be held as soon as possible. Any new matters raised in an appeal may delay an appeal meeting if further investigation is required.

The employee will be provided with written details of any new information which comes to light before an appeal meeting and also be given a reasonable opportunity to consider this information before the meeting.

Where practicable, an appeal meeting will be conducted by a manager senior to the individual who conducted the sickness absence meeting.

Depending on the grounds of appeal, an appeal meeting may be a complete rehearing of the matter or a review of the original decision.

Following an appeal the original decision may be confirmed, revoked or replaced with a different decision. The final decision will be confirmed in writing, if possible within 5 days of days of the appeal meeting.

There will be no further right of appeal. The date that any dismissal takes effect will not be delayed pending the outcome of an appeal. However, if the appeal is successful, the decision to dismiss will be revoked with no loss of continuity or pay.

The organisation will always ensure they follow up to date employment law and guidance in regards to this policy. <http://www.acas.org.uk/media/pdf/q/k/Managing-attendance-and-employee-turnover-advisory-booklet.pdf>

Related Policies

Appraisal
Code of Conduct for Workers
Disciplinary
Equal Opportunities
Supervision

Training Statement

During initial Induction staff are made aware of the organisations policies and procedures. Regular reviews of training needs are identified via the Supervision and Appraisal systems. This ensures that the needs of the service and its Clients are met.

This policy will be reviewed, by the Registered Manager

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

SMOKING

Constantia Care Ltd

Policy Statement

Constantia Care's smoking policies is based on the anti-smoking laws that are now in force under the *Health Act 2006* and the *Smoke Free (Premises and Enforcement) Regulations 2006*. However, they are in an unusual position regarding the new legislation. The non-smoking laws apply to public places and workplaces. This means that no employee can smoke inside an organisation's or service premises. But Constantia Cares service work takes place in the private homes of people who receive their services and which are not workplaces as defined in the legislation; there is no ban on smoking in private places.

Company smoking policies need to be reviewed as a result of the *Health Act 2006*, which now bans smoking in all enclosed public places. The new law requires enclosed public places (including workplaces) to be smoke free. Vehicles used for business purposes are also affected by the law. Outdoor areas are not covered by the legislation. The legislation affects most public premises with only a few exemptions, mainly on humanitarian grounds. Any smoking by clients should not present a hazard.

Staff Smoking

Many employers have provided a designated smoking area for staff to use during their breaks. The *Health Act 2006* now makes such provision illegal. All staff, volunteers and contractors are now covered by the legislation and are banned from smoking in the workplace. Employers are empowered to apply a total ban on smoking inside and/or outside their premises. Managers should agree a suitable policy with their staff, including designated staff representatives, wherever possible.

Smoking is only permitted outside the reception area in Building 3 at North London Business Park.

Smoke-free vehicles will need to display a no-smoking sign in each compartment of the vehicle in which people can be carried. This must show the international no-smoking symbol in dimensions of at least 70mm in diameter.

Guidance

The principles of any policy in light of the current legislation and general trends are as follows:

- Non-smoking should be regarded as the norm
- Priority should be given to the needs of non-smokers who do not wish to inhale tobacco smoke
- Special provision that complies with anti-smoking legislation is made for any smoking permitted
- Smokers should be segregated from non-smokers
- The wishes and views of staff, concerning exposure to second hand smoke from clients who do smoke, should be carefully considered.

Care managers and co-ordinators must take reasonable steps to make all staff and clients aware of their policies, which have been made to comply with anti-smoking legislation. Constantia Cares smoking policy applies to all its staff and carers. The policy has been developed after consultation with the people who use our services.

As an organisation we recognise our duty to provide an environment that enables clients to follow their preferred lifestyles and for staff and carers to meet their contractual duties.

When a client is a smoker, included with the Health and Safety Risk assessment of the client's property is a home fire safety checklist. Any identified risks are discussed with the client and their family and where necessary they are encouraged to have a visit from their local Fire and Rescue Home Fire Safety Officer. If, however no action is taken and the danger of fire continues a safeguarding alert would be sent to the Local Authority and the service may be withdrawn if it is deemed an unsafe working environment.

We respect people's rights to smoke, particularly in and around their own homes. At the same time, we must safeguard the health of everyone who does not smoke and who does not want to inhale smoke from others. Our policy is to ensure that no-one is subject to second hand smoke against their wishes.

Constantia Care is committed to promoting the health and safety of its staff and carers and all the people who use its services. There is now a substantial body of research that links smoking to a variety of serious medical conditions, and evidence is increasingly suggesting that these health risks apply equally to passive smokers. There is also evidence that links smoking to increased fire risks.

The Policy

There must be no smoking in respect of the following:

- Company staff and carers are not allowed to smoke in either clients' homes or outside areas.
- Staff must not smoke in their cars on any occasion that they transport clients, or in transport provided by or paid for by the company.
- The company does not provide any breaks or respite for its employees to smoke at any time or in any place.
- The company undertakes to identify the smoking/non smoking behaviour and habits of all clients and co-residents when contracting to provide a service to them. It has also prepared an information leaflet that it issues to prospective clients and everyone who uses the service.
- Constantia Care also undertakes to obtain the views of its staff on whether they are prepared to inhale second-hand smoke in clients' own homes and to accommodate their wishes, e.g. not to be exposed in any way to second-hand smoke wherever possible.
- The organisation might need to carry out a risk assessment and management plan to reduce the health risks to carers to an acceptable level.
- It then forms an agreement with the client and co-residents who smoke, which is written into the care plan and contract. This states the conditions under which the service will be provided, based on the information they have about the client's smoking behaviour and habits and the health risks involved.
- All clients and co-residents who smoke will be asked not to do so during a visit from a member of the company's staff. Where there is a risk of staff inhaling considerable amounts of second-hand smoke, clients might also be asked to put aside a room that is smoke free for the purpose of the visit.

Violations

The company's management treats breaches of the rules as serious matters of discipline and are dealt with accordingly. Staff violations of the policy are subject to the normal disciplinary procedures and sanctions. The company instructs all new staff to read the policy on smoking as part of their induction and refers them to the no-smoking clause in their contract of employment, or employee handbook.

Disputes

Staff and carers who find that they are exposed to unacceptable amounts of second-hand smoke during a visit should discuss the matter with the client and co-resident with reference to the organisation's policy. If the situation does not improve, the care worker should report the matter to their line manager to investigate and discuss with the client with reference to their initial agreement. All such disputes should be recorded.

Support for Stopping Smoking

Clients who wish to stop smoking can be referred to their GP or put in touch with the local NHS smoking cessation service. Staff wishing to give up smoking should discuss the matter with their supervisor or care home manager; they may be able to refer the staff member to an occupational health support or smoking cessation service.

This policy will be reviewed by the registered manager.

Signed: *M Collier*

Date: 20/02/18

Review Date: 20/08/18

ADDENDUM TO SMOKING POLICY

E.CIGARETTE USE

STATEMENT

The use of e-cigarettes has been rapid and taken the NHS by surprise. E-cigarettes are to be licensed and regulated as a medicine from 2016, in order that the government can be sure if they are effective and safe for use.

Questions of Safety

It is not clear whether e-cigarettes are safe until they have been thoroughly assessed and monitored in a large population over time. However, compared with regular cigarettes, they are certainly the lesser of two evils.

First, e-cigarettes do not contain any tobacco-only nicotine, which is highly addictive but much less dangerous. For this reason, smoking e-cigarettes (known as 'vaping') is generally regarded a safer alternative to smoking for those unable or unwilling to stop using nicotine. Also, while the US **Food and Drug Administration (FDA) found the liquid and vapour to contain traces of toxins (PDF-273kb)** including cancer-causing chemicals **nitrosamines** and formaldehyde, the level of three toxins is about **one thousandth of that in cigarette smoke.**

We cannot be certain that these traces of toxins are harmless, but **tests on animals** and a **small study of 40 smokers** are reassuring, providing some evidence that e-cigarettes are well tolerated and only associated with mild adverse effects (slight mouth or throat irritation, a dry cough etc.).

Public health charity *Action on Smoking and Health (ASH)* is cautiously optimistic, concluding in its **January 2013 briefing (PDF-447kb)** that 'there is little evidence of harmful effects from repeated exposure to propylene glycol, the chemical in which nicotine is suspended'.

Others are more wary. **Some health professionals do not recommend them** because they believe the potential for harm is significant. It is worth bearing in mind that nicotine is not altogether harmless, for example, it has been **linked to anxiety** and research suggests nicotine **plays a direct role in the development of blood vessel disease.**

E-cigarettes are **banned by other countries** and by some UK schools concerned about their influence on adolescents (see '**What are the other concerns?**').

Risks to Others from E-Cigarette Vapour

It's not clear until more studies are done (see 'Are e-cigarettes safe?'). Research to date has not shown the vapour to be harmful, since it largely consists of water.

According to ASH any health risks of second-hand exposure to propylene glycol vapour are likely to be limited to irritation of the throat. To support this, it cites a **1947 study** that exposed animals to propylene glycol for 12-18 months at doses 50 to 700 times the level the animal could absorb through inhalation. Compared to animals living in a normal room atmosphere, no irritation was found, and the kidney, liver, spleen and bone marrow were all found to be normal.

Contents of E-Cigarettes, and How They Work

Most e-cigarettes contain a battery, an atomiser and a replaceable cartridge. The cartridge contains nicotine in a solution of either propylene glycol or glycerine and water, and sometimes also flavourings.

When you suck on the device, a sensor detects the air flow and starts a process to heat the liquid inside the cartridge, so it evaporates to form water vapour. Inhaling this vapour delivers a hit of nicotine straight to your lungs.

This is the latest updated information from NHS Choices. This organisation is aware of the current discussion around the use of e-cigarettes but is not going to ban their use; Where staff raise concerns we will listen and try to resolve the situation. At present, e-cigarettes are

deemed on balance to present very little risk to passive smokers whilst benefiting those who are trying to stop.

Related Policies

Code of Conduct for Workers

Health and Safety

Meeting Needs

Risk Assessment

Guidance

Fire safety in the Home

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564803/Fire-Safety-in-the-Home.pdf

NICE quality standard [QS92] Published date: July 2015 Smoking; harm reduction offers advice and tools to help a person stop smoking

E- Cigarettes Tobacco Products Directive 2014/14/EU (TPD)

New Smoke - Free (private vehicles) Regulations 2015 came into force on 1st October 2015. All staff who use company vehicles must co-operate with these regulations. Staff are also reminded that the use of their own vehicle is included in this particular set of Regulations. These are fixed penalty notices payable for any offence.

http://www.legislation.gov.uk/ukdsi/2015/9780111126004/pdfs/ukdsiem_9780111126004_en.pdf

SOCIAL INCLUSION POLICY

Outcome 1 Regulation 17

Constantia Care Ltd.

Policy Statement

Social inclusion promotes the involvement and participation in everyday activities which are often taken for granted in our day to day lives.

Isolation often comes with ill health, old age and disability, it is important therefore that links to friendships, familial relationships and community based groups are encouraged and pro-actively managed in order to be maintained and enjoyed.

Aim of the Policy

Constantia Care aims to ensure that through a comprehensive and robust assessment and care planning system service users are enabled to participate and contribute, to their fullest potential in any activity which assists in maintaining their links to the community in which they live.

Client choice

No individual can be coerced into being a participating member of society, but often it is the obstacles they have to overcome e.g. transport, access, escort, which are the reasons for exclusion, not their willingness to participate.

A full and comprehensive assessment of need is the first step in identifying their social and emotional well-being and how these can be met. Respecting their right to not be included through their own choice is also important but should be set in the context of everyone being able to change their mind. Timing is the key. It would be natural to withdraw from activities and regular contracts during the first stages of bereavement perhaps, but choices should always be reviewed.

People can often be engaged in different ways and this too should be available as a method of slow inclusion into a social circle e.g. Pets of all or any kind can be the opening up of communication.

There is no "one size fits all", but rather a slow and gradual trust which builds up that allows participation and inclusion to become part of the relationship at the pace chosen by the individual.

It is important that equal access is afforded everyone and that appropriate communication and assistance is available, particularly to those who may lack capacity.

Labelling of "traits" should be avoided e.g. "she's always difficult, grumpy etc" only add to isolation because of perception and bias. Any "labelling" is inappropriate within a care setting and should be dealt with immediately.

All activities should be available and reviewed regularly as part of the care plan, and individual choice should be paramount in the maintenance of those activities.

You will, occasionally, have clients who do not wish to participate and their view must be respected, recorded and revisited.

TRAINING

Staff will as part of their Induction be familiar with Inclusion whilst promoting an "enabling" rather than a "doing" ethos.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

SOCIAL MEDIA & NETWORKING

Constantia Care Ltd

Policy Statement

This policy provides guidance for employee use of social media, which should be broadly understood for purpose of this policy to include blogs, wikis, microblogs, message boards, chat rooms, electronic newsletter, online forum, social networking sites, and other sites and services that permit users to share information with others in contemporaneous manner.

The Policy

The following principles apply to the professional use of social media in this organisation on behalf of this organisation's personal use of such media and includes, where relevant, the

- Employees needs to know and adhere to the Skills for Care Code of Conduct and Employee Handbook
- Employees should be aware of the effect their actions may have on their image, as well as this organisation's image. The information that employees post or publish may be public information for a long time.
- Employees should be aware that this organisation may observe content and information made available by employees through social media.
- Although not an exclusive list, some specific examples of prohibited social media conduct include posting commentary, content, or images that break confidentiality, pornographic, proprietary, harassing, libellous, defamatory material, or material that can create a hostile work environment is strictly forbidden.
- Employees are not to publish, post, or release, any information that is considered confidential or not public. If there are questions about what is considered confidential, employees should check with the supervisor or manager.
- Social media network, blogs and other types of online content sometimes generate press and media attention or legal questions. Employees should refer these inquiries to their manager or appropriate person in this organisation.
- If employees find or encounter a situation while using social media that threatens to become antagonistic, employees should disengage from the dialogue in a polite manner and seek the advice of the supervisor.
- Employees should get appropriate permission before they refer to or post images of current or former employees, members, vendors or suppliers. Additionally, employees should get appropriate permission to use a third party's copyright, copyright material, trademarks, service marks or other intellectual property.
- Social media use should not interfere with the employee's responsibilities. The computer systems are to be used for business purposes only. When using the computer system, use of social media for business purpose is allowed (e.g. Facebook, Twitter, this organisation's blogs and LinkedIn), but personal use of social media networks or personal blogging of online content is forbidden and could result in disciplinary action.
- Any online activity that violates the Constantia Care's Code of Conduct or any other company policy may subject an employee to disciplinary action or termination of their contract.

Related policies

Adult Safeguarding

Code of Conduct for Workers

Cyber Security

Disciplinary

Training Statement

Use of social media and network is part of this organisation induction. Staff are continually updated.

This policy will be reviewed by the registered manager.

Signed: *M Collier*

Date: 20/02/18

Review Date: 20/08/18

STRESS MANAGEMENT

Constantia Care Ltd

Policy Statement

Constantia Care is committed to protecting the health, safety and welfare of its employees and recognises that workplace stress is a health and safety issue and acknowledges the importance of identifying and reducing workplace stressors.

Employers have a duty under the Health and Safety at Work Act 1974 to ensure, so far as is reasonably practicable, the health, safety & welfare of its employees. Under the Management of Health and Safety Regulations 1999 employers must assess the nature and scale of risks to health in the workplace and base control measures upon this assessment.

The guidance contained within this policy will allow the identification of measures already in place to tackle stress and identify through risk assessments, areas in need of further development.

This policy covers everyone that is employed by Constantia Care whilst in the course of their duties, including self-employed carers

Principles

Constantia Care places a high value on maintaining a healthy and safe working environment for all its employees and recognises its duty of care extends to the physical and mental well being of the workforce

- A manageable level of pressure can be healthy and lead to improved motivation, job satisfaction and performance
- A manageable level of pressure means that the worker feels in control and pressure only becomes stress when the worker feels a lack of control or an inability to manage the pressure
- Constantia Care is committed to identifying sources of pressure in the workplace and taking action in conjunction with the worker where reasonable and practicable to reduce or remove harmful stress
- This organisation does not expect staff to accept incidents of violence or aggressive behaviour as the normal part of the job and we will work with patientss to manage the risks.
- Constantia Care seeks to have an organisational culture that is both supportive and empowering; with a management style that reflects this culture
- Staff and Carers are also encouraged to take personal responsibility for themselves at work and support others to do the same.

By implementing this policy, it is expected that awareness of the causes of stress will increase, as will awareness of the support available. This will lead to a reduction in the overall levels of stress within the organization and promote an open and transparent dialogue between management and workers which will assist in the management and reduction of absence.

The Policy

- We aim to increase general awareness of stress and deploy methods to prevent and combat harmful, excessive work place stress through training initiatives for managers, line managers and other workers.
- To identify workplace stressors and conduct risk assessments to eliminate or reduce stress and/or control the risks from stress.
- To assist staff in managing stress in others and themselves
- To manage issues that occur and provide supervision for staff affected by stress caused by either work or external factors
- To manage the return to work of those who have had stress related problems
- To provide adequate resources to enable managers to implement this Policy on Stress.
- As an organisation we endeavour to support staff through difficult personal issues however we offer support not counselling, and therefore the support, mechanisms will be discussed and reviewed regularly.
- Staff will be encouraged to seek other means of support via there GP surgery.

Occupational Health

Constantia Care provides:

- **An Open Door policy and 24 hour Help-Line is available to all staff and carers.**
- **Resident Psychotherapist is available by arrangement.**

Management Responsibilities are:

- To ensure that they, in consultation, set clear objectives, have good communications channels, involve staff in decision making, provide management support and appropriate training
- To ensure that tasks and responsibilities are well defined, skills are used appropriately and suitable training is provided
- To ensure that staff are treated with respect and dignity, have effective systems in place for dealing with interpersonal conflict e.g. bullying or harassment
- To ensure they seek advice from the senior management team where appropriate.
- To acknowledge that their own behaviours and managerial approach can lead to or exacerbate symptoms of stress in others.
- To access training made available in managing work related stress in their teams
- To provide detailed supervision with accompanying written records should be in place.
- To review dates and mechanisms and should be clearly stated in the supervision notes.

Where specific adjustments to the work schedule or duties and responsibilities are requested the senior management team must be involved in the decision making. Where this is agreed a full written letter of variation must be issued to the employee and should include review dates.

Responsibilities are:

- To take a share in the joint responsibility of management of the health and stress hazards in the workplace
- To ensure they highlight to managers/supervisors anything that may lead to stress or other health related hazards
- To take responsibility for their own health and wellbeing including working healthily, taking regular breaks, rest and holidays and supporting one another
- To be responsible for attending work on a regular basis in accordance with their contracted working hours and to fulfil their contract of employment. The employee should comply with the absence reporting procedures and adhere to the policies of this organisation.
- To seek support at any time and if they feel they cannot approach their manager about a stress-related issue, they should approach *the named manager*.
- To report to their manager if they are absent from work with ill health as a result of work related stress.

What Causes Stress?

People react in different ways to different types of stress. What one person finds exciting and challenging another can find daunting.

An individual's reaction to stress can often be influenced by their personality, experience, motivation and the level of support received by their line manager, colleagues, friends and family

Stress can come from a variety of sources and can often occur when:

- Pressures pile on top of each other or are prolonged (overload)
- There is inadequate or inappropriate level of knowledge and skills for the job
- The job attracts certain stressors given the nature of the work
- Staff become confused by conflicting demands upon them
- Staff feel a high degree of uncertainty about their work, objectives, and job or career prospects
- There is lengthy travelling involved for work purposes
- There are poor working relationships between individuals
- There is lack of understanding, leadership or support
- Staff are working additional hours
- Staff are not taking appropriate breaks
- There is inadequate or unreliable equipment to undertake their duties
- There is insufficient training and development for their role
- There is little communication from line managers/colleagues
- Staff find it difficult to manage their work and personal time effectively
- There is inadequate feedback from line managers/colleagues on how well an employee is undertaking their role
- Certain jobs may place extra emotional demands on staff as well as physical conditions within the workplace

It should also be remembered that the source of stress may be from outside the workplace. Staff experiencing stress from home, family or financial pressures may find it difficult to separate these from their working life and consequently are not able to deal with work matters efficiently and effectively.

Risk Assessment

Risk assessments should be undertaken when a staff member indicates that they feel that they are unable to cope with the demands placed upon them at work to proactively manage the pressures prior to them leading to ill health and absence

Risk Assessments should also be undertaken on a reactive basis when a staff member returns to work following a period of absence diagnosed as work related stress

What to do if you believe you, or a work colleague, are experiencing work related stress

There are many things which can be done to relieve the symptoms of stress. The leaflet produced by the HSE outlines some of them; this is available from the office.

If you notice symptoms of stress in yourself or experience any health issues which affect your work, you should discuss this with your line manager.

If you are suffering ongoing stress-related ill health, whether or not you believe work may be a factor, you are advised to contact your own GP.

Identifying the signs of stress

People can react in many ways when facing danger or feeling threatened. Listed below are a few of the common signs that may indicate when someone may be suffering from stress:

Physical Effects

- Raised heart rate
- Blurred vision
- Increased sweating
- Aching neck/shoulder
- Headaches
- Skin Rashes
- Dizziness Loss/gain in weight
- Tiredness
- Faster breathing/pulse
- Lowering resistance to infections

Behavioural Effects

- Poor work Mood swings/depression
- Lack of self esteem
- More accident prone
- Changing sleep patterns
- No enthusiasm
- Poor concentration
- Increased anxiety/irritability/frustration/aggression
- Inability to deal calmly with everyday tasks/situations
- Tendency to drink more alcohol/smoke more

Related policies

Appraisal

Challenging Behaviour, Anger and Aggression

Sickness/Absence

Supervision

Guidance

NICE Quality Statement QS147 Healthy Workplaces: improving employee mental and physical health and wellbeing published March 2017

Good Work The Taylor Review of Modern Working Practices

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/627671/good-work-taylor-review-modern-working-practices-rg.pdf

Training Statement

All staff will receive awareness of this policy through their Health and Safety induction and mandatory training updates.

Should anyone require support, advice or guidance on any element outlined in this policy they should in the first instance speak to their line manager. Where this is deemed inappropriate they should discuss with a senior manager.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 20/02/18

Review Date: 20/08/18

SUPERVISION POLICY

OUTCOME 14, REGULATION 23 (Supporting Workers)

Constantia Care Ltd.

Policy Statement

Constantia Care believes that staff supervision plays an essential role in protecting both staff and residents, in developing and maintaining high care standards and in supporting and developing individual staff. In this regard Constantia Care expects all members of staff to be supervised in their work and to have an appointed supervisor.

Constantia Care adheres fully to Outcome 14, Regulation of the Care Quality Commission Guidance about compliance, Essential standards of Quality and Safety, which relates to the degree to which the registered manager of Constantia Care ensures that residents benefit from being cared for by well-supported and supervised staff.

Aim of the Policy

This policy is intended to set out the values, principles and policies underpinning Constantia Care's approach to staff supervision.

Definitions

Constantia Care understands supervision to be a formal arrangement which enables each member of its staff to discuss their work regularly with another more experienced member of staff. The more experienced member of staff, known as the supervisor, facilitates the discussion with the less experienced member of staff, the supervisee.

Constantia Care understands the aim of supervision to be to:

1. Identify solutions to problems
2. Improve practice
3. Increase understanding of work-related issues.

All supervision will have three core functions. It will:

1. Promote quality care.
2. Promote personal and professional development
3. Provide support to staff in their work

Models of Supervision

Formal Supervision

A number of models of supervision exist, each having its own merits. Constantia Care recognises that its staff work in a wide variety of settings and one model of supervision will not suit all staff. Therefore, individual staff will agree with their supervisor the model of supervision which best meets their needs. However, the following guidelines must be followed.

1. All staff must have a nominated supervisor whose name will be entered in their personal development file. The line manager will assume responsibility for the supervision of all staff.
2. All staff will have appropriate levels of supervision dependant upon qualifications, experience and their own identified need
3. Supervision time must be planned, protected and uninterrupted. Sessions will be held in private but will not be considered confidential.
4. Supervision time will be taken while on duty, but at a time that is convenient to other staff on duty and to residents.
5. Where possible the conducting of the supervision will be agreed between supervisor and supervisee.

6. A reflective model of supervision is vital within a social care setting in order that staff can learn from any errors or situations where on reflection they might do things differently. This ability to reflect is very important and contributes to a learning culture

Recording Principles.

Many staff like to make notes during supervision but this will be agreed between supervisor and supervisee beforehand. A written record of supervision will be signed by both supervisor and supervisee. Where there are areas of disagreement these will also be recorded.

It is important to differentiate between privacy and confidentiality. Supervision cannot be confidential because of the very nature of the discussion. In order for the supervisee to oversee and promote safeguarding they must be free to discuss any aspect of formal supervisions where necessary.

Copies of the notes and sessions can be included in their CPD portfolio and, for other staff doing qualifications, the notes can provide evidence for their competencies.

The registered manager will be responsible for the allocation of any delegated supervision tasks.

It is a principle of Constantia Care that the registered manager has responsibility for the supervision and appraisal of all staff unless this task is delegated to a competent and trained member of staff.

The Supervision Process

A preliminary session will be planned between the supervisor and supervisee to formally discuss supervision, how it might take place and what they hope to achieve in supervision. The supervision method of recording will be discussed and agreed. Confidentiality and its boundaries will be written into the contract.

Basic Principles

We are committed to ensuring that:

1. Supervision in principle is available for all staff, though may take the model of coach and mentor for Registered Managers in place of formal supervision.
2. Supervision or any information revealed during supervision will not be used to assess performance or competence but must be dealt with as appropriate using the separate disciplinary mechanism
3. Supervision is distinct from managerial processes.
4. Informal supervision is the day to day advice and guidance shared between all staff. This can also be recorded but in truth this rarely happens. In order to make it happen Constantia Care Ltd makes an agreement with staff at the appropriate levels as to what will be recorded and by whom. This is part of the informal support mechanism available to staff from all tiers of Constantia Care and good practice in capturing this informal element will be in place.

Evaluation and Review

At the staff member's annual appraisal the format and frequency of supervision will be discussed, review and amended as necessary as to meet the needs of the individual staff.

Training

Training is required to prepare staff to engage in the process for maximum gain. Training will be provided through an accredited supervision course for supervisors

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

TRAINING, DEVELOPMENT AND QUALIFICATIONS

Constantia Care Ltd.

Policy Statement

In an organisation such as ours, it is important to recognise and value our workforce. In order for us to maintain the required standard of care delivery, a planned and systematic approach to workforce training and development needs to be in place.

Training: the process of learning a skill

Development: The process by which someone or something grows or changes and becomes more advanced.

Both processes are inherent to the care sector and both contribute to the ability of our organisation to continually improve for the benefit of our staff and in meeting all regulatory requirements.

The Policy

Training and development of staff is a priority in achieving a benchmark rating of good from the new inspection regime. The New Fundamental Standard Regulation 18, whilst avoiding prescriptive models of training or development nonetheless makes clear the following:

- All persons employed by the service provider in the provision of a regulated activity must receive such appropriate support training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, and
- Be enabled, where appropriate to obtain further qualifications, appropriate to the work they perform.

Training

In April 2015, the Care Certificate replaced the current Common Induction Standards, for new starters to care.

“The Care Certificate is the start of the career journey for these staff groups and is only one element of the training and education that will make them ready to practice within their specific sector. Although the Care Certificate is designed for new staff that are new to care and offers this group of staff their first step on their career ladder, it also offers opportunities for existing staff to refresh or improve their knowledge”.

<http://www.skillsforcare.org.uk/Standards/Care-Certificate/Care-Certificate.aspx>

The Care Certificate Standards

1. Understand your role
2. Your personal development
3. Duty of Care
4. Equality and Diversity
5. Work in a Person Centred Way
6. Communication
7. Privacy and Dignity
8. Fluids and Nutrition
9. Awareness of Mental Health, Dementia and Learning Disability
10. Safeguarding Adults
11. Safeguarding Children
12. Basic Life Support
13. Health and Safety
14. Handling Information
15. Infection Prevention and Control

The following is now in place:

- An induction to the organisation for all new staff.
- Staff who are new to care will be taken through the Care Certificate and following Skills for Care guidance. All new to care staff will commence their Care Certificate once recruitment is complete, wherever possible staff will complete in 12 weeks.
- In certain circumstances this will not be possible, due to such things as; the amount of contracted hours worked e.g. part time workers, the academic abilities of the new member of staff requiring extended support to understand and become competent, the opportunities for observation of every standard due to the type of work initially carried out by the staff member or sickness.
- A plan will be set for these new to care staff identifying target dates for completion after the 12 weeks.
- Constantia Care has identified standards that must be completed within the 12 weeks along with the practical training of Moving and Handling/Positioning and Basic Life Support. This will include the observation requirements to meet the Care Certificate, incorporated into our current spot checking and monitoring arrangements, to measure competencies.
- The Care Certificate Workbook issued by Skills for Care will be completed and signed off by the assessor/training manager/registered manager.
- Staff who carry out the assessment of competency observations for the Care Certificate Standards will be competent to do so having up to date occupational knowledge and experience along with an initial assessing or teaching qualification.
- For staff new to the organisation but with previous care qualifications and experience the manager will take the decision regarding the need to complete certain standards to reflect the current provision they are working in. Observations of competency will be incorporated into their ongoing training
- Mandatory training requirements will be reviewed to reflect any changes within the Care Certificate. This will be done by the in-house training dept.

On completion of the above, some of which is already underway, a training plan for will be implemented.

Managers Induction

Skills for Care have updated and refreshed the above standards. There are now 8 Core Standards and 4 Optional Standards. As Constantia Care we use these standards as a versatile tool for new managers, existing managers and for use as a planning tool for aspiring managers.

Code of Conduct. (Skills for Care)

The Code of Conduct will be made available for all staff, this is readily available in the Policies and Procedures, the Code of conduct is also sent to all the care staff. It is seen as an essential tool in the induction and informing of staff into our organisation and will be used as required at supervision, appraisal and disciplinary.

Development

All staff development will be linked to the Business plan to assist with the growth of the business. As part of their appraisal, staff will have a development discussion which will be used to identify particular training, coaching, or mentoring, pertinent to the needs of the business. Individual development needs will be discussed and agreed on a one to one basis. Where the relevance to the business is not the first priority, consideration of such personal development needs will be determined by the organisation, with the individual, recorded in their appraisal, with a detailed explanation of the decision.

Please Note:

As an organisation, any “Champion” roles e.g. Dignity or Dementia champion, must be clear about their role and function and how their learning and increased competency is cascaded through the organisation for the benefit of our clients and the development of all staff. It is important from an inspection perspective that such roles are well embedded and make a contribution to the overall quality of care being delivered.

Qualifications

These have changed significantly over the last few years and we are aware of the need for qualified workers within the care sector. It is important to keep up to date with any Regulatory requirements in addition to a robust Training Plan which fully reflects the needs of our service delivery. Please refer to the Training Plan for further classification.

Records

All records required and arising from this policy will be complete and accessible by our Regulatory bodies, as required. A Training Matrix will be available, up to date and complete, which will ensure that all training is in date, relevant and meets all Regulatory requirements. As part of Recruitment and Selection, all qualifications will be checked - originals viewed and copies taken. Where relevant, qualifications will be authenticated by the relevant Regulator e.g. Nursing and Midwifery Council (NHS) Health and Care Professions Council (HCPC).

Nursing staff

All nursing staff will not only be required to produce evidence of updating their Pin each year but will also complete their own training development programme including regular clinical and medication administration updates. They must have available their Nurse and Midwifery Council (NMC) required CPD evidence at supervision and appraisal meetings and at other times when it may be requested.

A revised Code of Practice was issued by the NMC in March 2015 which details what the updates mean for revalidation of nurses qualifications. As an organisation we will support our nursing staff on the implementation of the requirements of this Code.

www.nmc.org.uk/code

NICE Guidelines**Older people with social care needs and multiple long-term conditions [NG 22] Published November 2015**

This guideline covers planning and delivery of social care and support for older people who have multiple long-term conditions. It promotes an integrated and person-centred approach to delivering effective health and social care services. As an organisation we are working towards ensuring these guidelines are implemented, proportionate to our service, using the tools and resources available from NICE in relation to effective staff training.

Related policies

Appraisal
Meeting Needs
Recruitment and Selection
Supervision

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

VACCINATIONS POLICY

OUTCOME 14, REGULATION 23 (Supporting Workers)

Constantia Care Ltd.

Policy Statement

This policy on vaccination applies to all staff who might contract an infectious illness through the course of their work, which is preventable through immunisation. This outcome is cross referenced to Outcome 8 Cleanliness and Infection Control, Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance.

Aim of the Policy

The aims of the vaccination policy are:

1. To protect Constantia Care's staff, their families and friends, from infections contracted at work
2. To protect the people receiving the services of Constantia Care from contracting infections from Constantia Care's staff, particularly those who do not respond well to their own immunisations
3. To protect other staff who are in contact with infected staff
4. To help Constantia Care to deliver its services without disruption.

Constantia Care also accepts that it has a responsibility under the *Control of Substances Hazardous to Health (COSHH) Regulations 2002* to take all possible steps to protect its staff from any infectious illness or hazardous substances to which they are at risk from contracting during the course of their work.

It exercises its responsibilities by ensuring that risk assessments have been or are carried out wherever there is a possibility of an employee contracting any infectious illness from their work.

Constantia Care does not consider that vaccinations to be a ready substitute for adequate risk assessments and good infection control procedures as described in its infection control policy.

Depending on the outcome of the risk assessment it will then take all necessary steps to protect its staff from contracting the identifiable illness or illnesses.

The first step will be to agree a risk management plan with all concerned and which staff will be expected to implement.

In the case of new clients, the risk assessment and any management plan will be part of the initial assessment and agreed with clients and commissioners or care managers.

Where risks are identified at a later stage, Constantia Care will discuss how to control any risk by reviewing the situation with clients, commissioners and care managers.

Constantia Care expects to be fully informed of any risks from infectious illnesses, which have already been identified from the original needs assessment. It will discuss with the service commissioners or case managers in the contractual process how any continuing risks are to be assessed and managed. It will ensure that the risks continue to be monitored through the care plan and are kept under review.

As a general rule Constantia Care recommends to the entire staff that they are vaccinated against any infections or infectious illnesses they are at risk from within the general population. It then expects its staff to have maintained their vaccinations against such common illnesses as are provided through the NHS.

Routine vaccinations, which all staff will keep up to date through the NHS include tetanus, diphtheria, polio and measles, mumps and rubella (MMR). Department of Health guidance states that the MMR vaccine is especially important where there is a risk of transmitting measles or rubella infections to children or adults.

Vaccines that may be offered on a selective basis following a risk assessment include Hepatitis B and Varicella.

Hepatitis B

In line with Department of Health guidelines Constantia Care recommends vaccination against Hepatitis B for any of its staffs, who have direct contact with clients' blood or blood-stained body fluids. This includes anyone at risk of injury from blood-contaminated sharp instruments or of being deliberately injured or bitten.

Varicella

Constantia Care recommends staffs who are proven through screening or testing not to have had chicken pox or herpes zoster to be given the Varicella vaccination.

Influenza

Constantia Care also follows Department of Health guidance in recommending to its staff that they have annual vaccinations against influenza. The guidance states that influenza immunisation for health and social care staff is likely to reduce the transmission of influenza to vulnerable people, some of whom may have impaired immunity and reduced protection from any influenza vaccine they have received themselves.

Employment Procedures

On appointment each new employee completes a pre-employment health questionnaire, which will give information about previous illnesses and immunisation against relevant infections (or refusal to give consent to immunisation). This enables Constantia Care to review with the employee any new immunisation needs, which can be identified from Constantia Care's general health and safety risk assessments.

To protect clients and other staff, staff are also asked to report episodes of possible infectious illness to Constantia Care particularly if contracted after travel abroad. When necessary, Constantia Care might need to exclude staff, who have been infected, from work until they have recovered or the results of specimens are available.

Where the risk assessment indicates this, Constantia Care will support affected staff to have any vaccinations that are recommended and pay for these or reimburse any costs to the employee. Where appropriate and reasonable to do so, Constantia Care will then negotiate any costs it incurs with the service purchasers or commissioners.

Consent

Constantia Care asks that staff give their consent to vaccination voluntarily and freely. All staff who are being considered are informed about the process, benefits and risks of immunisation and their decision is recorded.

It also respects the rights of staff to take their own decisions on whether to be vaccinated and recognises that some staff will not wish to be vaccinated for their own reasons. It will then fully discuss the implications with those individuals and the further risks that will need to be managed.

Vaccination /Procedures

Where vaccination is the most effective way to protect against an infectious illness Constantia Care will follow these procedures.

1. Constantia Care will make clear to all staff affected the reasons for supporting and recommending vaccination, including the extent of the risks involved.
2. Constantia Care will outline any measures to be taken to protect staff who agree to vaccination during the period before vaccination and between vaccination and the onset of immunity.

3. Constantia Care will outline any measures to be taken to protect staff who do not give their consent to being vaccinated and who will be exposed to any risks of contracting the illness in consequence.
4. Constantia Care will need to consider the position of any employee, who refuses not only to be vaccinated but also to work in the at-risk situation(s), as this might create problems of equity and fairness in relation to other staff members. If the staff member has good reasons for withholding consent, eg they are allergic to the vaccination, all measures will be taken to reduce the risks to that person or they might be transferred to other care situations.
5. Constantia Care will keep a record on the staff' files of any vaccinations carried out in relation to the work situation including monitoring the need for follow ups, boosters etc.
- 6.

Staff Training and Information

1. Constantia Care encourages its entire staff to have access to occupational health advice.
2. It seeks information and advice as needed from its local occupational health service and infection control units.
3. It provides staff with up to date information it receives on vaccination guidance.
4. Staff receive information on Constantia Care's policy on appointment and during their induction programme. They receive further training on selective vaccination issues as required and are encouraged to raise specific concerns in supervision.

Further Information

The Department of Health's (updated 2008) *Immunisation Against Infectious Disease* — "The Green Book" presents latest information on vaccines and vaccination procedures for all the vaccine preventable infectious diseases that may occur in the UK. Relevant chapters can be downloaded from the Department of Health's website www.dh.gov.uk.

This policy will be reviewed by the registered manager.

Signed: *Morag Collier*

Date: 30/01/18

Review Date: 30/06/18

WHISTLEBLOWING

Constantia Care Ltd

Policy Statement

Whistleblowing is the term used when someone who works for an employer raises a concern about bad practice, or risk, for example to a person's safety, wrongdoing which harms, or creates risk to harm, to people who use the service, colleagues or the wider public.

Constantia Cares policy on whistleblowing sets out to comply, in every aspect, with the *Public Interest Disclosure Act 1998* in protecting and not victimising staff who seek to report, and who have investigated genuine and reasonable concerns about any form of malpractice that they encounter in their work.

At the same time, the company aims to create an atmosphere of open communication and commitment to high standards of work, within which criticisms can be frankly made and thoroughly investigated.

Constantia Care also recommends that its staff make arrangements to have access to independent legal advice in the event of any involvement in allegations as whistleblowers or as people against whom allegations are made. They are encouraged to do this through membership of a trade union or professional organisation that includes legal advice as part of its services.

Speak up, we will listen

Speaking up about any concerns you have at work is really important. In fact it's vital because it will help us to keep improving our services for all service users and the working environment for the staff.

You may feel worried about raising a concern, and we understand this but please don't be put off. In accordance with our duty of candour, our senior management are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need

The Policy

This document outlines Constantia Cares policy for responding to allegations or reports of abuse of service users, and other forms of misconduct, made by one or more members of staff against other staff. These actions are known as whistleblowing.

The requirement for such a policy arises because it was previously the case that management considered individuals involved in whistleblowing as trouble-makers. It is now legally recognised that carers who are in a position to observe and report bad practice should be enabled to do so without fear of repercussions on their conduct and career prospects. Indeed, failure to report malpractice could lead to accusations of colluding in it, and therefore of being guilty of misconduct.

Obligations on Staff to Report Abuse

Constantia Care requires its entire staff to observe the organisation's work carefully and report diligently on anything that causes them concern.

We believe that teamwork and loyalty to colleagues should not be allowed to deter staff from reporting suspected abuse, criminal acts, and neglect of service users or bad practice, and follows the guidelines issued by the Care Quality Commission (CQC).

Any member of staff who witnesses or suspects abuse by another member of staff should report it as soon as possible to their line manager. The manager will accept responsibility for the actions that follow and will assure the whistleblower that they have acted correctly by reporting the matter and that they will not be victimised.

Despite the assurances given by our organisation, we accept that there may be incidents that a staff member does not feel confident enough or able to report in the first instance to the manager. Where this is not appropriate or considered too sensitive the worker should report to a director or other service manager/advisor. Where this is not considered appropriate the organisation then accepts the right and obligation of the staff member to report their concerns to an outside authority such as the police, the local authority safeguarding unit or to the CQC to initiate an investigation.

Constantia Care provides every staff member with the contact details which are also included in this policy of these agencies in the staff handbook. The company will not penalise or victimise any staff member who responsibly reports their concerns in these ways.

Investigating and Dealing with Allegations

The manager to whom abuse by a staff member is reported should take the necessary steps under the Adult Safeguarding Policy. In addition, they should also protect the source of the information, if possible. If a manager fails to act promptly, suppresses evidence, or is involved in any action to discourage whistleblowing, they may render themselves liable to disciplinary action.

Dealing with Interference with or Victimisation of Staff who have Reported Abuse

Any member of staff who attempts to prevent a staff member from reporting their concerns to a manager, or who bullies, attempts to intimidate or discriminates against a colleague in these circumstances will be dealt with under disciplinary proceedings. A whistleblower who feels themselves to be subject to hostile action from colleagues should inform their manager, who should, if necessary, take steps to alter the staff member's duties so as to protect them from the hostile action. The company includes in its staff handbook information on how to make contact with the Public Concern at Work organisation that has been established to protect whistleblowers from victimisation and bullying as a result of their actions.

What concerns can be raised

Risk, wrongdoing and bad practice which you believe is harming the service we deliver should be raised as a concern.

Some examples are;

- unsafe care
- unsafe working conditions
- inadequate induction or training
- lack of or a poor response to reported incidents
- bullying culture

This list is not exhaustive

Proof is not required, we encourage you to raise the matter while it is a concern. It does not matter if you turn out to be mistaken as long as you are genuinely troubled.

Unjustified Reporting

Constantia Cares managers take reports from whistleblowers seriously and investigate all allegations thoroughly. Any allegations against colleagues that are found to be merely flippant or malicious may render the accuser liable to disciplinary action and criminal proceedings.

Confidentiality

We want you to feel comfortable raising your concerns openly but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity, therefore we will keep your identity confidential unless required to disclose it by law. You can choose to raise your concern anonymously without giving anyone your name but that may make it more difficult to investigate thoroughly and give you feedback on the outcome

Related Policies

Adult Safeguarding

Duty of Candour

Cyber Security

Recruitment and Selection

Guidance

- In addition, the government has set up a whistle blowing helpline for NHS and Social care.
This is available to both managers for advice and staff for reporting purposes.
This telephone number is 08000 724 725.

www.wbhelpline.org.uk

CQC whistleblowing "Guidance for providers who are registered with CQC (issued November 2013)

www.cqc.org.uk/whistleblowing

Contact Details

Care Quality Commission (CQC)

Citygate

Gallowgate

Newcastle Upon Tyne

NE1 4PA

Local Authority Safeguarding Unit

LOCAL POLICE

Insert Your local numbers

Training Statement

All new staff receive training in this policy on whistle blowing as part of the induction training.
Staff receive updated training as needed due to policy changes.

This policy will be reviewed by the Registered Manager.

Signed: *Morag Collier*

Date: 20/02/18

Review Date: 20/08/18