Learning work book to contribute to the achievement of the underpinning knowledge for unit: HSC 3046

Introduction to Personalisation in Social Care

Credit value 3

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INTRODUCTION

This workbook provides the learning you need to help you to achieve a unit towards your qualification. Your qualification on the Qualification and Credit Framework (QCF) is made up of units, each with their own credit value; some units might be worth 3 credits, some might have 6 credits, and so on. Each credit represents 10 hours of learning and so gives you an idea of how long the unit will take to achieve.

Qualification rules state how many credits you need to achieve and at what levels, but your assessor or tutor will help you with this.

Awarding Organisation rules state that you need to gather evidence from a range of sources. This means that, in addition to completing this workbook, you should also find other ways to gather evidence for your tutor/assessor such as observed activity; again, your assessor will help you to plan this.

To pass your qualification, you need to achieve all of the learning outcomes and/or performance criteria for each unit. Your qualification may contain essential units and optional units. You’ll need to complete a certain amount of units with the correct credit value to achieve your qualification. Your tutor/assessor can talk to you more about this if you’re worried and they’ll let you know how you’re doing as you progress.

This workbook has been provided to your learning provider under licence by The Learning Company Ltd; your training provider is responsible for assessing this qualification. Both your provider and your Awarding Organisation are then responsible for validating it.

THE STUDY PROGRAMME

This unit is designed for individuals who are working in or wish to pursue a career in their chosen sector. It will provide a valuable, detailed and informative insight into that sector and is an interesting and enjoyable way to learn.

Your study programme will increase your knowledge, understanding and abilities in your industry and help you to become more confident, by underpinning any practical experience you may have with sound theoretical knowledge.
WHERE TO STUDY

The best way to complete this workbook is on your computer. That way you can type in your responses to each activity and go back and change it if you want to. Remember, you can study at home, work, your local library or wherever you have access to the internet. You can also print out this workbook and read through it in paper form if you prefer. If you choose to do this, you’ll have to type up your answers onto the version saved on your computer before you send it to your tutor/assessor (or handwrite them and post the pages).

WHEN TO STUDY

It’s best to study when you know you have time to yourself. Your tutor/assessor will help you to set some realistic targets for you to finish each unit, so you don’t have to worry about rushing anything. Your tutor/assessor will also let you know when they’ll next be visiting or assessing you. It’s really important that you stick to the deadlines you’ve agreed so that you can achieve your qualification on time.

HOW TO STUDY

Your tutor/assessor will agree with you the order for the workbooks to be completed; this should match up with the other assessments you are having. Your tutor/assessor will discuss each workbook with you before you start working on it, they will explain the book’s content and how they will assess your workbook once you have completed it.

Your Assessor will also advise you of the sort of evidence they will be expecting from you and how this will map to the knowledge and understanding of your chosen qualification. You may also have a mentor appointed to you. This will normally be a line manager who can support you in your tutor/assessor’s absence; they will also confirm and sign off your evidence.
You should be happy that you have enough information, advice and guidance from your tutor/assessor before beginning a workbook. If you are experienced within your job and familiar with the qualification process, your tutor/assessor may agree that you can attempt workbooks without the detailed information, advice and guidance.

**THE UNITS**

We’ll start by introducing the unit and clearly explaining the learning outcomes you’ll have achieved by the end of the unit.

There is a learner details page at the front of each workbook. Please ensure you fill all of the details in as this will help when your workbooks go through the verification process and ensure that they are returned to you safely. If you do not have all of the information, e.g. your learner number, ask your tutor/assessor.

To begin with, just read through the workbook. You’ll come across different activities for you to try. These activities won’t count towards your qualification but they’ll help you to check your learning.

You’ll also see small sections of text called “did you know?” These are short, interesting facts to keep you interested and to help you enjoy the workbook and your learning.

At the end of this workbook you’ll find a section called ‘assessments’. This section is for you to fill in so that you can prove you’ve got the knowledge and evidence for your chosen qualification. They’re designed to assess your learning, knowledge and understanding of the unit and will prove that you can complete all of the learning outcomes.

*Each Unit should take you about 3 to 4 hours to complete, although some will take longer than others. The important thing is that you understand, learn and work at your own pace.*

**YOU WILL RECEIVE HELP AND SUPPORT**

If you find that you need a bit of help and guidance with your learning, then please get in touch with your tutor/assessor. If you know anyone else doing the same programme as you, then you might find it very useful to talk to them too.
Certification

When you complete your workbook, your tutor/assessor will check your work. They will then sign off each unit before you move on to the next one.

When you’ve completed all of the required workbooks and associated evidence for each unit, your assessor will submit your work to the Internal Verifier for validation. If it is validated, your training provider will then apply for your certificate. Your centre will send your certificate to you when they receive it from your awarding organisation. Your tutor/assessor will be able to tell you how long this might take.
Unit HSC 3046: Introduction to Personalisation in Social Care

About this unit

This unit is aimed at those working in a wide range of settings. It provides the knowledge and skills required to support an individual to choose the level and service they require and to implement personalisation.

Learning outcomes

There are four learning outcomes to this unit. The learner will be able to:

1. Understand the meaning of personalisation in social care
2. Understand systems that support personalisation
3. Understand how personalisation affects the way support is provided
4. Understand how to implement personalisation

What is personalisation?

The term ‘personalisation’ is still new to a lot of people, and unknown to others. Personalisation is not just about personal budgets, but about achieving choice and control in many ways and in different settings, including basic needs such as being able to access public transport if a person is disabled.

In 2007, the government published “Putting People First”, which introduced ‘Personalisation’ as a way to make sure that people are at the centre of our processes, systems and ways of working. The aim is to give people more choice and control in their lives through ‘Self Directed Support’. The aim is that by 2012 every adult will be in control of their care and support.

Personalisation is about the dignity and well-being of the individual. Delivering personalised services will mean different things to different people – it’s about self-determination and self-directed care. The relationship between social workers/PAs and service users should be based on respect and a recognition of equality.
You may already have heard one or more of the following terms, which are used to describe activities or approaches that are part of a personalised approach:

- In control
- Self-directed support
- Person-centred planning
- Person-centred approaches
- Individual budgets
- Personal budgets
- Direct payments
- Citizenship
- Independent living
- Needs led

These activities and approaches are all part of a significant change in social policy now referred to as 'personalisation'. As part of this change, people receiving social care services are increasingly being given more choice and control over the support they receive. These approaches will also be applied to other public services, including health and education. It could totally transform adult social care.

Personalisation means starting with the person, not the service. It recognises that the individual is best placed to know what support they need and how their needs can best be met, and it gives them the opportunity to arrange their own care.

While many people will need support to make these decisions, their parents and carers are often well placed to help them decide what will work best.

**How is a personalised approach different from the current system?**

In most cases today, anyone who wants to access social care services will be assessed by their local authority, who will decide what support they should receive. In order to receive support, the person must meet certain eligibility criteria, and they will then be given access to existing services.

With this system, the emphasis is more on 'fitting people in' to the services that already exist rather than creating and shaping services based on what people really want and need.
Personalised approaches recognise that the individual in need of support, and often their family, are the best people to describe the kind of support they need. Personalisation means giving individuals real choice and control over their lives.

**The ‘professional gift’ model vs. the ‘citizenship’ model**

Another way of describing personalisation is to look at the ‘professional gift model’ of providing services compared to the ‘citizenship model’.

**The professional gift model**

This is the way of providing services still widely used today. Society as a whole is taxed by the government who then distribute some of that money to local authorities. The local authority sets out its own priorities and allocates money to different departments. Social services get their ‘pot’ of money and then make decisions, using social care staff such as social workers and care managers to assess needs and allocate services to the people that need them. It is now widely accepted that this system is ‘broken’ and is not fair to all.

**The citizenship model**

Here the person needing support is at the centre of the process. Money is collected in the same way and goes to local authority departments as before. But then things are very different from the ‘professional gift model’.

People needing support assess their own needs and this assessment is translated into an actual amount of money that is paid directly to the individual - this (plus money from other sources such as the Independent Living Fund, and Supporting People) becomes a personal budget - for the individual to spend on support as they see fit.

In this way, personalisation signals a radical transformation in the way adult social care and other services will be provided in the UK.
What does personalisation involve?

Many people think personalisation just means having direct payments or an individual budget, but it also involves:

- Ensuring the support offered is designed to meet the needs of the individual
- Service providers working together in partnerships to offer a range of options for people to choose from
- Opportunities for social inclusion
- Early intervention
- Recognising and supporting carers
- Ensuring that all services in the community are accessible to everybody.

In control and the seven stage model

In control is the organisation that championed and pioneered personal budgets and self-directed approaches to organising social care. They have developed a seven stage model to help people bring about their own personalised support.

Stage one - self assessment

This process is about finding out whether the person with a learning disability will be eligible to receive help from the local authority and if so, how much. They will be given a set of questions to answer to find out the type and amount of support they need and this will be expressed as an amount of money - their personal budget. The way the local authority work all this out is called the 'resource allocation system'.

Stage two - plan your support

When they know how much money they have got they can start to plan how to spend it to get the support they really want. Family carers and other professionals can help to put together a plan.

Stage three - the local authority agrees the plan

The local authority has to agree the support plan. Once they have done so they can put the agreed support in place.
Stage four - decide how to manage the money

There will be various options for managing the money in the personal budget. These include:

- The person receiving the support can keep it in a bank account
- A family carer could keep it
- A trust fund could be set up
- A service provider could look after the money
- A voluntary organisation might act as a managing agent

Stage five - organise your support

Once the support has been planned and approved, it can be put in place. A personal budget can be used very flexibly. A person can use a personal budget to:

- Buy services that already exist, such as day services
- Employ a personal assistant to support the person with a learning disability
- Employ a service broker to arrange support.

Stage six - live your life

Now the person you care for can get on with living the life they want!

Stage seven – review

Every plan needs to be reviewed. What is going well? What is not going well? What changes need to be made to the plan? The local authority will want to be involved in the review.

Safeguarding and personalisation

Underlying principles:

- Individual adults who use social care and support services and / or their carers should be able to make their own decisions and take risks which they deem to be acceptable to lead their lives their way.
No professional or organisational risk assessment process should prevent or inhibit the individual’s right to make their own decisions and lead their life in the way they choose.

All support for decision making should be in line with the core principles of the Mental Capacity Act 2005.

**Self Directed Support and Risk**

We all have to make a range of choices throughout our lives, some of which may be considered by others, or indeed ourselves, to be risky. The philosophy behind Self Directed Support is that individuals are experts in their own needs and should be supported to make their own choices and have control over their lives. Self Directed Support can only truly flourish in a culture of positive approaches to risk.

We should not deny someone the opportunity to enjoy and control their own life simply because they are a user of care and support services. On the other hand, social care staff have a responsibility to ensure that individuals who would put themselves at risk of harm from others are aware that they have the right to live a life free from such abuse or neglect. Individuals who lack capacity still have the right to be supported to make choices as far as they reasonably can, and any choices which may be made for them should be made with a clear discussion of what is in their “best interests” as defined by the Mental Capacity Act 2005 Guidance.

**Supporting citizenship and promoting safety**

Self Directed Support has at its heart a commitment to supporting citizenship for all, and the belief that achieving true citizenship will inevitably lead to individuals being more healthy, safe and well. There are seven keys to citizenship and each one leads in it’s own way to an improvement in an individual’s level of safety.

Self-determination – people are at greater risk of abuse if they do not direct their own life, if they cannot communicate or are not listened to. Therefore the aim of enabling people to self determine what happens in their lives, and in particular, in relation to how their care and support needs are met, must lead to an increase in safety.
Direction – people are at greater risk of abuse if their lives do not suit their preferences or character, or if they are perceived by others as lacking social value. We know that abuse and neglect have historically been rife in institutions, where people are often seen as having no purpose or direction in life other than to be cared for.

Money – people are at greater risk of abuse if they lack money or if they cannot control their own money. Many people fear that individuals who are self directing their support will be given Direct Payments when these are inappropriate for them, and that they will then be vulnerable to abuse by others who will try to obtain this money from them. However, this belies a common misconception about Self Directed Support that it is only about Direct Payments and people employing Personal Assistants: this is one of a menu of options available for people, and where someone is deemed to be vulnerable to this kind of abuse, a Direct Payment would not be the only option available to them.

Home – people are at greater risk of abuse if they cannot control who they live with, who comes into their home, or if they cannot protect their privacy. Current patterns of service provision frequently place people in shared accommodation without any opportunity to influence who the other people are with whom they are expected to share, and regularly create packages of support in which a multitude of different people come in and out of an individual’s home, often using keys or key safes which are necessarily made available to all of them.

Support – people are at greater risk of abuse if they have no one to help them or if they cannot control who helps them. Traditional services often leave people in a situation where they not only have little say in who supports them, but often have no idea who it will be until the member of staff arrives on shift or at their house, and a high turnover of staff in many care services means that they are often supporting an individual with very little knowledge of what good support should look like for that person. Self Directed Support enables people to take control of who supports them and how this support is delivered, promoting their right as a person to be respected and treated fairly.
Community life – people are at greater risk of abuse if they are not part of their community, if people do not know them or if they have no chance to make a contribution to their local community. The most vulnerable people in our society are those who are not visible, and a traditional approach to providing services often fails to address visibility, with only people who are paid going in and out of a person’s home, or regularly taking the person out of their home and community to distant day centres. Self Directed Support demands that people are supported to be part of their own community and this necessarily makes them more visible, and therefore, by definition, less vulnerable.

Rights – people are at greater risk of abuse if there is no publicly understood and enforced protection for them from the abuse of their rights. Self Directed Support has at it’s heart a commitment to promoting the rights of individuals who use care and support services, and the whole ethos of putting the individual at the centre of their life and support clearly demonstrates a recognition of their rights in a way that a traditional approach sometimes fails to do.

DID YOU KNOW?

Eskimos use refrigerators to keep food from freezing.
ACTIVITY ONE

Circle the words or phrases below that you would associate with promoting safety

Bacon  Community  Rights

Risk  Sausage  Approach

Directed  Support  Eggs

Policy and legislation

2001-2009
The New Labour government proceeded with guidance and legislation to promote independent living for disabled people, and to give greater choice and control over care and support and they explore the possibility of 'individual budgets'. In 2003 'in Control 'offers a new model of social care provision, initially for people with learning disabilities, based on self-directed support and personal budgets.

The Health and Social Care Act (2001) Section 57 made it mandatory rather than discretionary to offer direct payments to those with an assessed need. Valuing People White Paper (2001) has the key objective to make direct payments available to more people with a learning disability and officially introduces 'person-centred planning' as part of social work practice.

'Improving the Life Chances of Disabled People' (2005) outlines proposals to introduce individual budgets to improve choice and control over the mix of care and support. 'Independence, Wellbeing and Choice' (2005) reinforces the role of social care services in helping people to maintain their independence by 'giving them greater choice and control over the way their needs are met' and outlines the human skills required from social care practitioners. In the modernising mental health services policies, New Labour considers the 'recovery' approach which is much more focused on the individual, their self-determination and citizenship.
Our health, our care, our say: a new direction for community service (Department of Health White Paper – 2006) heralds a radical shift to the way services are delivered giving people more control and choice in achieving personalised care. It lays foundation for better working between health and social care to address people's needs and to achieve their chosen outcomes.


Commitment to enabling individuals to direct, manage and control own support through individual/personal budgets. Drive to increase universal, preventative services in each community.

The Independent Living Strategy (2008) is published by the Office of Disability Issues sets out a five year plan that seeks to realise the Government's aim that all disabled people (including older disabled people) to have the same choice, freedom, dignity and control over their lives as non-disabled people. Further proposes personalisation of social care support, including personal budget options.

Theory: The values, policies and practice which are to lead to personalisation are set out and begin to be implemented.

Personal health budgets: 'first steps'(2009) begins to explore how a personal health budget option could work for people with long-term conditions. The Green Paper, Care Support Independence: Shaping the Future of Care Together (2009) begins to consult on how personalised social care and support can be delivered and funded in the long term through the development of a National Care Service. The proposals aim to build a system that is fairer, more simple and more affordable.

Assessing needs

Personalisation is about more than just using new words. Current policy is about working in ways that genuinely put the individual at the centre of decision making about their life, and the services and supports they want and need.
This applies to:

- People with learning disabilities
- People with mental health problems
- People with physical disabilities
- Older people who need support
- Young people in transition to adulthood

The aim of personalisation and person centred care is to ensure that the person is an equal partner with health and social care professionals in assessing, identifying options for, and delivering the most appropriate package of care for that individual across organisational boundaries. It involves the provision of full information on all aspects of the patient’s needs and available services and requires the patient to be treated with respect, courtesy and dignity at all times. It is vital that the person is at the centre of any plans that are made and that the assessment takes account of the ‘whole person’, needs social as well as medical. All plans agreed must be accessible and easily understood, and regularly reviewed and updated.

To begin with the person is the centre of the plan i.e. to be consulted and their views always to come first. It should include all aspects of care both Social Services, Health, family and voluntary sector.

It is vital to consider the following-

- Planning is used to formalise the role of all professionals involved in the care of a specific individual
- No two care plans are alike
- Care plans must be reviewed regularly
- The individual should be involved at every stage

The process of assessing need in social and health care is currently very well defined in government policy and guidance. This guidance is associated with several key acts of parliament which give a framework for the help and services that individuals are entitled to receive.

The National Assistance Act brought in some of the biggest changes in the welfare state since the Second World War.
The community care changes were originally described in a 1989 government document called Caring for People. The NHS and Community Care Act 1990 which followed translated these ideas into legislation.

The Government's aims are to:-

- Make the best use of public money
- Encourage local authorities to set priorities
- Ensure that local authorities check on the quality of care which is being provided
- Encourage local authorities to use other organisations to provide services

Who is involved in care planning?

- A single professional e.g. a social worker or nurse
- A team of professionals (multi professionals.)
- The individual
- Sometimes, the individual’s relatives or friends who act as informal carers

It has been stressed that person centred planning is not a professional activity done to people; instead people themselves (with their friends, families or other allies) must lead it. Yet professionals still have an enormous role to play in responding in a more person centred way to people with learning disabilities. Critically this means:

- Helping people say what is important to them
- Helping them get the help they need
- Making sure people are in control of their lives

**Care planning**

**PHASE 1**

**Initial assessment of need**

The kind of people you involve in assessment obviously depends on your organisation. Take the example of an organisation that provides help in a home for elderly people.
In one case you might need help and information from the individual’s GP and/or district nurse; for another individual you could ask the individual’s partner, family or friends.

Sometimes you may need to talk to the individual’s key worker, if they have one, or to another agency responsible for providing a service to the individual. You might even need to speak to someone in the courts if the individual’s situation has a legal aspect. This may be particularly relevant if the individual is a young child in foster care. It’s important to consider carefully who should be involved in an assessment process and the service being offered. It’s important that the individual is clear about who is involved and why.

Most people find that they obtain a lot of information when they try to learn about an individual’s or family’s problems and needs. Some of the information is factual, e.g. names, addresses, age, and so on. This is called objective information.

Information is factual, e.g. names, addresses, age, and so on. This is called objective information.

Other pieces of information might be based on people’s opinion, e.g. ‘The answer to my mum’s problem is day care. She just gets lonely and depressed on her own.’ This sort of information is subjective. Information about people’s problems and needs can be obtained through observation, too. If the information you receive gives out mixed messages about the individual, think why this might be so – could it have something to do with where the information came from?

Some people may find it hard to be entirely objective about an individual’s needs. The son or daughter quoted above may be finding it hard to accept the extent of their mother’s needs. They may be denying how ill the parent is, because it is too painful to accept. You need to check their opinion against that of someone less involved – like a health professional.

You also need to be aware of your own views. If you prejudge an individual’s needs, the information you give will not be objective.

Summarising information about an individual’s needs and wishes in a way that guides the planning of services is not an easy task.
Some staff write far too much, others write far too little. Care planning meetings are usually held in order to collect information, explore options and make decisions. Individuals’ needs should be the focus of such meetings.

Some individuals will require physical care services, perhaps including intimate personal care. Others need more social contacts, emotional or financial support, or advice on legal or employment matters. People’s needs and wishes often change over time. No individual is static.

Needs of the individual can be identified as:

- Social
- Physical
- Emotional
- Communication
- Identity
- Cultural
- Intellectual

This aspect can sometimes be very challenging. The individual’s needs and wishes have to be balanced with services actually available. Many individuals find the idea of a care programme very helpful but other individuals may find the idea of a care programme frightening or daunting and this could potentially be the time where the balance of power is not equal. Relatives or carers may determine the level and type of care to be provided and not consult with the individual concerned.

Methods used to assess an individual can be:

- Observation
- Questioning
- Use of secondary sources e.g. medical records, relatives

Tell the individual clearly who you are and what your role is.

Don’t ask the individual for personal information in a very public setting.

Give people time to answer your questions and to ask questions of their own.
How we ask questions has an effect on how much other people share what they think and feel and there are good and bad ways of finding out information. Possibly without realising it, you use different sorts of questions in all your day-to-day communications with people. The types of questions people use are often referred to as ‘open’, ‘closed’ or ‘leading’ questions.

Open questions normally begin with words such as:

- How...? Where...? What...? Who...? When...? Why...?
- Tell me...? In what way do you mean...?

Closed questions lead to a specific answer; they don’t encourage people to talk about how they feel or think.

Open questions allow the individual to respond in whatever way they wish. They can give you their opinion, share their preferences and explain in their own words what their needs are.

A leading question, for example ‘You’d be better off if you had a home carer once a week, don’t you think?’ This puts pressure on the individual to say yes to your idea. It makes it a lot more difficult for them express themselves openly.

Sometimes it may be right for you to make your own views known to individuals. For example, you may want to suggest an option your individual has not considered. If you feel it right to make your own views known, then make it clear that you have heard and understood what the individual wants don’t put pressure on individuals to accept your suggestions.

Building up a good picture about an individual is an essential part of any assessment. It is often a good idea to reflect back to individuals what they have said. The point of this is to check that you have understood them.

Always keep in mind the individuals rights.

- The right to independence
- Identity maintenance
- Choice and control
- Confidentiality
The care planning cycle

- PROVIDE INFORMATION
- REFER FOR ASSESSMENT
- ASSESS NEED
- IDENTIFY EXISTING SERVICE
- PLAN CARE
- IMPLEMENT CARE
- MODIFY CARE
- REVIEW AND EVALUATE
- MONITOR CARE

PHASE 2
The development of the care plan

- Identify any needs that are not being met and reasons why
- Identify goals (desired outcome) to be met
- Identify actions to be taken
- Set a review date

There may be the need here to identify any shortfalls in provision or resources and ensure that these are reported on for further action. Joint working can potentially cover aspects of shortfall but not unless they are aware of the gaps that exist.

Taking a holistic approach

Needs Assessment

Suggested questions:

1. Environment and housing
   Any problems with the heating or the person’s ability to control it? Any problems with access when providing services? Can the individual use the telephone, answer the door? What about handles, taps, switches, plug sockets? Is there a microwave? Are there stairs or is it a bungalow? Where are the toilet/bathroom facilities? Does the individual live alone?
Is it warden controlled? Is the cooker gas or electric? Is the house owned, privately rented, council? Does the individual have access to transport? Is the house secure?

2. Communication
Does the individual have any problems communicating? Do they need an interpreter? What about the individual’s sight, hearing, speech?

3. Personal Care
Dressing/undressing, washing, continence, mobility, transfers to chair/bed/toilet? Any equipment needed?

4. Housework
Prepare meals? Feed themselves? Shopping, laundry, cleaning? Equipment needed?

5. Physical and emotional health

6. Abilities and Hobbies
What does the person like/dislike? Where do they go – clubs? Is there anything that they would like to do but are unable to at the moment? Any equipment needed?

7. Educational or Employment Needs
Applicable to relevant social groups.

8. Financial Information
What benefits is the individual receiving? Are there any other benefits that the individual is entitled to? Do they own their own house; do they have money in the bank?

9. Individual concerns?
Worried about caring for animals, not getting to their club, heating bills, loneliness etc

Providing support to meet the needs and preferences of individuals

Some service users may see themselves as vulnerable because they feel that they cannot control the way in which their needs are met. They may also perceive themselves as dependent upon their care workers to organise all their daily living and activities. Younger people may have to rely on adult guidance in order to be safe. So as well as being vulnerable in relation to their care needs, individuals can also be at risk from exploitation, abuse or physical and emotional damage resulting from their needs not being met fully or appropriately.
In this instance plans are needs led therefore draw upon the resources of the organisation. Often plans can be service led but this does not necessarily mean that the most appropriate service is provided.

**How needs may change**

**Maslow’s Hierarchy of Needs**

A widely accepted model for interpreting human needs was developed by Abraham Maslow. Each of us is motivated by needs. Our most basic needs are inborn, having evolved over tens of thousands of years. Abraham Maslow's Hierarchy of Needs helps to explain how these needs motivate us all.

Maslow's Hierarchy of Needs states that we must satisfy each need in turn, starting with the first, which deals with the most obvious needs for survival itself.

Only when the lower order needs of physical and emotional well-being are satisfied are we concerned with the higher order needs of influence and personal development. Conversely, if the things that satisfy our lower order needs are swept away, we are no longer concerned about the maintenance of our higher order needs.

Maslow’s original Hierarchy of Needs model was developed between 1943-1954, and first widely published in Motivation and Personality in 1954. At this time the Hierarchy of Needs model comprised five needs. This original version remains for most people the definitive Hierarchy of Needs.
According to Maslow, people may be perceived to be vulnerable on different levels, as shown in the pyramid below.

### Maslow's Hierarchy of Needs

**Learning and development theories**

In addition, there are key learning theories which affect how we view the world, how we behave and our surroundings, and in turn impacts greatly on how our needs are met. Approaches need to be adapted to take into account past experiences. For example if someone has been very used to eating at a certain time, and are ‘conditioned’ to this, this must be borne in mind when creating and agreeing a plan of care.

**Behaviourism**

The behaviourist view of learning focuses on behaviour and its modifications rather than hidden mental processes, and is an approach to studying learning which has been, and remains, very influential. Conditioning is regarded as the learning process in behaviourism. There are two different types of conditioning.

Classical conditioning can be defined as the formation of an association between a conditioned stimulus (signal) and a response through repeated presentation of the conditioned stimulus in a controlled relationship with an unconditioned stimulus that originally elicits that response.
The original response to the unconditioned stimulus is called an unconditioned response; the learned response to the conditioned stimulus is called a conditioned response.

A well known example of this phenomenon is Pavlov’s experiments: where dogs salivate when a light is turned on.

Operant conditioning is another approach to the study of habit formation. In Pavlov’s experiment the conditioned salivation resembles the response evoked by the unconditioned (reinforcing) stimulus. In operant conditioning the behaviour that is reinforced bears no resemblance to the behaviour that is normally evoked by the reinforcing stimulus (that is, salivation is a dog’s normal response to food but rolling over is not). Operant conditioning refers to increasing the probability of a response by following the response with reinforcement. Usually the reinforcement is something that can satisfy a drive, for example: a food pellet to satisfy hunger. Using reinforcement techniques Skinner trained pigeons to discriminate between a circle and a square and to dance.

Constructivism

The constructivist views of learning stem from the work of Piaget. Piaget’s approach has been termed constructivist because of the emphasis on the learner’s construction of his or her understanding. Whereas in operant conditioning the emphasis is on the learner ‘being shaped’ by the instructor, (or computer) through selective reinforcement, here the learner is seen as an active participant, who, in the course of learning is structuring his or her experience and knowledge.

Constructivism also builds on the work of Lev Vygotsky, Jerome Bruner and John Dewey. There are two main schools of thought within this view of learning:

1) Cognitive constructivism and
2) Social constructivism – this will be dealt with in the section:

Vygotsky’s Socio-cultural theory
Cognitive constructivism is based upon the work of Swiss developmental psychologist Jean Piaget. ‘Piaget’s theory identifies four developmental stages and the processes by which children progress through them’

Piaget’s theory is built on the premise that a child structures his or her experience and knowledge in the form of schemata. Schemata can be thought of as cognitive structures. A child then experiences his or her environment using these cognitive representations (mental maps). It is in conjunction with the existing schemata that new knowledge is structured and organised. The broad stages of thinking development are:

- Sensori – motor stage (0-2 years)
- Pre-operational stage (2-8 years)
- Concrete reasoning (8 to adolescence)
- Abstract (formal) reasoning (adolescence onwards)

Knowledge readily fits into existing schemata if it comes from a repeated experience. However, if the experience is new or different then the cognitive representation is altered in order to accommodate the new experience. As the child encounters more new and different experiences more and more adequate cognitive structures are developed. The term assimilation is used to describe how new knowledge is incorporated into existing schemata, whereas accommodation is the term used to describe a schema that has had to be changed to cope with new information.

Piaget’s theory places emphasis on the underlying understanding of an experience or knowledge. This is supported by the fact that Piaget showed interest not only in a child’s correct responses but also in the errors that a child makes in response to a given situation as these can give insight about the processes a child uses to construct his or her understanding.

Since the late 1980’s an understanding by researchers has been developing, of learning that grows out of cognitive and developmental psychology. The basis on which this ‘new theory’ - constructivism - is founded is that people learn by constructing their own understanding.
Vygotsky’s socio-cultural theory emphasises that culture is the most important contributing factor to an individual’s development. Through culture children acquire much of their knowledge. Language plays a vital role in cognitive development, problem solving and learning. According to Vygotsky: ‘Children solve practical tasks with the help of their speech, as well as their hands’ Vygotsky did not perceive children to be “lone-learners” but that the surrounding culture and social agents such as parents, other adults and more competent peers, contribute significantly to a child’s intellectual development.

**Summarising information about a individual’s needs and wishes**

Most people find that they obtain a lot of information when they try to learn about an individual’s or family’s problems and needs.

Some of the information is factual, e.g. names, addresses, age, and so on. This is called objective information. Other pieces of information might be based on people’s opinion, e.g. ‘The answer to my mum’s problem is day care. She just gets lonely and depressed on her own.’ This sort of information is subjective.

**Checklist: Writing information about individuals**

- Know WHY you are writing down the information
- Be clear WHO will have access to it
- Know WHERE the information will be recorded
- Know exactly WHAT you are going to write about
- Always write records in INK
- If you summarise someone else’s opinion about the individual’s needs, state CLEARLY whose opinion it is

Use **language** that is suitable for others in the care team and for your individual

- Try to report in an OBJECTIVE way
- Sign and date the information you record
- Ensure that the right people have the information at the right time
- Check with your individual that the information is correct
Confidentiality and record keeping

You need a working knowledge of confidentiality policies and the laws that may affect your role in obtaining information about individuals. These include laws such as the Children Act 2004 and the Data Protection Act 1988. What do you know about the laws affecting individuals you work with?

The use and sharing of service user personal information forms an essential part of the provision of health and social care. It benefits individual service users, enables health and social services to function effectively and is often necessary in the public interest. However, the essential nature of such uses needs to be set alongside the expectation service users have that all personal information will be kept confidential. The relationship between health and social care staff and service users should be one of fidelity and trust. Service users have a tacit understanding that private information will not be used or disclosed without their knowledge and consent. All health and social care staff therefore have strong ethical and legal obligations to protect service user information. The right to confidentiality is guaranteed partly by the Data Protection Act 1998, partly by the Human Rights Act 1998, and partly by principles established by judges on a case by case basis (the common law). In addition there are ethical standards which staff within health and social care are obliged to abide by. Disciplinary consequences may follow from a breach of ethical standards.

Service users’ right to privacy and the staff’s duty of confidentiality apply regardless of the form in which information is held or communicated, for example electronic, paper, photographic or biological.

Particular care is needed on the part of health and social care staff to ensure that the right to confidentiality of vulnerable people – especially children and adults with incapacity – is respected and the duty of confidentiality owed to them is fulfilled.
In many circumstances it is extremely beneficial for the health and social care system as a whole to be able to use information about individuals, for example in the efficient planning of how to provide services, the proper maintenance of accounts, the provision of appropriate training of staff and adequate monitoring of the outcomes of treatments. In all circumstances information should, wherever possible, be anonymised or coded in some other way to conceal identity. If it is not possible to conceal identity, information can normally only be used if service users have provided their consent.

There may be other times when the law allows disclosure of service user information because it is very much in the public interest. For instance, disclosure may become necessary to reduce the chances of someone suffering harm, especially if that person is a child or other vulnerable person, to enable alleged misconduct by health and social care staff to be investigated, or to protect the general public against the spread of infectious diseases.

Throughout the process of obtaining information it is vital you make sure you are constantly checking that individuals are fully aware of what is happening and feel that they are in control of the process. Some individuals may see themselves as vulnerable because they feel that they cannot control the way in which their needs are met. They may also perceive themselves as dependent upon their care workers to organise all their daily living and activities. Younger people may have to rely on adult guidance in order to be safe. So as well as being vulnerable in relation to their care needs, individuals can also be at risk from exploitation, abuse or physical and emotional damage resulting from their needs not being met fully or appropriately.

**DID YOU KNOW?**

The Vatican is the world’s smallest country, at 0.16 square miles (0.44 square km).
ACTIVITY TWO

Circle the words or phrases below that you would associate with confidentiality

Spain    Vulnerable    Control

Data    Portugal    Information

Disclosure    Harm    Greece

Developing and monitoring service delivery

You may be involved in a care planning meeting organised to develop or review an individuals’ care plan or to review service delivery. The responsibility for arranging the meeting may also lie with you but it is important that you provide the necessary information and materials as soon as possible prior to the meeting.

Encouraging participation

Individuals and/or their relatives and friends should have a full part to play in the care planning process. This could mean becoming involved in meetings – either at the actual meeting or in the preparations for it. Part of your role is to encourage individuals and those close to them to play an active part.

A first step may be to give them basic information about things such as:

- Why your organisation is having the meeting
- Where and when the meeting will take place
- Whether transport will be needed for the individual to get to the meeting
- Who will attend the meeting?
- Why the different people are there
- How the individual should present their views
- What will happen when the individual and relative/or friend arrive
- What they will be asked to say or do
What happens if they decide to say nothing?

Before any meeting, you need to:

Make sure everyone involved is aware of the individual’s needs and wishes.

Circulate any written reports well in advance. What they can do if they disagree with what’s being said.

How long the meeting might take. What happens at the end?

A good care home will follow the principles of person-centred care. Person-centred care aims to see the person as an individual, rather than focusing on their illness and on abilities they may have lost. Instead of treating the person as a collection of symptoms and behaviours to be controlled, person-centred care takes into account each individual’s unique qualities, abilities, interests, preferences and needs.

Care providers that follow the philosophy of person-centred care aim to bring out the best in the people who live there. Each home has its own written philosophy, or mission statement, based on this concept. This influences every aspect of the life of the home and makes it possible to measure how well the home is living up to its standards at any time.

The care plan should summarise how staff can encourage and maintain the unique strengths of the individual while meeting their needs for support. This plan should be reviewed at regular intervals.

Personal dignity and privacy should be respected at all times. Individual cultural or religious beliefs should also be taken into account. For example, staff should address the person in whichever way the person prefers, whether by their first name or more formally. Individuals, for example those with dementia, have the right to expect those caring for them to try to understand how they feel and to make time to offer support rather than ignoring or humouring them. Staff should sit and chat to residents while they are helping them with physical tasks such as washing and dressing.
One member of staff should have particular responsibility for the care of each person. This staff member should have a clear idea of that person’s life history, habits and interests.

**Restrictions on the recording of information**

**The Data Protection Act 1998**

The Data Protection Act relates to information held about an individual. This includes medical records or social services files, anything which is personal data (facts and opinions about an individual).

All information, however it is stored is subject to the rules laid down in the Act. Anyone processing personal data must comply with the eight principles of good practice. These say that the data must be;

- Fairly and lawfully processed
- Processed for limited purposes
- Adequate, relevant and not excessive
- Accurate
- Not kept longer than necessary
- Processed in accordance with the data subject’s rights
- Kept secure
- Not transferred to countries without adequate protection

Individuals are entitled to see information about themselves but they cannot see any part of their record which relates to someone else. People are entitled to be told if any personal information is held about them and if it is;

- To be given a description of the data or information
- To be told why the record is held
- To be told who the information contained in the record may have been given to
- To be given a copy of the record with any technical terms explained
- To be given any information available to the holder of the record about the source of the information
- To be given an explanation as to how any decisions taken about them has been made.
Other legislation and codes of practice which make reference to the access and security of information include:

- The Freedom of Information Act 2000. This extended the rights of individuals to access information held about them in official records, such as medical or education records.
- Human Rights Act 1998
- Caldicott Committee Report 1997. This made recommendations aimed at improving the way the NHS handled and protected confidential patient information between NHS organisations.

Health and social care organisations have policies and procedures for recording, storing and passing on information held about their service users. Although these policies and procedures exist, it is the health and social care workers who have the responsibility to implement them.

If you hold any information on computer, whether it is about staff or people who are cared for in your workplace, it is governed by the previously mentioned Data Protection Act. The way information can be used is restricted.

And people also have the right to know what information is held on them.

The Data Protection Act also relates to all written information held on individuals therefore this information must be stored appropriately and only used for the purpose intended.

**Communication needs to be a two way process**

- Each person should try and understand the other person's viewpoint
- The ‘communication cycle’ requires professionals to have ....
- Advanced listening skills, and
- The ability to check their understanding of others’ responses

This is particularly important when passing on such vital information as a care plan; therefore it must be in a medium and format that has been agreed with the individual concerned.
Barriers to effective communication

BARRIERS

- Emotions
- Environment
- Disability
- Differences
- Attitudes
- Lack of opportunity to participate

Supporting care plan activities

When a care plan is in place, as well as carrying out your own duties under the plan you will need to support and supervise colleagues to carry out their specified activities.

Monitoring is essential to ensure that any plan of care is continuing to meet the needs it was designed to meet. A plan of care will have originally been assessed, planned and put in place to meet a particular set of circumstances. The original service user plan should include plans for monitoring and review, because plans put in place with even the most thorough assessment and careful planning will not necessarily be appropriate in six months or a year’s time, and continue to provide services of the quality or at the level originally expected.

Monitoring may seem a complex process but its principles are very simple. Monitoring of care services needs to pick up and address changes in the circumstances of those receiving the services, their carers and service providers. For example someone recently discharged from hospital following treatment for mental health problems may receive quite extensive support under the care programme approach.
However feedback on their progress may show that their mental health has improved to the point that day care is no longer needed on the previous level and that a lower level of care input can be planned for.

**Checking resources**

Checking on resources can also be important if changes in the availability of those resources means that a care package will have to be altered in some way. A reduction in the finding available or an increase in demand for a particular service may mean that adjustments in the level of service provision will have to be made. Regular monitoring makes it easier to be aware of where resources are being used and where changes can be made.

**Ways of monitoring**

Whatever approach is taken to monitoring, it will be decided at the outset how a particular plan of care will be monitored and the methods will be agreed with the individual and their carers. Your feedback will be an essential part of the process. This may involve the following key people;

- The individual concerned
- Their carers and/or family
- Other health care professionals
- The service provider

The most important person in the monitoring process is the individual receiving the service, so they must be clear about how to record and feedback information on the way the care package is working. This can be achieved by completing a checklist on a regular basis, by maintaining regular contact with the care manager or coordinator or by recording and reporting any changes in the needs or in the care provision.

Carers and families are also likely to participate in monitoring care provision but it is important they are not obliged to do this but do it willingly. Other health care professionals will also maintain contact between reviews and can offer a useful insight into how the package is being delivered. Your role in overseeing the plan of care means that you are in an ideal position to identify changes in an individual’s circumstances that may mean a service is no longer appropriate.
The changes do not have to be major but can have a significant impact on a person’s life.

Throughout any monitoring and evaluation process you are looking for and responding to change. It is important that you are clear about the difference between types of change requiring immediate action and those which are much simpler and easier to implement. For example there may be a change to financial income, a deterioration or improvement in mental health, a change on the level of family support or a change in housing conditions.

The purpose of review

Review is essential because care situations and needs rarely remain the same for long periods of time. As circumstances change, the care package may need to be reviewed in order to accommodate those changes. At agreed intervals all of the parties involved should meet to reflect on whether or not the package of care is continuing to meet identified needs. A review will gather together all information about the circumstances of the individual, the service provided and the service providers. This will then give all those concerned with the provision of care the opportunity to express their views and opinions and to be involved in dialogue about how effective care provision has been and the any changes which may need to be made.

Checklist: Guidelines for talking in meetings about individuals when they are not present

- State clearly why the individual isn’t present
- Check what you are saying is accurate
- Mention all the appropriate needs and wishes of the individual
- Give the facts in a sensible order
- Clarify what is fact and what is opinion
- If you are giving information that you got from other people, state whose information it is and how long ago you got it
- Use language that everyone understands
- If different people have different views about the individual’s problems and needs, state all the different views that you have obtained and whose they are
- Be clear about what services you are requesting
If possible, explain in full how the individual feels, about the services being discussed

Supporting people to contribute

Check out what people say and reaching agreements that ensure needs are fully met.

Building up a good picture about an individual is an essential part of any assessment. It is often a good idea to reflect back to individuals what they have said. The point of this is to check that you have understood them. Here is an example of reflecting.

Individual: I feel so much better now. I think I can manage by myself. I can do everything I need to do – it just takes time. The thing is I’ve got plenty of time. I think I’d prefer it really. At least while I can.

Worker: I’m glad you’re feeling much better now. It sounds as though you’d prefer not to have a home help for the moment. You think you can manage on your own. Is that right?

People who are vulnerable need to know that their needs have been noticed and understood.

Below is a checklist of things you should ask yourself whenever you obtain information from an individual about a service they might require.

You may find it useful to read through this list both before and after any interview or chat with an individual.

Checklist: collecting information

- Have you obtained the correct factual information, e.g. their name, address, age?
- Have you understood correctly what it is that they want help/support with?
- Have you told them exactly why you need the information?
- Have you talked to them about who you are going to share the information with and why?
- Have you discussed what will happen next as a result of them giving you information about themselves?
Have you checked that the individual is happy about the next steps?
Have you asked them if they want you to talk with anybody else about their needs and preferences?
Have you told them where the information will be recorded?
Have you checked that you correctly understand what the individual has said?

Barriers to personalisation

You can find yourself in a difficult position when an individual’s views and expectations of the service needed are different from the views of the other professionals, or of the individual’s own relatives or carers. Your role is to represent the views of your individual service users and you should not get drawn into the role of attempting to manipulate the procedures to ensure that the individual achieves their desired outcome. Neither should you become involved in disputes with other professionals; you should simply ensure that the individual’s views are clearly expressed.

DID YOU KNOW?

There are no letters assigned to the numbers 1 and 0 on a phone keypad. These numbers remain unassigned because they are so-called “flag” numbers, kept for special purposes such as emergency or operator services.

ACTIVITY THREE

Circle the words or phrases below that you would associate with barriers to personalisation

Lemonade       Outcome       Views
Expressed       Achieve       Ginger beer
Expectations    Cola          Role
UNIT HSC 3046: SIGN-OFF

Assessor’s Name: _________________________________
Assessor’s Signature: ___________________________ Date: __________
Learner’s Name: _________________________________
Learner’s Signature: ___________________________ Date: __________
Mentor’s Name: _________________________________
Mentor’s Signature: ___________________________ Date: __________
UNIT HSC 3046: ASSESSMENT

ASSESSMENT ONE

Define the term 'personalisation' as it applies in social care

ASSESSMENT TWO

Explain how personalisation can benefit individuals
ASSESSMENT THREE

Explain the relationship between rights, choice and personalisation

ASSESSMENT FOUR

Identify legislation and other national policy documents that promote personalisation
ASSESSMENT FIVE

List local and national systems that are designed to support personalisation

ASSESSMENT SIX

Describe the impact that personalisation has on the process of commissioning social care
ASSESSMENT SEVEN

Explain how direct payments and individual budgets support personalisation

ASSESSMENT EIGHT

Explain how person centred thinking, person centred planning and person centred approaches support personalisation
ASSESSMENT NINE

Describe how personalisation affects the balance of power between individuals and those providing support

ASSESSMENT TEN

Give examples of how personalisation may affect the way an individual is supported from day to day
ASSESSMENT ELEVEN

Analyse the skills, attitudes and approaches needed by those providing support or brokering services, in order to implement personalisation

ASSESSMENT TWELVE

Identify potential barriers to personalisation
ASSESSMENT THIRTEEN

Describe ways to overcome barriers to personalisation in day to day work.

ASSESSMENT FOURTEEN

Describe types of support that individuals or their families might need in order to maximise the benefits of a personalised service.
UNIT HSC 3046: ASSESSMENT SIGN-OFF

Assessor’s Name: ___________________________________________
Assessor’s Signature: ___________________ Date: ____________

Learner’s Name: ___________________________________________
Learner’s Signature: ___________________ Date: ____________

Mentor’s Name: ___________________________________________
Mentor’s Signature: ___________________ Date: ____________