Guide to the Standards of Proficiency for Social Care Workers

Domain 3

written by social care workers
for social care workers

Edited by Dr Denise Lyons and Dr Teresa Brown

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Although comprising individually written chapters, this e-book is a team effort creating a collective voice of social care practice. We are eternally grateful to the social care workers, in different stages of their writing and practice journeys, who sacrificed their limited free time during a pandemic, when they were frontline workers, juggling work, family life and COVID-19, to share their vast knowledge and practice expertise.

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- The Irish Association of Social Care Managers IASCM.

This e-book is also the product of an amazing partnership that began as a co-editing relationship and evolved into friendship. This book became our focus, a welcome distraction from the loss of our beloved family members in 2020, Teresa's daughter Hollie, aged 9, and my nephew Adam, aged 10. This book is dedicated to them both.

Hollie Brown Quail (March 2011 – May 2020)

Adam Lyons (February 2010 – June 2020)

Foreword

One of the most beautiful gifts in the world is the gift of encouragement. When someone encourages you, that person helps you over a threshold you might otherwise never have crossed on your own **(John O' Donohoe 1956-2008).**

We were very privileged to receive many gifts of encouragement for this project and we are delighted to include their voices as the foreword to this e-book.

Bernard Gloster (Chief Executive Officer TUSLA Ireland's Child & Family Agency, previously a social care worker and health services manager).

In late 2020 I had the pleasure of writing the foreword for a special edition of the Irish Journal of Applied Social Studies (IJASS) all of which focused on the competencies and development of the social care profession. In that journal, I had the pleasure of reflecting on a book preview as follows; "If you want to engage more on the 80 proficiencies, then the book preview by Denise Lyons and Teresa Brown is a snapshot of what is up ahead. This is an e-book with a chapter on each proficiency (that's a lot of reading), but it has all the hallmarks of being compelling because of the style of capturing the voice of social care workers with their understanding and experience of the proficiencies now set out to be achieved. That e-book might well be the basis within which the proficiencies, when they are reviewed, and no doubt they will be in the future, will be considered against that lived experience of the worker. The worker has so much to achieve in this new set of proficiencies…" I am delighted now to welcome that same e-book available for all to consider and reflect on. The format and style approach is particularly attractive as each domain has its own book within a book and that certainly means that social care workers and students can go to and indeed go back to specific parts and reflections. Written by social care workers, it is for social care workers and educators a unique opportunity. With 75 contributors, the base of experience and reflection is wide and rich. Enjoy Reading.

Mark Smith (Professor of Social Work University of Dundee Scotland, esteemed author, academic, and keynote speaker).

I am delighted to have been asked to provide this brief endorsement for this project and the five e-books that constitute it. I know both Denise and Teresa having served as external examiner for both their doctoral viva voces and it is great to see them bring their manifest commitment to and wide knowledge of social care to this project. The results of their labours are both comprehensive and impressive. They have taken the five CORU generic domains of practice and their associated proficiencies and have prevailed upon a host of experienced professionals to customise these for social care in a series of freely available e-books. It is a vital task the editors have taken on. Practice standards are of little use if they exist only in some codified and abstracted form. They only achieve any utility if they are grounded and contextualised in the messiness and ambiguity of social care practice. And this can only be done by those who have encountered and negotiated this complexity in their everyday practice. So, these volumes are, avowedly, written by social care workers for social care workers – each proficiency is explored and considered though a social care lens anchored in practice. Being anchored in practice, the books provide a rich and credible resource for practice educators in their work with students, but they will also generate discussion and reflection in staff teams. What struck me in perusing the list of contributors is just how broad a base social care is developing in Ireland – it is a profession coming of age. There are eighty chapters between the volumes and while there is rightly some overlap, most are written by different authors. This exercise will itself enhance the status, confidence and identity of the profession. Each of the contributors, but most especially Denise and Teresa, have given the profession a gift that comes from within the profession itself and is all the more valuable for these origins.

Pat Brennan (Director of first social care programme (childcare) in Kilkenny 1971-1981, child care consultant, author).

There is no way I could do justice to this 2021 publication 'Guide to the Standards of Proficiency for Social Care Workers'. It contains eighty contributions from highly qualified and experienced authors. The range of knowledge, research, qualifications, experience and education/training is quite stunning. This guide is a huge compendium, starting with the key term: Social care is … a profession that requires an in-depth understanding of and interest in people. Practice is centred within the relationship between you and another person. Social care work places an onus on the worker to constantly reflect on her/his attitudes, physical and mental health and ongoing ability to focus on and be present with the service user(s). The work is emotionally and physically challenging because you use your self as the 'tool' (Lyons 2013). Every possible aspect of the work of social care is essayed with added examples, key terms, cases, tasks, tips for educators, references and biographies. All the time rooted in best practice, in accordance with legal and statutory requirements, underpinned by social justice and human rights. The emphasis is on human relationships with clear and principled explorations of what can be a fraught area of endeavour and task. In the long run, education and training are central, enabling students to move through knowledge to wisdom so that they do not work 'to the book', but to the reality and the needs of their clients. The main tool being the 'Self. It is an astonishing, comprehensive articulation of the work. It will surely remain the fundamental text with regard to social care for many years to come. This then should give all those in anyway involved in social care great confidence in themselves and in their profession. It must also give substantial standing within the whole welter of professions concerned and involved with the citizens and agencies of this State. An outstanding achievement, heartiest congratulations to all concerned (Pat Brennan, Kilkenny 2021).

Noel Howard (First Social Care Ireland Media Spokesperson, Editor of the CURUM, Leader in the professionalisation of social care work, to name a few of his many roles within social care over his long career).

The editors of this work took on a gargantuan task. Not only did they succeed in that task, but the results are foundational for those who are and will become part of a profession faced with another gargantuan task – making a difference in the lives of those with whom they are privileged to work. Social care workers simply have their own personalities, forged by their past and influenced by their experiences and training, to bring with them to do what they do each day. Denise and Teresa have delivered a rich, comprehensive touchstone, covering the myriad aspects of what that is all about. Moreover, it is written by the real experts, who know in their hearts and souls the loneliness of despair, the stultifying jargon of bureaucracy, the humbling lived experience of misery and failure as well as the uplifting light of the small steps of success. The editors and contributors are to be congratulated and thank you for the touching dedication.

List of Contributors

Dr Denise Lyons is a social care worker who lecturers on both Social Care and Creative Skills modules in the Institute of Technology Carlow. She is also a qualified art therapist. Denise served as secretary for Irish Association of Social Care Educators (IASCE) for five years, and was one of the founding members of Social Care Ireland Executive, serving as president from 2012 until 2014. Denise's publications include Creative Studies for the Caring Professions (2010) and Social Care: Learning from Practice (2014), which she co-edited with Noel Howard. Denise's PhD, which she completed in 2018, explored the experiences of social care workers in different settings.

Dr Teresa Brown is a social care worker currently lecturing on Social Care degree and masters' programmes in the Technological University of the Shannon: Midlands Midwest TUS. Teresa has extensive experience as a social care worker in Northern Ireland, Ireland and Romania. She has practised in the areas of residential care, secure care and child protection/family support. Teresa is currently a board member of Social Care Ireland and an active member of the Irish Association of Social Care Educators (IASCE). Her PhD, completed in 2016, focused on social care workers' experiences of relationship-based practice.

John Balfe is a lecturer at the Wexford Campus, Institute of Technology, Carlow. John commenced his social care career working in a family therapy centre as part of a multidisciplinary team of professionals including social care workers. Having worked in areas of disability, community care and early years, John then joined the Irish Probation Service and worked with young people and in homelessness, addiction and mental health, and managed teams as a senior probation officer. John is also a Director on the Board of Management of Le Chéile youth mentoring service and a member of Tusla's Prevention, Partnership and Family Support subcommittee. He is currently undertaking a doctorate in Social Science at University College Cork.

Claire Barry manages a large day service for men and women, many of whom have complex needs in addition to their intellectual disability. Claire's responsibilities include managing a large staff team; developing a programme of activities, education and leisure interests; and co-ordinating the provision of clinical supports to the right people at the right time. Claire has previous experience in providing home support services to enable independent living. Claire received her BA in Social Studies in Social Care from Technological University Dublin and her MA from National University of Ireland Maynooth.

Deborah Brady is a social care leader with twenty years' experience in the disability field. Her research for her master's in Advanced Social Care Practice focused on 'Supporting people with an intellectual disability to make decisions: An exploration of the South Australian Supported Decision Making Model'. Deborah is currently Chair of Social Care Ireland Disability Special Interest Group and founding member of the charity Accessibility Ballinasloe.

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Caroline Costello is a social care lecturer in the Institute of Technology Sligo. She is also joint Director of the Social Care Practice Programme, and lectures in professional practice. Caroline also co-ordinates social care practice student placements. She has extensive experience as a social care worker in the child and family sector, predominantly in the area of youth justice. Caroline is a certified mediator and National Youth Council of Ireland (NYCI) child protection trainer. She is an active member of the Irish Association of Social Care Educators (IASCE) and the Social Care Ireland (SCI) Education Advisory Group. In 2019, Caroline developed the Use your Brain Not

Your Fists: Promoting Positive Social Behaviour Workbook.

Orla Dowling, an area manager in a charity organisation working with children, young people and families who are at risk within their home or community, also lectures in Sociology part-time at Athlone Institute of Technology. Orla is passionate about and has been involved in policy and programme development and delivery throughout her career in social care.

Jamie Grennan is a social care worker who began his career working in a variety of residential settings for both children and adults with Nua Healthcare and then the Muiriosa Foundation. Jamie has also worked with children internationally in the United States following the model of wilderness therapy. Jamie has worked on Tusla's Prevention, Partnership and Family Support (PPFS) Team in County Offaly since 2018. He is a trained Parents Plus and Non-Violent Resistance (NVR) programme facilitator and also leads a number of child and youth and parental participation projects across both Offaly and Laois.

Noel Howard moved from a teaching career in 1973 to become a social care worker in residential juvenile justice until 1996, and as a manager until his retirement in 2008. He is a founder member of Social Care Ireland and edits the association's bi-annual magazine, Curam. With Dr Denise Lyons he co-edited Social Care: Learning from Practice in 2014.

Jacqui McCann, the Person in Charge of Crannóg Nua Special Care Service, Tusla, has worked for seventeen years in Crannóg Nua as both a high support and special care service. Jacqui has a BA (Hons) in Social Care and in 2020 gained an MSc in Leadership in Healthcare. Jacqui is also a therapeutic crisis intervention (TCI) trainer and has a particular interest in the management of behaviours that challenge. In 2017, Jacqui began working closely with childcare consultant Stuart Mullholland on the implementation of the Welltree Model of Care and Outcomes Framework in Crannóg Nua. To date, Jacqui has implemented the measures for over forty young people in their progress through special care.

Michael McCarthy is an assistant lecturer in Technological University Dublin, City Campus, tutoring undergraduate and postgraduate social care students since September 2021. Prior to this, Michael worked as an aftercare manager for an NGO in conjunction with the Child and Family Agency (Tusla) in Dublin, North City. Michael has a master's degree in Social Care Leadership and Management, a master's Degree in Sociology and a BA Honours Degree in Social Care. Michael commenced his career working in disability services, followed by several years working in residential care. Subsequently, Michael worked as a case manager in family homeless services before moving into social care leadership roles.

Victoria McDonagh is a social care worker with over twelve years experience in both Ireland and Australia. She is currently a lecturer in Social Care and Early Childhood Studies in Waterford Institute of Technology. Victoria has worked with a wide range of service users in the areas of family support, mental health, dementia care, chronic illness and disability. She has also worked in management, leading social care teams and programmes. Following her degree in Social Care, Victoria has completed postgraduate study in Family Therapy and a master's in Child, Youth and Family Studies. Victoria is passionate about empowering service users to reach their full ability as well as providing person-centred support. She is also active in research in social care and early childhood.

Audrey Moore qualified with an MA in Social Care Leadership and Management from Technological University Dublin in 2021. She also has a BA in Social Care Practice from Dublin Institute of Technology and a BSc in Psychology from University College Dublin. Since 2002 she has worked with young people in specialised residential care and adults with intellectual disabilities up to social care manager level. Currently a consultant with Trust Social Care Consultancy, Audrey provides mentoring and external supervision to practitioners while working to improve service delivery in various organisations. Audrey is also an associate lecturer at TU Dublin and a non-executive director of a housing charity.

Dawn Murtagh graduated from Athlone institute of Technology with a BA (Honours) in Social Care Practice and an MA in Child and Youth Studies. She has worked with young people in residential care. She is currently working for ChildVision the National Education Centre for Blind Children. She works with young people who have visual impairments and additional needs, supporting them in their education and helping them to gain the skills necessary for independent living.

Marie Nolan is a social care leader with the Muiríosa Foundation, an organisation that supports individuals (and their families) with an intellectual disability and/or autism to live self-directed, connected and fulfilling lives. Marie completed the MA programme in Advanced Social Care Practice in Athlone Institute of Technology in 2017 and based the research for her dissertation on a study on the care of people with intellectual disabilities in general hospitals in Ireland. Since then, Marie has completed practitioner training in supported self-directed living, a model of care that supports individuals to exercise choice and control over their lives and to become valued, participating members of society on a par with typical citizens.

Grace O'Flynn is a social care worker currently working for Acquired Brain Injury Ireland. Prior to this, she worked in services supporting people with intellectual disabilities. Grace is currently completely her MA in Social Care Leadership and Management. She is a member of the Disability Special Interest Group on behalf of Social Care Ireland.

Sheena O'Neill is a social care lecturer in the Institute of Technology Sligo, Joint Director of the Social Care Practice Programme, and lectures in professional practice. She also co-ordinates social care practice student placements. She has extensive experience as a social care worker, predominantly in the disability sector, working with adults with intellectual disabilities. Sheena is an active member of Irish Association of Social Care Educators (IASCE), the Disability Special Interest Group with Social Care Ireland, and the SCI Education Advisory Group. Her practice-based experience saw Sheena regularly working with service users who had a dual diagnosis with mental illness, which led her to complete her MA in Advanced Practice Mental Health in 2016.

Lorna O'Reilly is a social care worker who began her career working in several children's residential centres with both the Midlands Health Board and the London borough of Ealing. Lorna then worked as a community childcare leader with the Midlands Health Board, then as social care leader with the HSE and then Tusla. Lorna has been a member of the Prevention, Partnership and Family Support (PPFS) team since its inception. She is now senior child and family support network co-ordinator on the Tusla PPFS team in County Offaly. Lorna was the lead on child and youth participation for a number of years in the Tusla Midlands area.

Gráinne Ridge is the Programme Manager in St John of God Liffey Services. In this role she oversees the running of community respite, residential and early intervention services for children and adults with moderate to profound intellectual disabilities in south-west Dublin and north Kildare. Prior to this role, Gráinne gained extensive experience in intellectual disability and children's crisis intervention services. She has a particular interest in supportive and measurable outcomes for the people accessing services. As part of her MSc in Health Services Management in 2013, she undertook research delving into the quality of life that is afforded to adults with intellectual disabilities in various residential settings.

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Introduction

Wednesday, 31 May 2017 was a landmark date. On that day CORU launched the Standards of Proficiency for Social Care Workers and started the clock ticking towards statutory registration. CORU was assigned the task, under the Health and Social Care Professionals Act 2005, of establishing the criteria for all twelve professions included in the legislation. CORU designed the standards of proficiency to include five domains, and the first four (professional autonomy and accountability; communication, collaborative practice and teamworking; safety and quality; and professional development) were deemed generic, forming the general guidelines for all twelve professions. Domain five, described as profession-specific (SCWRB 2017), was adjusted to suit each discipline.

This book is a professional response to the standards of proficiency, written entirely by social care workers for students, workers and educators. Here the voice of social care workers is at the centre of each standard of proficiency, providing a valid, meaningful and practice-rich discussion. The book has a single chapter on each of the eighty proficiencies. Each chapter represents the writer's understanding of the proficiency they have chosen and offers insights into the context in which they work, their professional relationships, and how these shape their professional identity as social care workers. A lot of practice is performed intuitively and draws on personal and professional knowledge and experience built up over a lifetime.

The standards of proficiency are portrayed as a threshold framework for creative and informed practice that views service users as central to social care work. Here the worlds of practice, policy, research and regulation are brought into much closer proximity, presented as an integrated practice-informed body of knowledge with the relationship at the core. The keywords and language of the proficiency are explored and considered though a social care lens anchored in practice. A unique section of each chapter is called 'Social Care is …', in which the author explains what social care practice means to them, based on their knowledge and experience. The aim here is to provide as many perspectives as possible on what this evolving profession means to social care workers. Reflections of practice are drawn upon from the 'coal-face' using fictional case studies to maximise students' engagement with the proficiency. The final section of each chapter contains 'Tips for Practice Educators' with a focus on how they might teach the proficiency as practice educators, using practical exercises, reflective questions, quotes and points to consider. The social care workers involved have given their time and expertise to help strengthen the profession and their contributions are a testament to their competence, generosity, passion and pride in social care work.

- Social care worker is a protected title, and the preferred professional title by authors in this publication. In some chapters, authors have used 'social care practitioner', and 'social care worker' interchangeably.
- The Case Studies included in this eBook are either completely fictional, or loosely based on real people. In all cases, names and identifying details have been changed.
- Remember all the links in the chapters and references list are live, so use them to find other relevant resources to support your practice and education.
- This book was written by 75 of us, for you, so enjoy.

Chapter 41 – Audrey Moore

Domain 3 Standard of Proficiency 1

Be able to gather all appropriate background information relevant to the service user's health and social care needs.

KEY TERMS

Identifying information required

Safeguarding information

Gathering information

Alternative sources of information

Social care is … meeting a person where they are at, using skills, knowledge, experience and the relationship to assist them to create a life of their choosing. This proficiency allows the social care worker to find out where the service user is at.

Identifying Background Information Required

Social care workers endeavour to engage with and ensure the best service is offered to service users. This cannot be achieved without all appropriate background information. Relevant appropriate background information refers to information needed to support and assist the service user. This can include personal information about a person's family history and relationships, education and health assessments, prior placements and past interventions.

The background information required varies depending on the type of social care service on offer and on the individual's health and social care needs at that point in time. For example, background information necessary to provide supports for a person living in full-time residential care can be much broader than the information required to provide supports for a person receiving support in a community day service. Each type of service is unique in the background information it requires.

Knowing where to start when gathering appropriate background information relevant to the service user's health and social care needs can be a daunting task. Initially, background information can be gathered from the individual service user through interviewing or spending time with the person. For some, such as persons with disabilities or children, alternative sources of information may be required to gather the necessary information to provide the service. It might be helpful for the social care worker to use the ecological systems theory (Bronfenbrenner 1977) as a starting point (see Figure 1). Using the environmental systems within which an individual interacts to gather information, beginning with the individual, then moving to the microsystem (the groups and institutions that have most directly impacted on the individual's development, such as family, school, community), a practitioner can identify many of the relevant sources of information for an individual. The mesosystem consists of interconnections between the microsystems, for example between the family and teachers or between the child's peers and the family. By moving out through the layers of the ecological systems, further possible sources of information may be identified and further information may be gathered. See Box 2: Reflections on Practice for an example of this in practice.

Figure 1: Bronfenbrenner's ecological systems

Effective communication is a vital skill for gathering the information needed. A practitioner needs to be able to convey clearly what they need and why they need it. Good written and oral communication is a necessary part of this skill, linking with relevant people, GPs, other medical professionals, social workers, family, and having some influence or compelling reason for the information to be given.

The more specific a request for information, the greater the chance of receiving it. For example, when searching for past daily records or behaviour incident reports, having a date or year is better than requesting 'all' or 'any' of these records. Information sources such as social work departments or residential services may not have the resources to trawl through files to find vague information requests. A specific request with a compelling rationale will garner more co-operation. As seen in the reflections on practice, the social care worker needs to consider the quality of the information gathered and be able to distinguish between fact-based information and opinion-based information.

Factual and Opinion-based Information

Factual Information

Information that can be verified or supported by documentation. Examples include date of birth; dates of attendance at school or work; qualifications; dates of hospital admissions; medical records; psychological or psychiatric assessments or diagnoses.

Opinion-based Information

Subjective information that may be the result of a person's perspective, understanding, particular feelings, beliefs and desires. Two different people may have different opinions based on the same facts. Examples include memories of family, friends, teachers, colleagues, etc.; eyewitness accounts of an event or events; professional opinions in case notes or assessments.

Reflections on Practice

During my time working in an admissions assessment unit and residential care in the community, service users were sometimes admitted with limited background information and limited ability to convey the information required to help them. This limited knowledge of the service user's background information was at times compounded by challenging behaviour and difficulty settling in by the new admission. Trust was often a significant issue and had to be built up between the staff members and the person and their family.

As part of my role as social care worker, I used tools to assess the needs of the service user, such as an admissions form, needs assessment or comprehensive behaviour supports assessment (see Chapters 2-5 in Domain 3 for further information on assessments). This often required the gathering of information from many areas of a person's life: medical history, family history, education, employment history, social history. Informal interviews with service users coupled with a person's file notes would garner much information. Oftentimes, the service user proved very helpful in indicating their needs and wishes. However, where the service user was a child or had an intellectual disability, the informal interviews were not as effective because they were often unable to remember or provide details from their past. Alternative sources of background information were required to gather all relevant information.

Family members are the natural next step as a source of information; however, depending on the circumstances of admission, family members were often not accessible or not open to sharing information, or, in many cases, not reliable with details they shared. Where families were available and open to sharing, great care was required when asking about sensitive topics in order to preserve the developing relationship between social care worker/key worker and family. Diplomacy and good judgement were key skills needed for these interactions. Identifying key persons in the family who could provide reliable information proved effective on several occasions. Using Bronfenbrenner's ecological systems theory, other individuals could be identified in the person's microsystem as good sources of information, such as teachers, GP and social workers. At times, oral accounts of events conflicted with each other and with prior documentation. A clear distinction had to be made between factual information and opinion-based information when documenting information (see Box 1).

Support plans and programmes were developed and implemented despite some gaps in information. Some gaps in information were filled as the relationship and trust grew between social care worker and family or quite by accident during conversation with a family member or other professional. For example, relevant yet unknown past medical history was revealed by a parent while chatting with a social care worker, despite the parent having been asked for medical history information when the service user was admitted.

While it is not always necessary to gather significant amounts of information about a person's health and social care needs, large gaps in information can hinder the support provided to a service user and therefore action may be needed. The process has helped me to learn how to gather information in a tactful and non-threatening manner with individuals, professionals and families and realise that different approaches may be needed depending on the person being approached.

Safeguarding Service Users' Information

In the course of their work, social care workers are privy to a lot of personal and sensitive information about service users and their families. Practitioners must understand and respect the confidentiality of the information they have been given as well as the limits of confidentiality in the context of their role in a social care setting. (See Chapters 4, 10-12 and 14, Domain 1: Professional Autonomy and Accountability for further information on confidentiality).

Practitioners must be aware of and practice within the legal boundaries of data protection legislation[1] by protecting the personal data of service users. See Box 3 for an explanation of some relevant terms related to data protection legislation. Data protection principles ensure that personal information is processed in a lawful, fair and transparent manner, only for the purpose specified to the individual when collected, is accurate and kept up to date, is only stored for as long as necessary for the specified purpose and is done in a way that ensures security, integrity and confidentiality. In order to collect personal data from or about a service user, consent must be freely given, specific, informed and unambiguous. Documentary evidence of consent must be maintained and the individual has the right to withdraw consent at their will. Children under 13 years of age can only give consent with permission from their parent. See dataprotection.ie for further information.

General Data Protection Regulation Terms Explained

Personal Data

Any information relating to a person, identifiable directly or indirectly by name, ID number, or other identifiable factors related to that person.

Processing Personal Data

Any action performed on or with a person's personal information whether manually or by automated means including collecting, recording, organising, storage, consultation, use, disclosure or destruction.

TASK 1

Think about your own personal information. Do you know what organisations or companies have access to your personal data? How is it processed? What consent have you given?

1 General Data Protection Regulation (GDPR), Data Protection Act 2018, the 'Law Enforcement Directive' (Directive (EU) 2016/680), which has been transposed into Irish law by way of the Data Protection Act 2018, the Data Protection Acts 1988 and 2003, the 2011 'ePrivacy Regulations' (S.I. No. 336 of 2011 – the European Communities (Electronic Communications Networks and Services) (Privacy And Electronic Communications) Regulations 2011).

Gathering Information from the Individual – Interviewing

Personal interviewing is helpful for gathering appropriate background information relevant to a service user's health and social care needs and is employed by social care workers in many different settings (Allen & Langford 2008). Interviewing can help a practitioner, through active listening, gain an understanding of the other person and their lived experience. Good practice for personal interviewing ensures effective information gathering and the practitioner can glean much more than through the spoken word. How a person presents in terms of their appearance, demeanour, speech, pitch, tone, facial expressions and body language can add complexity and depth to the information gathered. For example, if a person is saying one thing but their tone of voice and body language indicate the opposite, a skilled social care worker may identify and address this.

GOOD PRACTICE TIPS FOR INTERVIEWING
• Ensure the area allows adequate privacy for the conversation, with limited distractions.
• Sit at the individual's level and make eye contact if it is culturally appropriate for them.
• Sit in a relaxed position and use open body language during the interaction.
• Speak to the individual's level of understanding; avoid jargon and organisation-specific abbreviations.
• Listen attentively and stay centred on the conversation – use active listening skills.
• Open questions are useful when exploring. For example, 'Tell me about your experience at school.'
• Closed questions are useful when seeking specific answers or clarifying. For example. 'What year did you complete your education?'
• Document responses as you go, by taking brief notes. Write up the appropriate details of the interview as soon as possible afterwards. Writing brief notes will assist recall later, while writing too much when interviewing may impede the flow of information.

Special considerations need to be made when gathering information from or interviewing children as their safety and wellbeing is of primary concern. Child protection guidelines must be followed in all interactions with children. Some information-gathering tools in use for children in social care include the Three Houses method and life story work. The Three Houses method is a useful tool which brings the voices of children and families forward when gathering information for the planning of interventions and services (Weld 2008). See domain 3.2 for a further explanation of The Three Houses. Life story work may also be helpful in some situations to assist children to make sense of their past. Care must be taken when gathering information from children, particularly where they have been victims of criminal activity or abuse. Great knowledge and skills are required for formal interviews with children due to the risk of harming or re-traumatising a child who has suffered (Wilson & Powell 2001) and should only be carried out by persons trained to do so.

Alternative Sources of Background Information

There will be times when gathering information from an individual service user is difficult. This might include working with a service user who has not been part of services before and cannot provide reliable information, or where the service user is a child. In these cases, a social care worker may need to source information from third parties such as family, other social or health care professionals or other services. See Box 4 for alternative sources of health and social care information.

Oftentimes, due to a range of factors, information is difficult to get access to or is simply unavailable. These factors could include a family's distrust of services, a language barrier or where a service user originated from another country. See Box 2 for an example of how the developing relationships with service users' family members were utilised to identify people who could provide reliable information. A social care worker sometimes needs to get creative to access information and use resources and skills at hand to piece together information. A social care worker can use oral accounts as well as documentation to build a picture of a service user's background information. Box 5 outlines the advantages and disadvantages of these sources of information. Triangulation can be used as a method to validate the information collected. This involves comparing information gathered through interviews, documentation and observation. Despite being time-consuming and requiring greater planning and organisation, triangulation allows practitioners to confirm and verify information gathered from various sources.

Sources of background information

Advantages and Disadvantages of Oral and Documented Sources of Information		
	Advantages	**Disadvantages**
Oral accounts Formal or informal interviews with an individual, their family, previous support staff, teachers and others.	• Personalised, more detail. Clarification available through the conversation can build a more extensive account of a person, their needs, desires and motivations. • Subtext from pitch, tone, facial expressions and body language can provide further information. • Further information may be gathered as trust builds between the two parties.	• Bias, forgotten or distorted memories or differing accounts may distort the facts. • Possible language barrier. • Misunderstandings and false assumptions may creep in during the interview. • A poor relationship between interviewer and interviewee may limit information exchange.
Documentation Social work records, daily records, school reports, case histories, personal planning information, psychological assessments, social work reports, incident/accident reports.	• Details are preserved and unaltered with time. • High reliability. • Formal accounts. • Can verify and fill in details of verbal accounts.	• Records may be illegible or incomplete; use of jargon/ abbreviations all contribute to poor interpretation. • Social, emotional, environmental or political context of document may be absent. • May only give a more formal picture of a person. • Only significant or serious accounts may be recorded, which may be biased towards the negative. • Possible challenges getting access to documentation, especially from other countries.

Tips for Practice Educators

This proficiency will require students to have an understanding of how information is gathered in relation to service users' health and social care needs. Organisations or services may use specific methods or tools to gather information relevant to the service user's health and social care needs, such as interviewing techniques or forms. Forms may include specific documents or templates in either hard copy or electronic. It would be helpful to discuss the methods or tools employed by the service with the student, allowing them to explore examples from the placement and familiarise themselves with methods or tools in use in the organisation for this purpose.

Introduce the student to the information systems in use in the organisation for individuals' personal information. This may include information storage systems (computer files, hard copy files, filing cabinets), security, disposal and archiving. Share any relevant policies and procedures with the student on information gathering, storage, disposal and archiving.

Giving a student the opportunity while on placement to examine the personal plans of service users with their consent could create an opportunity for the student to learn about the categories of information gathered on individuals. Although not suitable in all settings, a service user might show the contents of their personal file to a student, sharing their past life experiences, family history and significant life events.

Should the opportunity arise, a student may benefit from shadowing a staff member who is in the process of gathering relevant background information.

How does the service manage information for service users transitioning to or from other services? Discuss this with the student, including the legal implications of processing personal data.

The student can be encouraged to reflect on the following:

- The purpose of gathering information relating to a person's needs
- The different types of health and social care information that may be gathered
- The methods used to source and gather relevant information
- Boundaries in relation to what information is relevant and what is not
- The significance of confidentiality in relation to a person's personal information
- Legislation in relation to collecting, storing and using personal information.

References

Allen, G. and Langford, D. (2008) *Effective Interviewing in Social Work and Social Care: A Practical Guide.* London: Palgrave Macmillan.

Bronfenbrenner, U. (1977) 'Toward an experimental ecology of human development', *American Psychologist* 32*(7)*: 513.

Weld, N. (2008) 'The Three Houses Tool: Building Safety and Positive Change' in M. Calder (ed.), *Contemporary Risk Assessment in Safeguarding Children*. Lyme Regis: Russell House.

Wilson, C. and Powell, M. (2001) *A Guide to Interviewing Children: Essential Skills for Counsellors, Police, Lawyers and Social Workers*. New York: Routledge.

Chapter 42 – Noel Howard

Domain 3 Standard of Proficiency 2

Be able to justify the selection of and implement appropriate assessment techniques and be able to undertake and record a thorough, sensitive and detailed assessment.

KEY TERMS

Assess – to sit beside

Assessment

Strengths-based assessment

Social care is … in terms of meeting the identified needs of individuals, Social Care is a profession, built around and based on a relational approach, delivered by professionally qualified staff.

We interpret what we see, and select the most workable of the multiple choices
(Joan Didion 1979)

Assess – To Sit Beside

Interestingly, the English word 'assess' comes from the Latin *assidere*, meaning 'to sit beside'. If one expands the idea of 'sitting beside' to mean 'being with', then social care workers are in a unique and, indeed, privileged position when it comes to assessment. Why? Social care workers spend a lot of time with those for whom they care, and accrue a depth of knowledge about those they work with, that few, if any, other professionals do. Some of that knowledge may be through using formal and informal techniques to ascertain certain wants, needs, problems, strengths and so on. However, beyond that, the closeness of living with someone every day gives many other insights. They are almost accidental, moments caught in time, and come about because of the relationship forged over time with the mutual ebb and flow of daily living and all its ups and downs.

Assessment

If you google 'assessment' you will get pages of different material from various quarters offering to give you a formula for assessing the needs of children and vulnerable adults. There are many different approaches that all claim to lead to better results for the individual being assessed. Much of the material is helpful, if somewhat repetitive, simply because there is only so much one can say about the subject. If you were to try to work your way through all the material that's available you could go on for ever. Or you may be fortunate to work in a situation where your organisation has its own assessment process, which is regularly reviewed, and you may work happily and effectively with that. For example, the HSE has the Single Assessment Tool (SAT) for older people. In the UK there is guidance under the Care Act 2014, which gives good examples of how good assessments lead to improved quality of life for those in receipt of social services.

Keeping the above in mind, remember again what the CORU section under Safety and Quality says: Graduates will...

Be able to justify the selection of and implement appropriate assessment techniques and be able to undertake and record a thorough, sensitive and detailed assessment (Domain 3.2).

The first thing to remember is that whatever the age or situation of the individual being assessed, there are common elements, some obvious and perhaps some not so obvious, in all the assessment techniques available. In that context, and in order to choose the most appropriate assessment technique, it is important to be as certain as possible that what your assessment will yield will be understandable and clear for the person for whom it is intended. More important still – the key element – is that it will ultimately benefit the person being assessed. Individuals in receipt of social care services deserve the very best we can put into their care but also the best, objectively, that we write about them. And of course, to do that effectively, we must know and understand, to the highest degree possible, what their view is too. The 2012 children's referendum has the voice of the child as a key component; this was very often not the case in the past. And we all know about Ireland's past and its treatment of children, which leads to the next point.

In cases where you or your team's assessment is for court purposes there may, in the case of children, be a number of other reports, including that of the guardian *ad litem*, a court-appointed individual whose sole aim is to represent the best interests of the child. You may very well say, 'Are we not all to represent the best interests of the child?' In other words, we are all there supposedly to ensure that what we say is what will ultimately be of benefit to the child. In theory that is the case. However, I am old enough to remember seeing different groups of officials, representing different departments (Health, Education and Justice), backed up by teams of lawyers, going in to court and all contending that they were there to represent the best interests of the same child. In fact, they were representing the best interests of their particular department and would fight tooth and nail to get their way even if it was obvious that they just wanted to hive off a problem (child) and move it as far away as possible from their responsibility. Often the result was to leave a child and a family in limbo, perhaps returning a child to a care setting that was totally inappropriate. Believe me, it happened. Always be aware that organisations – any organisation – often have their own interests to the fore. That's a fact and will be reflected in *their* assessments of situations.

Doing Your Assessment

Your assessment, then, must be responsible, objective and thoroughly professional. It must be in the best interests of the individual being assessed, and not in anyone else's best interests. In the context of the last paragraph, you may feel on occasion that your view or conclusion is being compromised. This can be by a staff team, influential staff member, manager or, indeed, the organisation you work for, which is ostensibly there to act in the best interests of those it is tasked with caring for and for which it is being paid. This is not to say that you should not reference or consider views other than your own within the staff team or the organisation. What is vital is that your assessment is reliable, valid and unbiased. An assessment report is a permanent record. Always admit to a genuine mistake – this can be a measure of your professionalism.

Strengths-based Assessments

The strengths, capacities, needs and preferences of the individual being assessed must be clear. This does not mean glossing over or minimising problems (which a court or other agency may be well aware of in any event). While particular assessment tools, such as a Problem Profile Approach, may seem to be focused on looking at the problems an individual has it can be helpful when used against an underlying principle of a strengths based approach. A strengths based approach can concentrate on what is evidence based and possible, especially into the future, assuming that particular problems can be effectively minimised in order for positive goals to be achieved in the medium to long term.

Assessment Tools

To be able to justify the selection and implementation of appropriate assessment techniques and be able to undertake and record a thorough, sensitive and detailed assessment, social care organisations need to create cultures that support workers with this task.

Key features of the organisational culture needed to support social care workers in undertaking detailed and sensitive assessments:
• A knowledgeable and competent social care team supported by ongoing training and development.
• Social care workers need to develop a knowledge and skill base on assessment practice that includes an insight into the impact of current issues on the lived experience of service users.
• The impact of parental alcohol and drug misuse, mental health problems, domestic violence and learning disabilities on parenting capacity and children's health and development. The importance of child observation.
• Resources – time and staffing, as well as services available – to allow social care workers to complete assessments and to plan and evaluate appropriate interventions.
• Good intra-organisational and inter-professional working relationships.
• An organisational culture that supports reflection and learning and avoids a 'blame culture'.

Central to any assessment is the child/young person's voice and experience. Keeping the service user in view is central to sensitive assessment. This can, however, be difficult to achieve. This is one area that warrants attention, as often service users are not always seen or engaged with during the assessment process.

The Three Houses

The Three Houses technique was created in New Zealand. It is considered an effective assessment tool in child protection and is widely used in child protection and welfare services. It is a tool that aims to elicit the voices and experiences of children, young people and parents. The information gathered is intended to guide professionals' decisions on child protection and welfare. The principles underpinning the Three Houses tool reflect the values of social care practice, the importance of working in partnership and collaboration with children, young people and families.

As social care workers, we are all aware that it can be difficult for children and young people to share their experiences with us. It requires a lot of courage and trust to open up and allow us into their world. This can also be the same experience for parents, who are often afraid of professional interventions for fear of judgement and criticism. Parents can sometimes think that professionals are not interested in their experiences and views. When social care workers convey a non-judgemental

attitude and demonstrate interest in service users' views and experiences, they are more likely to engage with services in open and honest manner.

The Three Houses tool was developed by Nicki Weld and Maggie Greening. The resource *Using the 'Three Houses' Tool: Involving Children and Young People in Child Protection Assessment and Planning* was written by and is copyrighted by Nicki Weld and Sonja Parker.

The following section is an adapted extract from the booklet, which is free to download from http://www.partneringforsafety.com/uploads/2/2/3/9/22399958/three_houses_booklet_updated.pdf.

The House of Vulnerabilities or Worries

Vulnerabilities include past and present hurts and issues that can make a person more vulnerable to danger and harm such as addictions, anger, sadness, past and current experiences of violence, or being involved in or exposed to criminal activities. Worries might include these types of vulnerabilities and also anything that may make a child, young person or adult feel sad, angry, scared and ashamed, and therefore worried about.

Elicit the child's views by using a broad question, such as one of the suggested questions below:

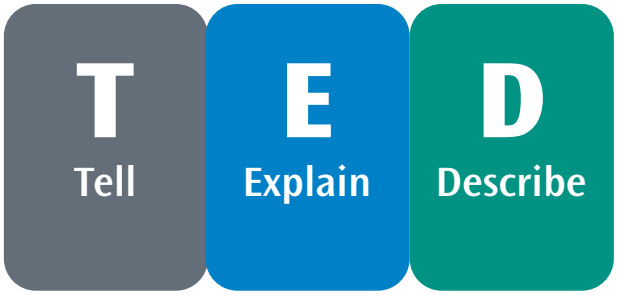
- Lots of kids I talk to often have worries. Worries might be things that make us feel sad, a bit scared, angry, or a maybe a bit bad.
- Are there any worries that you have at the moment?
- Can we put those in your house of worries?
- What are you feeling worried about at the moment?
- So what is happening that is worrying you at the moment?

The House of Strengths or Good Things

Exploring 'Strengths' or 'Good things' helps identify internal and external factors that are working well to support safety and wellbeing, and the things people feel good and okay about. The strengths and good things in a person's world often become the resources and ways to help manage the vulnerabilities and worries, and also to support people to reach their hopes and dreams. Strengths and good things might include humour, supportive family members or friends, positive values and beliefs, faith, positive self-identity, good engagement in work or school, and skills or talents. If people do not have a few strengths in this house, this is likely to indicate a need and it may be necessary to include additional resources here to help

Once the child is ready to start drawing or writing, or if you are writing for the child, it can be helpful to ask an initial eliciting question, such as:

- What are the good things that are happening in your life?
- What are the things in your life that make you feel happy?
- What is going well in your life at the moment?



The acronym **TED** is a helpful reminder to keep the questions in an open-ended format, so that there is no risk of you leading the child's responses. TED stands for **Tell, Explain, Describe** and prompts you to ask open-ended follow-up questions, such as:

- Could you tell me more a little bit more about that?
- Could you explain what's happening in this picture?
- Could you describe this picture a little more for me?
- Could you explain a little bit more about what you mean by that?

The House of Hopes and Dreams

This house explores what people would like to see happening in their world, especially in relation to their vulnerabilities or worries. This house helps us build understanding of what someone may like to be different in their world and their goals and aspirations around this. It is here that solutions and goals can start to be formed to build a future picture of increased safety and wellbeing. Without a future picture, people can become stuck and unable to see where they could be, or what might be, and thus feel less motivated to make positive changes. This is especially true for children, young people and adults who have experienced trauma and may have difficulty thinking longer-term or having goals and aspirations.

Questions to elicit child views:

- What are the important things that you want to have happening in your life that we need to put into your 'house of hopes and dreams'?
- What would you like to have happening in your life?
- How would you like things to be in your life?

Tips for Practice Educators

a) Really challenge students in terms of their values, attitudes, beliefs and prejudices.
b) Stress that a report, to be effective, must read well as a narrative.
c) Stress that grammar, syntax, etc. must be checked before any assessment report is submitted; poorly written reports reflect not only on the individual social care worker but on the profession as a whole.
d) Students must have a clear understanding of what is fact, opinion, conjecture, hunch, intuition, etc.
e) An assessment report is a permanent record.
f) Mistakes can be made; admitting a genuine mistake can be a measure of one's professionalism.

References

Department of Health (2014)The Care Act. London: Department of Health. https://www.scie.org.uk/care-act-2014/transition-from-childhood-to-adulthood/young-carer-transition-in-practice/references.asp

HSE (2018) Assessment and Care of Older People using the Single Assessment Tool (SAT). Available from https://www.hse.ie/eng/services/list/4/olderpeople/sat.

Chapter 43 – Lorna O'Reilly and Jamie Grennan

Domain 3 Standard of Proficiency 3

Be able to determine the appropriate tests/assessments required and undertake/ arrange these tests.

KEY TERMS

Five Pillars of Social Work Services

Role of Social Care Workers in the five Pillars

Case study

Social care is … a profession or calling where you go to work every day and strive to make a positive difference in the lives of those you are supporting, always being non-judgemental, empathic, understanding and trying to do so with a smile on your face, even on the most difficult of days. It is empowering service users to bring about positive change in their own lives and equipping them with the skills to manage any possible future crisis they may experience without the need for service provision.

This proficiency is focused on appropriate tests and assessments used in social care practice and what work is involved in undertaking or arranging the use of these practice tools. To help you understand this proficiency we, as social care workers in Tusla, have provided examples of the assessments used in the protection of children. The chapter begins with an overview of the structure of Tusla.

Five Pillars of Social Work Services

Social care workers in Tusla require a level of professional decision-making to be able to assess situations and plan interventions. To begin, let us give you a breakdown of the current Tusla structure and where social care falls into this. As of 2015, Tusla Social Work Services have been divided into five pillars. These pillars are:

1. **Duty social work team:** Often referred to as the 'front door', this is the team that deals with all child protection concerns reported in the area. This team is further broken down into two sub teams: the *screening team*, who screen every child protection concern reported and decide on the most appropriate action; and the *initial assessment team*. If the screening team feel that the level of concern meets the threshold for further assessment, the initial assessment team will then carry out an overall assessment on the family, looking at the risk of harm to the children and identifying areas for possible support.
2. **Child protection social work team:** If the initial assessment found that the children are at ongoing risk of harm attributable to parenting, they will refer the family to the child protection team, often referred to as the 'long-term team'. The social workers on this team work with the family around reducing harm, linking them to appropriate supports and measuring the family's engagement and progress with these supports.
3. **Children in care (CIC) social work team:** If a child has been deemed to be at ongoing risk of significant harm and all possible supports have been exhausted, in some situations Tusla then has to look at bringing that child into state care. When this happens, the child will be allocated a social worker from this team. The social worker will devise and work within the child's care plan, attending to any of their presenting needs.

The child's care plan covers areas such as:

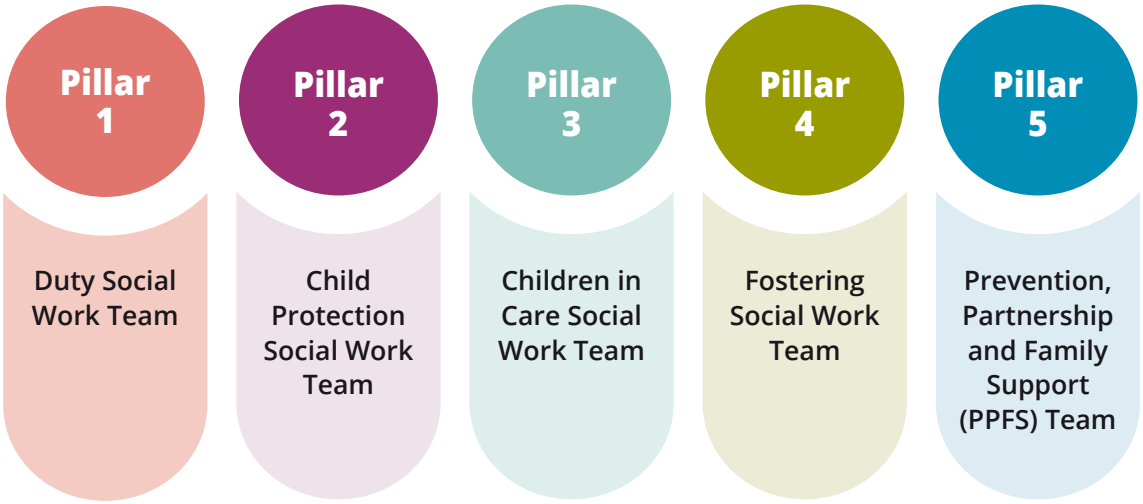
- Why the child needs a care placement.
- Legal status of the placement.
- The child's needs – health and education, emotional and behavioural, family and relationships, self-care and self-identity and the child's hobbies and interests.
- The child's own views and the parent's views.

The CIC social worker will also support contact between the child and their family, attend court when needed and assess whether reunification with the parents would be possible in the future.

4. **Fostering social work team:** The social workers on this team, often referred to as link workers, are the main support for foster carers of children in care. This team recruit, assess, train and support Tusla foster carers at all stages of the fostering process. The team also identify the most suitable foster placement for the child by looking at their presenting needs and care history. Appropriate matching of foster carer to the child's needs is very important to the success of the placement.

5. **Prevention, partnership and family support (PPFS) team:** This team consists of social care workers and family support practitioners, and this is where we work. Social care workers work directly with children, young people and parents to provide support around issues such as mental health, substance abuse, challenging behaviour, placement breakdown and family relationships. Family support practitioners work with parents on issues such as household management, budgeting, appropriate parenting and supporting these parents with their own health needs and welfare entitlements. The PPFS team also has a child and family support network (CFSN) co-ordinator, who co-ordinates Meitheal for our area and links with all appropriate services. Meitheal is a Tusla-led early intervention practice model designed to ensure that the strengths and needs of children and their families are effectively identified, understood and responded to in a timely manner so that the children and families get the help and support they need. It is an early intervention, multi-agency response, tailored to the needs of the individual child or young person (Tusla 2018). Many of our team members are also trained as lead practitioners and independent chairs for Meitheal. Unique to our area, our team is line managed by the senior child and family support network (CFSN) co-ordinator, who oversees and allocates all referrals into our team and supervises and supports the staff in all aspects of their work. The senior CFSN co-ordinator is also responsible for overseeing Meitheal and the Child and Family Support Networks in the area and supporting and encouraging all services to proactively work together in order to ensure the best services possible for children and families in the area. Meitheal is proactively advocated through the Networks.

5 Pillars of Tusla Social Work Services



Role of Social Care Workers in the Five Pillars

There are a number of social care workers in each of these five pillars. Each team requires a different style of work.

Duty Social Work Team and Child Protection Team

Social care workers on the duty team screen concerns reported to Tusla under the supervision of the duty social work team leader. They assess the needs using the RED process (review, evaluate and direct). This is the process through which cases are currently referred from social work services to the PPFS team. Social care workers also support the social workers on their team when needed for completing a home visit or responding to an emergency. Social care workers on the child protection team also assess the need in specific cases and can also make onward appropriate referrals to RED or directly to the community supports. On this team, the social care worker will also monitor families' progress with the supports identified for them, such as reviewing progress with the allocated worker on the PPFS team.

Children in Care (CIC) Social Work Team and Fostering Team

Social care workers on the CIC team provide direct work and support to children in care by way of completing life story work and supporting them in understanding their change in living situation. Social care staff on this team would also facilitate and supervise contact between the child and their family when required. Social care workers complete safeguarding visits of children in care awaiting allocation to a social worker. In doing this, the worker assesses how the child is doing in their placement and may identify areas of support needed for the child. The aftercare service is also a part of this team; it supports young people from age 16 in preparing to transition from Tusla care arrangements. All aftercare workers are also trained social care professionals with experience of practice in the field. Aftercare workers support young people in many ways, including sourcing allowance, housing, employment and education. The role of the social care worker on the fostering team is to address issues that may arise in the foster placement and support the child or young person so that the placement does not break down.

Prevention, Partnership and Family Support (PPFS) Team

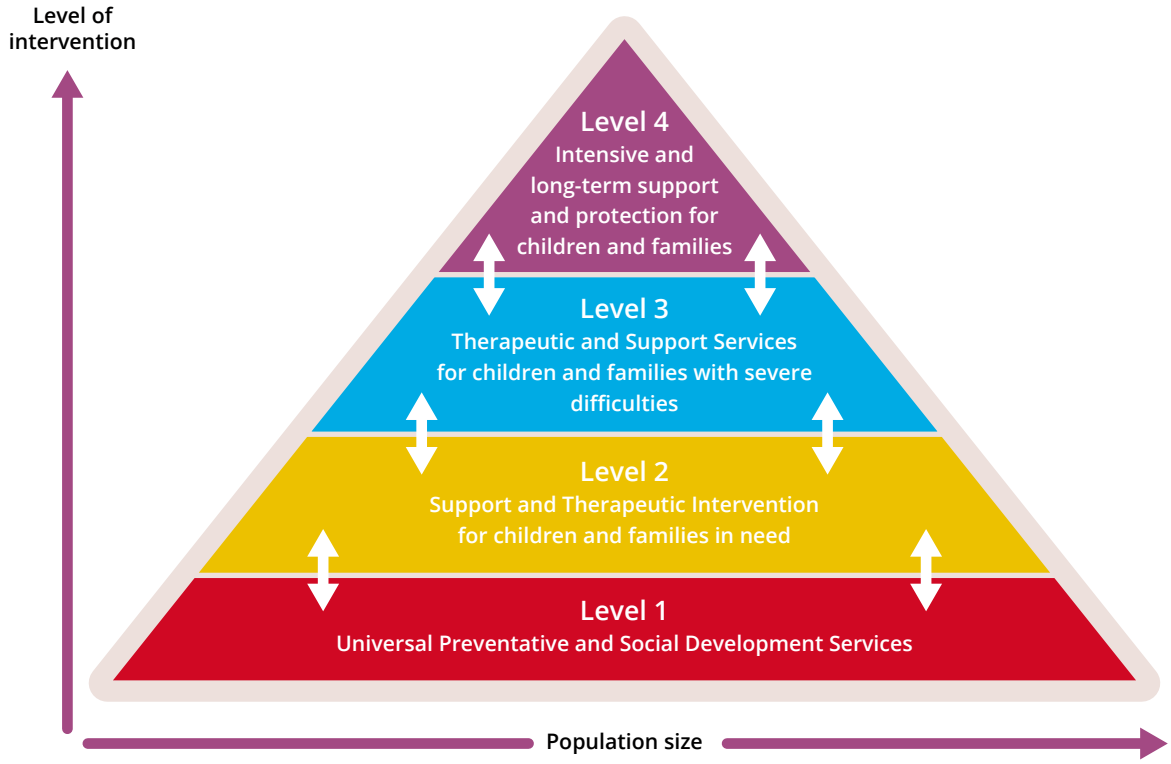
When working on the PPFS team, there is a requirement to be able to assess and plan an intervention for a child and family. The models we mostly use in our assessments include Signs of Safety (Turnell & Edwards 2017), Meitheal and My World Triangle. We are always mindful of theories in psychology and sociology such as attachment theory, systems theory and scaffolding. Our interventions are based on various models of practice. These include Karen Treisman's trauma-informed practice (Treisman 2017), which takes the trauma experienced by a child into account in assessing and planning an intervention for them. The adverse childhood experiences scale (ACES) is useful when assessing trauma present (CDC 2020). The Circle of Courage and Purposeful Use of Daily Life Events are also models of practice that we follow.

All our assessments and interventions are based on strengths and needs analysis, such as that used in the Meitheal process. When a member of our team receives a referral form, it will have identified needs present for the family. Our staff will begin their work by meeting with the child and parent to get an understanding of their exact situation and measuring where they are at currently. With this information, the practitioner will then plan the most appropriate intervention for this family. As each child and family is different, one approach does not fit all, and each intervention needs to be tailored to suit the person it is being delivered to. We find that including the child and parent in planning a support that works best for them yields the best results. Their participation and engagement is the key to the support being successful.

Our team continues to measure progress while completing the intervention, ensuring that it is best meeting the service users' needs at all times. There will be times where a certain approach may not be working so we would then consult with the child and family and identify what we can do to adjust the plan. We also continuously measure the progress of our interventions in supervision with our line manager. Sometimes, we identify that a child requires another support that our service cannot offer. We would then advocate on behalf of the child or family or empower the parent to ensure that they get this support. We work collaboratively with other services involved with the family to ensure that the best service is provided. This is done by way of a strategy meeting or a Meitheal where appropriate.

Social care workers on the PPFS teams work across all the levels of the Hardiker model (Hardiker *et al.* 1991) and across the Tusla pillars.

Hardiker model (DCYA 2012: 16)



Level 2 of the model corresponds with cases we work with that are not currently open to a social work team and are deemed low-level cases. These are typically families stepped down from social work or engaging with Meitheal. Level 3 of the model corresponds with cases where the families are open to social work. In this case, we would be working on actions set out in a child protection or family support plan devised by the social worker or following on from a child protection case conference. Level 4 of the model corresponds with cases where the child often has to be removed from the family home if it is found to be in their best interests to be placed into care. Staff from the PPFS team will do a case transfer to the social care workers on the CIC team to ensure that the child continues to get support.

In our practice, we have found that when we begin our assessment and work with a family, focusing on relationship building gives a good basis from which to deliver a meaningful programme to the child and family, which in turn will help bring about positive change. A positive relationship will also allow the family to be more open with you, which will enable you to get a more accurate assessment of the family and the progress they are making by measuring how this support has positively changed any aspects of family life.

Legislation and policy is in place to ensure that the voice of the child is heard in a meaningful way. Our core principle is to listen to the voice of the child in our practice and promote their views. We often do this creatively to ensure their voice is heard by adults in their lives, ensuring that the child understands that the decisions made by adults in their lives will include their opinions but not always their desired outcome. Child and youth participation is an important aspect of our work and this is how we ensure that young people's voices are heard. We have facilitated several child and youth participation groups, all of which have also been awarded Investment in Children awards. In being creative with our work in this way, we ensure that we remain professional throughout and are mindful of boundaries at all times in our practice.

Case Study 1

This is a fictional case study but reflects a possible referral to our service. None of the names or incidents are based on a real-life referral.

The Gardaí sent a notification to duty social worker Mary noting their concerns about a family where a 16-year-old male (Peter) was under the influence of drugs. Peter lives with his mam (Laura), who is parenting alone and is struggling with her son's behaviour. While under the influence, Peter would become quite aggressive in the home and had lashed out at his mam on several occasions. Laura stated that Peter is verbally abusive towards her on a regular basis. Laura also has an eight-year-old boy (Ryan) and notifying Gardaí are concerned about the effect that witnessing these violent incidents is having on Ryan.

On receiving the notification from the Gardaí, Mary began an intake record (IR) in relation to the incident. In linking with Laura, Mary established that Peter's behaviours have increased over the past number of years. According to Laura, Peter had begun smoking cigarettes with his friends but then moved on to smoking cannabis. Laura added that if she tries to address this with Peter he can become abusive towards her. Laura stated that she is worried that Peter will begin to use harder drugs if he continues on this cycle. Laura advised that Peter's school attendance began to drop when he entered secondary school; he did complete his Junior Certificate exams last year, but did not return to school.

When describing her eight-year-old son Ryan, Laura said that he is a quiet boy and that he is afraid of Peter. Laura said that when Peter begins to become aggressive towards her, she will usually contact her brother and sister-in-law to take Ryan for the night so that he is not in the home when Peter becomes heightened. Laura stated that on the night in question, Peter returned late from being out with friends and became abusive towards her. Laura did not have the opportunity to call her family for support at this time. In having family available to support her in this way, Laura is being proactive in putting safety in place for her son Ryan. In completing the IR, Mary reviewed closed files and established that there had been two previous referrals to the social work team five years ago regarding domestic violence from the children's father Shane towards Laura. Laura stated that Shane is no longer in the family's life. Laura is also concerned about Ryan having witnessed this domestic violence, as he has begun to ask her questions about 'the time when daddy used to hit you'.

Mary informed Laura about the supports available to her from the PPFS team. Mary described the role of the social care worker who could support Peter and Ryan individually in relation to their needs. Mary also explained the role of a family support practitioner who could offer support to Laura in her parenting as well as accessing her own supports for her past experiences. Laura stated she would be happy to receive this support and gave consent for a referral to be sent to the RED (review, evaluate, direct) meeting for this support. Mary closed the case to duty at this time as Laura had family support to help her when Peter becomes aggressive and has consented to a referral for support for the family.

The referral for support for the family was sent to be discussed at the fortnightly RED meeting. This meeting is attended by duty social work team leaders and PPFS senior child and family support network co-ordinators (senior CFSNs) to agree on the most appropriate delivery of support to the family. In discussing this family, Laura was accepted to the PPFS team for family support and Peter was accepted to the PPFS team for social care worker support. In discussing Ryan and his needs, it was agreed that he would most benefit from play therapy at this time. The senior CFSN can access this through the local child and family support networks by referring the child to the local family resource centre, which receives funding to offer play therapy support for children in the community. Following the meeting, the senior CFSN rang Laura, discussed the option of play therapy for Ryan and received her consent to send the referral to the local family resource centre for this intervention. The senior CFSN also advised Laura that she has been accepted to the PPFS team for family support and Peter has been accepted for social care worker support. The senior CFSN advised that the workers will be in contact with the family upon allocation.

A social care worker (Siobhan) was shortly allocated to work with Peter. Siobhan organised an initial home visit with Laura and Peter to discuss the referral. Siobhan described her role, explained that the intervention can be delivered in an informal way and discussed how they could incorporate Peter's interests into the intervention. Siobhan explored this with Peter, who said he enjoys playing hurling and would like to be a mechanic when he is older. Siobhan reassured Peter that the first few sessions together can be done by going hurling. Peter was happy with this and did agree to meet with social care worker again. Siobhan was aware that it was important for Peter to want to spend time with her and this was a great opportunity for relationship development. In meeting with Peter by way of activities such as hurling, Siobhan also assessed what support was needed for Peter at this time. She based her initial assessment in planning Peter's intervention using the signs of safety 'Three Houses' tool by way of a worksheet.

Taking Peter's age into account, the social care worker explored the questions from this by talking while hurling, etc. The Three Houses tool looks at the house of good things, the house of worries and the house of dreams and explores what these would look like for each child. This is in keeping with the signs of safety model, which is Tusla's current working model for practice. The social care worker explored with Peter what was good for him – he identified his family and friends; what he was worried about – he identified as his future prospects; and his dreams for the future – which Peter said were to be a mechanic and to have a sports car! The social care worker was also acutely aware of the My World Triangle tool for looking at children's development when planning an intervention with Peter.

The social care worker used this information and her newly formed positive relationship with Peter to work on steps to get Peter to his goals. In exploring his drug use, the social care worker gave Peter the space to speak about this and for Peter to identify that drugs are having a negative impact on his life and that he wants to quit. Peter agreed for the social care worker to make a referral to the Midlands Youth Drug and Alcohol Service (MYDAS). The social care worker supported Peter in engaging with a worker from MYDAS around harm reduction and eventually abstinence from drugs.

The social care worker discussed with Peter and Laura the Meitheal process. Both thought that this process would benefit their family and they agreed to engage in it. The social care worker completed the Meitheal request and the strengths and needs form and engaged as the lead practitioner throughout the process. The holistic approach to meet Peter's needs was ensured throughout this process.

In discussing things that are good for Peter, the social care worker gave him space to discuss his relationship with his family members and encouraged him around how to make these more positive. The social care worker discussed with both Peter and Laura activities they can do to improve their relationship and encouraged them to complete these. In exploring Peter's dreams of being a mechanic, the social care worker used their local network connections and linked Peter up with the local employment officer who gave support in applying for an apprenticeship. Peter began an apprenticeship and was very happy with his progress. At this time, Laura was also engaging well with a family support practitioner and Ryan benefited greatly from play therapy intervention. The social care worker supported Peter in settling into his apprenticeship and encouraging him in his drug abstinence. When the social care worker could clearly see that the family were doing consistently well and all goals for working with Peter had been completed, they completed closure work on the case. The social care worker ensured that the family were aware of where they could access support should they ever need it again.

In this case study, it is clear how the assessment tools used enabled the social care worker to deliver a beneficial intervention and bring about positive change in the life of Peter and his family.

TASK 1

Based on this case study discuss the key assessments and interventions that supported the family and young people.

Tips for Practice Educators

To support the students with this proficiency, provide them with literature and policies on tests, assessments and interventions used in placement.

Support the student with understanding of assessments/tests, set tasks that will help them develop their assessment skills.

Recommended reading for student on placement: Three Houses tool and Hardiker model (Hardiker *et al.* 1991).

References

CDC (Centers for Disease Control and Prevention) (2020) *Adverse Childhood Experiences Prevention Strategy*. Atlanta, GA: CDC.

DCYA (Department of Children and Youth Affairs) (2012) *Working Together for Children: Toolkit for the Development of a Children's Services Committee* (2nd edn). Dublin: Government Publications.

Hardiker, P., Exton, K. and Barker, M. (1991) *Policies and Practices in Preventive Child Care*. Aldershot: Ashgate.

Treisman, K. (2017) *A Therapeutic Treasure Box for Working with Children and Adolescents with Developmental Trauma.* London: Jessica Kingsley.

Turnell, A. and Edward, S. (2017) *Signs of Safety Workbook* (2nd edn). Perth, Australia: Resolutions Consultancy.

Tusla – the Child and Family Agency (2018) *Meitheal Toolkit*: Dublin: Tusla.

Chapter 44 – Victoria Mc Donagh

Domain 3 Standard of Proficiency 4

Be able to analyse and critically evaluate the information collected in the assessment process.

KEY TERMS

Assessment of needs
Analyse to assess
Critical evaluation
Assessment process and tools

Social care is … being able to offer and provide support to someone that empowers them within their own lives and story. Each individual is unique, with their own story and needs, and this should be at the centre of everything we do in practice.

Analysing and critically evaluating the information collected in the assessment process is a central part of social care practice.

Regardless of the social care setting, some type of assessment will need to occur, in order to be able to support and work with the service user. This assessment may look different depending upon the setting you are in, which includes the different interventions and approaches underpinning the work there. An *intervention* is taking action or completing a task with a service user that is designed to improve their needs and situation. An *approach* can be described as a particular way of working with a service user or in a particular situation, for example using a person-centred approach. This in turn may inform the type of assessment carried out and the assessment tools used to support this process. Assessment tools act as a means for the social care worker to carry out a full analysis and evaluation with the service user to identify their needs and, most important, evaluate how the service can best support them. Before we consider what the assessment process may look like, we first need to consider the terms 'analyse' and 'critically evaluate' in relation to social care work.

Analyse to Assess

In social care work, we analyse or begin an analysis for assessment by having a conversation with a service user, listening to their story and gaining an understanding of their situation. By using an analytical perspective, a social care worker can identify a service user's needs, or unmet needs. This may also allow a social care worker to identify goals with the service user and understand how the service can best support them. It can assist in assessing what intervention or approach may be appropriate or best to use. Barnard (2010) describes assessment as the second stage of a 'critical thinking model'. The first stage is description, where information is gathered from talking directly to the service user and the people involved in his or her care and using all these descriptions and relevant records to help you understand the service user's story, needs and situation. The final stage of the critical thinking model (Barnard 2010) is evaluation.

Critical Evaluation

Once we gain an understanding of and identify service user's needs in the assessment process, we then need to engage in the evaluation stage. According to Barnard (2010: 85) critical evaluation 'entails estimating the effectiveness, and therefore the value, of a particular strategy or action'. This can be identifying strategies in how to achieve identified goals and meet needs. Evaluating the information we gather contributes to our full understanding of the service user and their needs, but it also helps us to look at what might work, what has worked in the past and how we can keep moving forward. It provides a space for the social care worker and service user to understand the progress made and identify future goals or where goals may need to be altered. Needs are constantly changing and a flexible approach is essential to accommodate change and ensure we are reviewing and interpreting information correctly, and evaluating the information we gather.

Assessment Process and Tools

Many different types of assessment are used in different social care settings, for example the placement plan, a holistic needs assessment, and the strengths-based approaches including the good day/bad day tool (Sanderson *et al.* 2015), a strengths-based tool (Baron & Stanley 2019) and the decision-making tool (Sanderson 2021).

1. The Care Plan and Placement Plan

According to the National Standards for Children's Residential Centres (HIQA 2018), every child entering the care of the state will have a care plan and a placement plan. The care plan includes all the relevant and important information on the child needed to support their placement, including family details and contact information, where they go to school and details about their educational, medical and social needs. The placement plan is shaped by the care plan and this document includes information on their day-to-day life, their needs, likes and dislikes and hobbies. The social care worker engages with the child/young person to identify their needs and goals for their care and all information is included in the placement plan. This is an assessment tool, which enables the child to understand their needs but also supports them in achieving their goals and identifying how these goals may be achieved. The placement plan can be described as a living document that should be used with the service user to review or analyse how things are going in achieving identified goals, and also for them to be able to evaluate progress made and how to move forward. For example, what is working well? Is there anything that is not working as well? Does something need to be changed/altered? This also reflects how the service user's needs can change at any given time and the assessment process needs to be flexible to accommodate this.

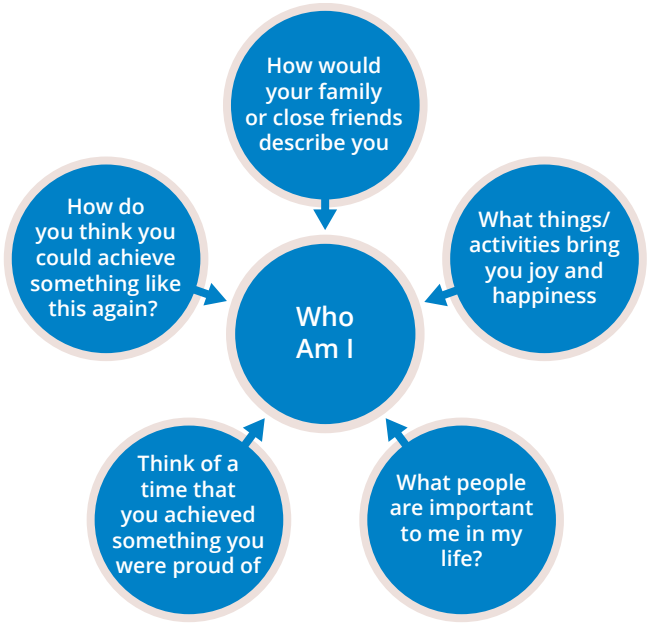
2. Holistic Needs Assessment

Another type of assessment used by a social care worker is a holistic needs assessment, which can be used in a service working with those experiencing homelessness or at risk of homelessness. This type of assessment examines the service user as a whole, considering their needs from physical, social, psychological, emotional and spiritual dimensions (Schaffer *et al.* 2000). The assessment does not just focus on the problem/issue of homelessness, but considers all the different factors for that person, in order to understand the best way to support and work with them. Since it takes into account many different considerations of need and support required, this type of assessment may require the engagement of different professionals working together to support the service user.

3. Strengths-based Approach and Tools

As well as using assessment tools, social care workers draw on their own knowledge, skills and abilities, all of which shape their approach to practice. One example is a strengths-based approach, which is about working with the individual, placing them at the centre of their support and care needs. The service user is empowered to make decisions about their life. This approach encourages service users to find solutions and ways forward by focusing on what they can achieve, based on their strengths (Baron & Stanley 2019). Below are examples of different assessment tools and tasks a social care worker could carry out with the service user using a strengths-based approach:

Figure 1. The Who Am I assessment tool. Getting to know your own strengths



This assessment tool, which could be used with a service user in a mental health support setting, achieves a number of things. By first focusing on aspects of a person's life that are more positive, it can help to remove the negative or unhelpful thinking often experienced. It takes the focus away from the 'problem' and looks at the strengths the person has. When an individual has a mental health issue, it can be difficult to see an alternative way of thinking. This tool can help to reframe an issue for someone by putting them at the centre and looking at what they can do, as opposed to what they cannot do. This tool also assists the social care worker to understand the needs of the service user, but it also helps to build rapport and a relationship. In analysing the needs of the service user, the tool goes further to evaluate them by asking questions such as 'How would a family member or close friend describe you?'

Figure 2. Good day/bad day tool (Sanderson 2021)

Good Day/Bad Day

How do you know when you are having a good day?

What does it look like?

How do you know you are having a bad day?

What does it look like?

TASK 1

Watch the video on how to use the good day/bad day tool from Helen Sanderson Associates at http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/good-daybad-day/

The good day/bad day tool could be used by a social care worker in a setting working with young people. This tool takes the focus away from a problem or an issue and looks at who the young person is and helps build a picture of that young person's strengths. Tools such as this can be simple ways of beginning a bigger conversation or the start of creating a placement plan with the young person. They can often work very well with a service user who is more visual, as they can imagine and describe what a good day or bad day is. It can also be useful with young children – you can get them to draw a good day or a bad day. This simple tool can provide a snapshot of needs, and provide an opportunity to analyse and evaluate these needs.

TASK 2

Download the decision-making profile from http://helensandersonassociates.co.uk/wp-content/uploads/2016/12/Decision-making-profile-copy.pdf and fill in the questions as shown in the sample below.

Decision Making Profile

How I like to get information	How to present choices to me	Ways you can help me understand	When is the best time for me to make decisions	When is a bad time for me to make decisions

The decision-making profile could be used by a social care worker working in a disability setting. This tool can provide the social care worker and the service user with a good understanding of their needs and their story. It places the service user at the centre of their care and support. Again, this tool is looking not at what cannot be done, but at what can be achieved and how it can be achieved by that specific service user. This can be a very empowering task for a service user, as they are given the opportunity to be heard and also to develop their own self-awareness around their own needs and how they would like them supported.

From my own practice experience in working in the area of mental health, I have seen how using such tools can assist the assessment process and help the service user and the social care worker in developing goals and strategies to achieve them.

TASK 3

Apply one of the tools discussed above to your own life and goals. In a classroom situation, it could be useful to do this activity in pairs, taking turns to act the role of the social care worker.

This chapter has explored the proficiency and what it represents for analysing and critically evaluating information that a social care worker may gather during the assessment process with service users. The chapter has explained why a social care worker may engage with this process and has given examples and tools used to complete this process across different settings. However, what also requires consideration is what happens if a social care worker does not engage in this process. What happens if we do not analyse and evaluate? Service users can have many different needs, ranging from the basic needs of food and shelter to more complex needs, such as support with addiction. Sometimes service users may have a variety of support needs at the same time. Applying critical analysis and evaluation enables the social care worker to understand these needs and, most important, to understand how best the worker and service can support these needs. It allows the social care worker to be person-centred in their work with service users, to be able to empower and facilitate service users in their own lives. If we were not to take this approach, could we truly identify and meet the needs of the service user in front of us? We may miss needs or not support these needs correctly. This approach enables us to build a relationship with the service user and understand their journey. If we can understand this, then we can assist in providing appropriate support and care.

Here is a fictional case study to help students learn how to assess and critically evaluate within their practice.

Case Study 1

(Please note: this is a fictional case study featuring a fictional service user.)

Social Care Setting

The setting is a disability service that comprises a day service and has independent living units/houses for residents. The service is situated a short walk from a village. The service strives to provide a safe and homely environment for all in its care. It uses a person-centred and partnership approach, in which the individual is at the centre of their support and care needs. The service has links to the local community and provides a therapeutic setting in both its day and residential services. It has some large gardens, which are used as part of the programme for service users, to garden and grow vegetables. The service has access to many professionals, depending on the needs of each individual, including occupational therapy, speech and language therapy, physiotherapy, advocacy worker, social care worker, psychology and GP care. Each individual will be supported with an individual support plan to support their needs and goals.

Service User Profile

David is a 32-year-old man who has just started at the day service with a view to moving into one of the longer-term residential units. David has Down syndrome and his primary carers are his elderly parents, with some shared care from his siblings. The idea of a transitional approach was suggested by his social care worker, who has worked with the family in supporting them to meet David's care and needs. This is to promote future planning for the time when David's parents come to a point where they can no longer care for him. David's family also want to empower David to become as independent as possible, as David has expressed this desire for his life. David has experience of attending a previous community workshop, which had similar aspects to the day centre in this service. It provided a social outlet for David to meet new people and make friends. The community workshop also provided training and employment opportunities in the local community. David enjoyed this and loves the social aspect of attending such a group service. He also has experience of respite care for periods of one and two weeks, to provide his parents with a break from their caring role. David also attends weekly physiotherapy appointments. David's family describe him as a kind and social person who loves a chat and a cup of tea. David also loves to cook and enjoys growing vegetables and listening to music. David has a very keen interest in sport, particularly rugby, and his favourite team is the Munster rugby team. At home with his parents, David lives as independently as possible and loves his routines. He a daily schedule and tasks and enjoys the routine and consistency this provides him with. He likes to keep busy, and he carries out a number of chores and jobs around the house that support his daily living skills. David's family have a dog, Rolo, and David has explained that he will miss Rolo when he moves into his new home.

David's Current Individual Support Plan (ISP)

The service has completed an initial ISP with David to establish his support needs and goals, both as he begins in the day service and with a view to future transition to the residential part of the service. This is an initial ISP and will be reviewed again after a few weeks when David has settled into the day service. The following initial needs and goals have been identified with David.

1. A key worker (social care worker) will be assigned to David to support his introduction and transition into the service.
2. David has identified that establishing a routine in the service will be very important for him. The key worker will work with David on this.
3. David would like to work in the garden and would like to learn how to grow vegetables. The key worker will link in with staff in the garden part of the service.
4. David would like to make some new friends in the service who he can chat to. David will be supported with this by introducing him to the other people in the service.
5. David has also identified that he would also like to do a baking course. The key worker will look into this with David and talk to the day service staff about this goal.
6. David is also concerned about missing his family when he moves into the house full-time. The key worker and David will work on a transition plan, to make the transition as smooth as possible and support David in continued contact with his family.

Tips for Practice Educators

To facilitate understanding of this proficiency, complete the following activities.

Use the case study above to analyse and evaluate the relevant information needed for the assessment process with this service user. You can use the following questions:

- *What does the assessment process and the **individual support plan** (ISP) tell us about the needs of the service user?*
- *What does the assessment process (ISP) tell us about the role of the social care worker in this particular setting?*
- *With the information you have of the service user, how does this help the social care worker to analyse and evaluate the needs of the service user? Why is it important to have such information?*
- *What do you think could be the impact if the social care worker did not analyse or evaluate the information gathered?*
- *Apply some of the assessment tools to this case study.*
- *Ask the student to apply some of the assessment tools to a fictional case study that is relevant to your social care setting.*
- *Using mind maps may be helpful to create links between analysis and evaluation within the assessment process.*

Reflective Activity

- *Think about a time you were supported to achieve a goal or something you are proud of. What do you think helped to achieve this? Was it a person?*
- *If someone were to gather information for your needs, what would be important for them to know? What would support you to analyse and evaluate your needs?*

References

Barnard, A. (2010) *Key Themes in Health and Social Care: A Companion to Learning.* London: Routledge Taylor and Francis Group.

Baron, S. and Stanley, T. (2019) *Strengths-based Approach: Practice Framework and Practice Handbook.* London: Department of Health and Social Care.

HIQA (Health Information and Quality Authority) (2018) *National Standards for Children's Residential Centres.* Dublin: HIQA.

Sanderson, H., Bown, H. and Bailey G. (2015) *Person-Centered Thinking with Older People: Six Essential Practices.* London: Jessica Kingsley.

Sanderson, Helen, Associates (2021) *Decision-making Tool.* Available at <http://helensandersonassociates.co.uk/wp-content/uploads/2016/12/Decision-making-profile-copy.pdf>.

Schaffer, M.A., Mather, S. and Gustafson, V. (2000) 'Service learning: A strategy for conducting a health needs assessment of the homeless', *Journal of Health Care for the Poor and Underserved* 11(4): 385-99, doi:10.1353/hpu.2010.0746.

Chapter 45 – John Balfe

Domain 3 Standard of Proficiency 5

Be able to demonstrate sound logical reasoning and problem-solving skills to determine appropriate problem lists, action plans and goals.

KEY TERMS

Safe holding spaces

Restorative practice

Trauma-informed practice

Pace in practice

Connection before correction

Social care is … a skilled and evidence-informed profession that has at its very core the principles of human rights and social justice to work with individuals and groups who are the most marginalised in our society today. The main toolkit for social care workers is their ability to work in partnership with people through relations-based interventions on complex social problems. They use not just the evidence-informed skills of care, but also, more critically, self-reflection to effectively help the lives of others through sound logical reasoning, problem-solving and action planning.

Introduction

The lives of our most vulnerable in society require interventions from social care workers who hold the requisite qualifications and knowledge of the standards of proficiency. In addition, the ability to problem-solve and develop goals in partnership with people using a relational and emotional dimension is critical for best practice. In this chapter, I argue that the nature of social care work encompasses both short interventions with lasting effects and also long-term relationships that require structure and an ability to build effective relationships. The domain of Safety and Quality is under-explored in this regard and can be interpreted to mean many things in different social care scenarios. In this section, I apply the concept of Safety and Quality of practice to that professional 'holding space' which social care workers can provide through a protective relationship using a structure of intervention, such as developing problem lists, action plans and goals. I use this particular proficiency as an example of how to maintain both short- and long-term relationships with the people we work with in social care settings by using a trauma-informed lens, concepts of PACE (playfulness, acceptance, curiosity and empathy) and a connection before correction philosophy of practice (Hughes 2011).

There has been a lot of focus on the technical application of the proficiencies to social care work following the publication of the 2017 Standards of Proficiency by the Social Care Workers Registration Board (Flynn 2020). I argue that in examining this proficiency we move away from the 'technical rational approach' of rigid application of the threshold standards (Mulkeen 2020) to a more critical commentary on the complexities of the relational dimensions of social care work. I propose to do this by exploring this standard with a case study example from my practice as a social care worker in a criminal justice setting. Using a restorative justice lens (Zehr 2005; Sherman & Strang 2007) I will apply the essence of this standard of sound logical reasoning through exploring the assessment process, then developing problem-solving skills by responding to the needs of clients and, finally, structuring an intervention using appropriate brainstorming of problems, action plans and goals in partnership with a young woman who had come through the care system.

Professional Holding Space

In many ways, this proficiency allows for demonstrating how we use sound logical reasoning and problem-solving skills to complement the concept of a safe holding relationship in social care practice. What do we mean by a safe holding relationship? Safe holding spaces are based on the concept of relationship-based practice, which is the cornerstone of much social care work (Ferguson *et al.* 2020). However, there is little attention given to the types of relationship that social care workers have with their clients. When we consider the domain of Safety and Quality, safety can mean giving the people that therapeutic space where we meet them on a regular basis and have meaningful encounters with them with the effect of helping them to change (Trevithick 2003). This proficiency adds value to the understanding of a 'meaningful encounter' as it provides a clear structure for long-term engagement with clients. It is the partnership element of our work that is critical to understand when we develop problem lists, action plans and goals with service users.

The concept of a 'holding relationship' has its foundation in psycho-dynamic theory (Kanter 2004; Winnicott 1989) and sociological theory related to concepts of power (Featherston *et al.* 2018). This is an important consideration. As social care workers, we often have more power than we realise and by developing problem lists, action plans and goals it is crucial that we critically self-reflect on how we work in partnership with our clients and that the problem lists are not how we see it, but are authentic to the individual's needs, goals and wants. In this way, we should consider the ethical engagement of clients by taking into account the nature of our relationships, power differentials, the wider social inequalities in the lives of others and using 'good authority' with our problem-solving skills (Ferguson 2011).

For some of the most vulnerable in society to make a list of problems, develop goals and action plans with a social care professional, they must first feel safe. Van der Kolk writes, *'being able to feel safe with other people is probably the single most important aspect of mental health; safe connections are fundamental to meaningful and satisfying lives'* (2014: 79). This is the professional holding space that social care workers provide and is the fundamental starting block for demonstrating sound logical reasoning and problem-solving skills to our clients. For our clients to take stock of their problems, develop action plans and key goals to meaningfully change their lives they first must feel truly heard and 'seen' by the social care professional. This is the skill of relational and emotionally intensive labour. A critical element of this proficiency of developing authentic problem lists can only exist if clients truly feel a reciprocity in the caring relationship: a 'visceral feeling of safety' (van der Kolk 2014: 79). I will explore how to develop this holding space and how I used it as a platform to work through problem lists, action plans and goals with a case study example from a social care practice scenario.

Social Care Case Study: Michelle (Aged 17)

Donald Winnicott claimed that 'one case proves nothing, but it may illustrate much' (1989: 369). This case study is an illustration of how this standard of proficiency was used in one social care context and the importance of relationship-based practice, using a trauma-informed lens and concepts from restorative justice.

Case Study 1

Michelle was referred to me by a District Court judge to complete a pre-sanction report on offences of assault, larceny, theft and attempted arson. These were serious charges that carried a maximum sentence of up to two years' incarceration in a young persons' detention centre. Michelle had just turned 18 years of age and was living in a residential care facility run by Tusla. She had been in the care system since the age of three and had been sexually abused by her father at a young age. She has little contact with her mother, who was an active heroin user throughout Michelle's life. Michelle had moved placement 13 times while in the care of the state. Her experience of residential care was irregular and she had a clear mistrust of professionals and her state care. As she was due to leave care at the age of 18 years, there was no onus on the state at that time to continue with aftercare supports as the legislation at that time indicated that the state 'may' have provided aftercare support in the event that she was continuing with education. At that time, Section 45 of the Child Care Act 1991 detailed the responsibility of the state in terms of aftercare provision. One of the main obstacles in the Act stipulated that the health board 'may' assist the young person for as long as the board is satisfied of his/her need for assistance. As a result, the provision of aftercare was inconsistent and ad hoc. This legislation under the Child Care Act 1991 was amended in 2017, and now Tusla conducts an 'assessment of need' for each young person leaving the care system and then creates an aftercare plan based on that assessment. However, at that time no such legislation existed, and Michelle's future was precarious on a number of fronts – questions remained about who would provide accommodation and the necessary supports for her leaving the care system.

When considering how to apply this standard of proficiency to this case it was clear that there were a number of issues that could be listed as problem areas in Michelle's life. From a criminal justice perspective, she needed to address her offending behaviour. Her future accommodation and vocational training was uncertain and there were also issues around her trust in professionals and hostility towards any type of intervention. However, no one had asked Michelle what she saw as the problem and what goals she had wanted to pursue in her life. She had constantly been told that she needed to make a plan for her future, to take responsibility for her behaviour and to address her anti-social behaviour. However, with so many professionals involved in her case I was concerned about over-crowding her with these requests and bombarding her with further demands, conditions or requirements. Needless to say, Michelle greeted me with hostility, anger and aggression, considering my role with the court and the power differential that existed between us. I knew that there would be no room to problem solve her issues and develop a list of problems, develop an action plan or achieve any goals until we established a relationship.

Consider this ...

- How would you feel if you were told that that you had to leave home and find your own accommodation with little support or knowledge of how to access accommodation?
- What if you were never asked what you wanted for your future and it was left for someone else to decide on your goals and plans? What if you didn't even know how to make these life decisions but were afraid to ask for help?
- What would it be like to have ten different people in your life all at the same time telling you different things to do? How would that make you feel?

These may happen to all of us at different points in our lives but when you come from a place of being moved around from place to place, not having any sense of identity or belonging and all the uncertainty of the future unknown then it can lead to a moment of paralysis and can appear that you lack any insight or awareness. In reality it can be a frightening experience.

We will now consider the process involved in how to apply this standard of proficiency to the case study in the context of relationship-based practice using a trauma-informed lens. This case study illuminates the need for developing appropriate problem lists, goals and action plans with the young person, but sound logical reasoning and the skill of problem solving indicate that this cannot be achieved unless there is meaningful engagement from the young person. It is in this context that we can explore the benefit of that safe holding space in more depth and how it can be achieved using the principles of restorative justice. When working with involuntary clients (Trotter 2015) it is not the skills, plans or goals that our clients remember or respond to, but in how you make them feel is often reported as the most significant antecedent to change. As Maya Angelou said, 'People will forget what you said, people will forget what you did, but people will never forget how you made them feel' (Angelou 2015). This is true for establishing that holding space in which social care practitioners create a feeling of safety for clients to explore their plans and goals.

Restorative Practice as a Means to Problem-solving and Goal-setting

Smith (2018) discusses the dynamics of sustaining relationships where there is anger, mistrust and hostility present. One of the concluding observations is that to sustain a holding relationship, practitioners should respond empathetically to feelings of anger, rejection and hostility, and, critically, keep going back.

My first encounter with Michelle was characterised by all these emotions but we didn't talk about courts or family or anything that would be threatening to her. Our meeting ended abruptly when she aggressively left the room saying she would never talk to me again! However, I came back the following week and every week for the next three years. The formal order of the court mandating that she meet with me was invoking further suspicion and resentment and we needed to try something different.

One simple way of doing this was to show Michelle everything that was being written about her and presented to the judge. Sometimes holding relationships have to be forged and made and this was one way to develop transparency and trust with Michelle. In addition, I would meet with Michelle before and after every court appearance to explain to her what was being said and what was happening in her case. The formal court retribution system can be daunting, the language of the court can be alienating and sometimes defendants don't even speak in the court hearings.

Restorative practice is the study of how to improve and repair relationships between people and communities. Its focus is on building healthy individuals in communities to decrease crime and anti-social behaviour, repair harm and restore relationships (Wachtel 2012). One part of restorative practice is the concept of using restorative justice, which is an alternative to processing criminal

cases through the court. When I met with Michelle, she was outspoken about how alienating the court system was for because she found it frustrating not knowing what was happening in her case. I proposed a restorative justice approach in this case to the court, with the consent of Michelle, and this meant she could speak openly and directly to the judge when her case was called. In this approach, the judge even cleared the court to allow her to discuss the more sensitive aspects of her case and her past. It also allowed for Michelle to make amends for her offences by returning the goods she had stolen, doing some work for the hair salon in which she had caused criminal damage, without feeling shamed, and coming away with a sense of wellbeing having corrected the wrongs she had committed. All these plans came about after much time building relationships with Michelle, presenting consistently, being transparent with information and reports and involving her in the process all the time. For example, when addressing the problem of what to do to make up for her offences it was Michelle's idea to return to the salon to do some work and to return the stolen items in person. All of this was done in the context of the relationship we had forged over time. As restorative practices focus on the relationship, Michelle was inadvertently identifying the problems in her life, making plans and achieving her life goals.

TASK 1

When working with young people who are before the courts, enquire about an alternative way of processing their case through the courts. Meet with the local garda/probation officer/defence solicitor and explore the option of a restorative justice approach. Check out Restorative Practices Ireland, http://www.restorativepracticesireland.ie/

When met with resistance from young people, consider a trauma-informed approach. Consider the concept that challenging behaviour is a form of communication and consider the work of Chris Trotter on working with involuntary clients. Check out Dr Karen Treisman's information on trauma-informed practice, http://www.safehandsthinkingminds.co.uk/

Become a restorative practitioner. Look out for CPD courses in your area in training and becoming a restorative practitioner in your organisation or educational setting. You could use the principles in a wide range of settings including social care organisations, schools, statutory organisations and NGOs. Here is a link to all training courses: http://www.restorativepracticesireland.ie/upcoming-training/

Trauma-informed Practice

A strength in the restorative practice approach is the use of the principles of inquiry and assessment that are based in trauma-informed and human rights concepts. This means that practitioners do not ignore or dwell on past childhood trauma but use this information to understand the client's current difficulties in the context of this past trauma. Trauma-informed practice aids practitioners in emphasising to survivors how their past influences their present and therefore empowers individuals to manage and problem-solve their lives better (Knight 2015). Therefore, the use of a trauma-informed lens can enhance the logical reasoning and problem-solving skills of social care workers by helping them to understand current behaviours in the context of past events. Such insight gives social care practitioners the ability to see the social world from the perspective of the client, in which feelings of powerlessness, insecurity, shame and a deep mistrust of others can prevail (McCann & Pearlman 1990). This insight and knowledge can enhance sound logical reasoning and assist in problem-solving skills when awareness of the trauma is utilised to understand current behavioural and emotional difficulties.

One of the approaches that Dan Hughes uses is PACE in practice (2009). PACE is a concept used in dyadic developmental psychotherapy (Hughes 2011) and is based on a way of thinking, feeling, communicating and behaving that aims to make a young person feel safe. It stands for playfulness, acceptance, curiosity and empathy. By applying these concepts to our practice we are invoking a sound logical way of reasoning and working with individuals who are traumatised. Holding a stance of being 'curious instead of furious' (Hughes 2009) takes blame and shame out of the interaction and encourages understanding of the individual's past. This is similar to applying the unique exception concept often used in family therapy (White *et al.* 1990). In this concept we look for the exception of good moments in the client's life when they achieved something, and build on the skills that were required to make this happen. This can be an interesting tool to model problem-solving skills and help people identify how they have overcome previous problems to master new ones.

Concluding remarks:

To work effectively with people who are traumatised, we need to be able to create a safe, holding space between the person and the social care worker. This standard of proficiency provides a structure and a platform for social care workers to use when developing and sustaining relationships with service users by introducing the concept of a safe holding space. This is renewed focus on the type and quality of relationship, experienced through reliability and critical thinking in our meaningful engagement with vulnerable populations. An understanding of the different dimensions of safety and quality is demonstrated through sound logical reasoning and problem-solving skills. By considering the types of interventions we use, for example, trauma informed practice, person-centred care, and restorative practice, we are being creative and innovative in how we approach problems, goals and plans. Sometimes our caring relationships focus on external elements such as housing, care arrangements, court proceedings, poverty, and social injustice. These are valuable ways of connecting with people on what is important in their lives. Caring relationships also help people connect with their lives - their sense of self in the world, of self-efficacy and self-worth.

Tips for Practice Educators

- When supervising students on placement, consider the organisational culture and the impact on the student and their work – consider the 'sanctuary model' by Dr Sandra Bloom on how to provide a trauma-informed organisational culture for the people and systems who provide care: https://www.thesanctuaryinstitute.org/about-us/the-sanctuary-model/
- Use this resource list about adversity, culturally, trauma-Informed, infused, & responsive organisations & systems here - http://www.safehandsthinkingminds.co.uk/trauma-informed-trauma-responsive-organisations-systems/ and checklist from Dr Karen Treisman as a guide or check out her book A Treasure Box for Creating Trauma-informed Organisations; Chapter 14 in particular, on supervision and team meetings, is an excellent resource for practice educators.
- Use a simulated educational game-based learning activity with your students - check out the Social Care CORU Standards of Proficiency Board game developed by Balfe (2021) in conjunction with FOCUS Games: www.focusgames.com. This will help both you and your students to understand the standards of proficiency in your supervision.

References

Andrews, D. A., Bonta, J. and Wormith, J. S. (2011) 'The Risk-Need-Responsivity (RNR) Model: Does adding the good lives model contribute to effective crime prevention?', *Criminal Justice and Behavior* 38(7): 735-55.

Angelou, M. (2015) *Maya Angelou: The Complete Poetry*. UK: Hachette.

Featherstone, B., Gupta, A., Morris, K. and White, S. (2018) *Protecting Children: A Social Model*. Policy Press.

Ferguson, H. (2011) *Child Protection Practice*. Palgrave Macmillan.

Ferguson, H., Warwick, L., Disney, T., Leigh, J., Cooner, T.S. and Beddoe, L. (2020) 'Relationship-based practice and the creation of therapeutic change in long-term work: social work as a holding relationship', *Social Work Education* 30 November, 1-19.

Flynn, S. (2020) 'Proficiency within professionalisation: A social constructionist critique of Standards of Proficiency for Social Care Workers in the Republic of Ireland', *Irish Journal of Applied Social Studies* 20(2): 6.

Hughes, D. H. (2009) *Attachment-focused Parenting: Effective Strategies to Care for Children*. New York: W.W. Norton.

Hughes, D. H. (2011) *Attachment-focused Family Therapy Workbook*. New York: W.W. Norton.

Kanter, J. (2004) *Face-to-face with Children: The Life and Work of Clare Winnicott*. Karnac.

Knight, C. (2015) 'Trauma-informed social work practice: Practice considerations and challenges', *Clinical Social Work Journal* 43(1): 25-37.

McCann, I. and Pearlman, L. (1990) *Psychological Trauma and the Adult Survivor*. New York: Brunner/Mazel.

Mulkeen, M. (2020) 'Care and the Standards of Proficiency for Social Care Workers', *Irish Journal of Applied Social Studies* 20(2): 4.

Sherman, L. and Strang, H. (2007) *Restorative Justice: The Evidence*. London: Smith Institute. Available at <https://www.iirp.edu/pdf/RJ_full_report.pdf>.

Smith, M. (2018) 'Sustaining Relationships: Working with Strong Feelings Part l: Anger, Aggression and Hostility' in G. Ruch, D. Turney and A. Ward (eds), *Relationship-based Social Work: Getting to the Heart of Practice*, pp. 95-112. Jessica Kingsley.

Trevithick, P. (2003) 'Effective relationship-based practice: A theoretical exploration', *Journal of Social Work Practice* 17(2): 163-76.

Trotter, C. (2015) *Working with Involuntary Clients: A Guide to Practice*. Routledge.

van der Kolk, B. (2014) *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma*. UK: Penguin.

Wachtel, T. (2012) 'What is restorative practice?', International Institute of Restorative Practices. Available at <http://www.iirp. edu/what-is-restorative-practices. php>.

Walsh, J. (2018). 'Being alongside: Working with complexity and ambiguity in caring relationships'. In G. Ruch, D. Turney, & A. Ward, (Eds.), *Relationship-based social work: getting to the heart of practice* (pp. 203-220). Jessica Kingsley.

White, M., Wijaya, M. and Epston, D. (1990) *Narrative Means to Therapeutic Ends*. New York: W.W. Norton.

Winnicott, D. W. (1989) 'Physical and Emotional Disturbances in an Adolescent Girl' in C. Winnicott, R. Shepherd and M. Davis (eds), *Psychoanalytic Explorations*. Karnac.

Zehr, H. (2005) *Changing Lenses: A New Focus for Crime and Justice* (3rd edn) Scottdale, PA: Herald Press.

Chapter 46 – Grainne Ridge

Domain 3 Standard of Proficiency 6

Be able to demonstrate an evidence-informed approach to professional decision-making, adapting practice to the needs of the service user and draw on appropriate knowledge and skills in order to make professional judgements.

KEY TERMS

Evidence-based approach

Professional decision-making

Freda principles

Social care is … a holistic approach to supporting people through care, advocacy, empowerment, innovation and personal development.

Evidence-based Approach

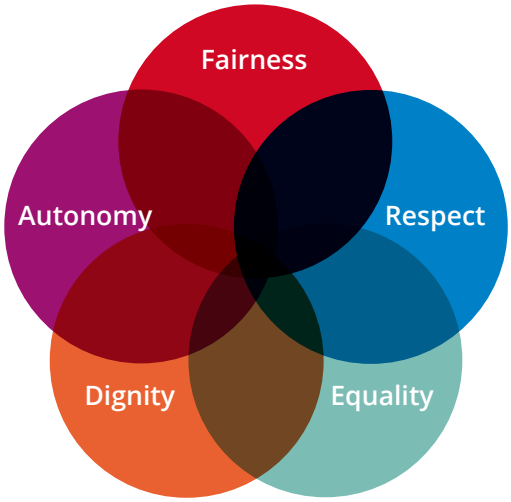
The role of a social care worker is wide and varied. A social care worker provides care and support, guidance, direction and education to people who are experiencing challenges at a particular time in their lives and/or who may be defined as vulnerable by society. Social care workers go the extra mile to really make a difference in the lives of the people they support and empower them to live fuller, enjoyable and independent lives. Social Care Ireland describes the core principles of social care work as 'respect for the dignity of clients; social justice; and empowerment of clients to achieve their full potential' (Social Care Ireland 2009). Social care workers make professional decisions that can impact on the lives of others, so taking time to consider how professional decisions are made is important.

In recent years, there has been a practice shift from a needs-based approach to a human rights-based approach (HRBA), with the development of the United Nations Convention on the Rights of Persons with Disabilities (2007) and the Assisted Decision-Making (Capacity) Act 2015. Chapter 64 explains the human rights based approach in detail, and should be read in conjunction with this chapter. The Health Information and Quality Authority (HIQA) text *Guidance on a Human Rights-based Approach in Health and Social Care Services* provides an evidenced-based framework to guide social care workers through the process of decision-making (HIQA 2019). This will provide a structure for this chapter and act as a guide and evidence-informed approach to professional decision-making,

Professional Decision-making

Social care workers' professional decision-making and practice is guided by policies, procedures, integrated knowledge and the relationship they have with a service user and his/her family. Decisions affecting the service user's life are made in the person's best interest, taking time to support the service user to communicate their wants and needs. It is the role of the social care worker to ensure that their views, choices or opinions are taken into consideration; however, this can be can be difficult at times, especially if the service user's capacity to make a decision is in question. The FREDA principles framework will help ensure that the service user's consent is present in all professional decisions made.

The FREDA principles (HIQA 2019: 11) included with permission



The following case study, from my master's in healthcare management (2012), is used here as an example on how to apply the FREDA principles to practice as an evidenced-informed approach to professional decision-making in social care practice.

Case Study 1

Mary is a social care worker in a residential care facility for adults with autism. She has worked there for 17 years and is part of a diverse staff team with different cultural backgrounds and practice experiences. The service users have autism and are non-verbal and she knows all of them very well. Mary described the service users as 'nearly like family' and said that she truly loved and enjoyed her work. As part of the interview, I discussed the daily running of the residential area and how the service users were involved in their home and the service delivery within it. She spoke so passionately about service users and her colleagues and the work that they did there. I asked about menu planning, grocery shopping and meal preparation. She proudly explained that the service users didn't need to worry about any of that, as it was all done for them. She described how the staff planned and compiled the dinners for the week, the staff were very efficient and went alone to the supermarket and did the grocery shopping, the staff prepared and cooked all the meals and all the service users had to do was to come to the table when it was ready, it was luxury, nearly hotel-type service. When I asked about the service users' involvement in the process, she laughed and said, 'Oh God no, sure they have challenging behaviour, they wouldn't be able for any of that.' I then asked about their likes and dislikes food-wise, she replied again that the service users were non-verbal and had challenging behaviour, they wouldn't be able to tell them what they liked and they didn't and there had been 'no complaints' about the food or cooking, so it was all fine.

The following discussion follows the five FREDA principles of fairness, respect, equity, dignity and autonomy and how this approach may help Mary include the service user's will and preferences in some of the activities in the house, including decisions made on the weekly menu.

Fairness 'means ensuring that when a decision is made with a person using a service about their care and support, that the person is at the centre of the decision-making process' (HIQA 2019: 14). Although Mary stated that the services users were non-verbal, there are many ways to include people in the decisions made in the house.

Respect 'is central to providing person-centred care and support. People who use services must be listened to, and what is important to them must be viewed as important to the service. The principle of respect must be upheld regardless of a person's impairment or loss of capacity' (HIQA 2019: 25). According to the FREDA principles, if a person cannot communicate their opinions and tastes, you can ask family members and another person nominated to be their advocate. Asking family or friends what a service user likes to eat when at home can expand the selection of meals that are served in the residential home.

Equality relates to equity and treating everyone the same regardless of ethnicity or ability. Within the FREDA principles, equality also includes respectful communication, where workers ensure 'that each person is provided with information in a format and medium that is tailored to their needs and preferences regardless of who they are or their communication ability' (HIQA 2019: 34).

Dignity is treating the service user in a compassionate way, making sure that they are treated like a human being, with rights and self-respect. Social care workers can uphold the dignity of the service user by 'enquiring about a person's preferred lifestyle, including routines, pets, personal care, clothing preferences, religious and cultural preferences, and facilitate their lifestyle as much as possible. This can be something as simple as providing preferred food options during mealtimes' (HIQA 2019: 41).

Autonomy relates to the service users having a say in their own life experiences and the decisions that are made on their behalf. To ensure that the service user has autonomy it is important to engage in meaningful communication on an ongoing basis and 'recognise that a person's wishes to engage may change over time and where a person chooses not to engage, regularly review their interest to re-engage' (HIQA 2019: 50). Just because the service users did not communicate a desire for meal-making in the past does not mean that this is true at this moment Workers need to constantly check in with service users to see if they would like to engage.

HIQA (2019) included with permission

Consider this ...

- How would you feel if you didn't have a voice in your daily life? If you were never asked what you wanted to wear? If clothes were just picked out of your wardrobe and put on you?
- What if you were never asked what you wanted to eat? If meals were just put in front of you whether you liked it or not?
- What if you were never asked where you'd like to go or what you'd like to do on your days off? If the day was pre-planned without you, where you went and what you did already laid out, how would you feel?

These may be all minor choices on the face of it, but we make hundreds of decisions every day, many decisions we make without ever thinking about them. How would you feel if that continued for weeks, months or even years?

Decision-making in Practice

In 2019, a residential care facility sought a High Court order to prohibit a man with Down Syndrome marrying his partner, who also had an intellectual disability (Healy 2019). It was claimed that under the Marriage of Lunatics Act 1811 the man did not have the ability or capacity to make a decision about getting married to his partner of 15 years. The man was subject to a wardship application by his family. Under the Lunacy Regulation Act 1871, a person can be found to be incapable of managing their financial and personal affairs or property. A wardship order ultimately takes away the rights of the person in relation to their medical and financial decisions. A ward of court cannot marry, make a will or travel outside the jurisdiction without the consent of the court (Inclusion Ireland 2018).

The man took a constitutional challenge against the two Acts. Four consultant psychiatrists and two psychologists argued in court that he lacked capacity to manage his own affairs or make life decisions such as marriage. The man was due to inherit a substantial amount of money and his family opposed the marriage. His partner, although she also had an intellectual disability, was viewed as being 'higher functioning' and her capacity was not questioned in the case, and her mother was in support of her marriage (Carolan 2020). While the case was being processed, the court ordered for their wedding to be cancelled rather than it going ahead and them being annulled if the ruling went against them (Healy 2019).

Articles 9, 22 and 23 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) relates to a person's right to respect for their private and family life, their relationships, their physical and mental wellbeing, and access to their own personal information. It also relates to a person being supported to communicate and have active participation in their communities (UN 2007).

TASK 1

Apply the FREDA principles to this example and discuss how you as a social care worker could support the man in the case.

Consider this ...

- How would you feel if other people made decisions about your life without taking into consideration your views, your choices, your will and preference?
- How would you feel if your family, your doctor and even doctors you've never met made decisions about your medical treatment and how you spent your money?
- How would you feel if your decision about who you wanted to marry was questioned? If your private life was discussed in court and reported in the national newspapers?

As social care workers, it is our responsibility to support the will and preference of the people in our care. We must advocate for their rights and their preferences, but that does not mean that we have to agree with all their choices. As with any of us, the people we support have the right to make a decision that we may think is unwise or goes against medical or other advice. Once the person is fully informed and all the options, eventualities and outcomes of their decision are communicated to them fully, in a format that is accessible to them, we as social care workers must uphold the person's autonomy to make that decision. The Assisted Decision-Making (Capacity) Act (2015) argues that you must always assume that the service user has the capacity to make their own decisions. A person is only deemed 'to lack capacity to make a decision if they are unable to understand the information relevant to the decision, retain that information long enough to make a voluntary choice, use or weigh that information as part of the process of making the decision and communicate his or her decision in whatever way they communicate' (HIQA 2019: 49).

The development of advance healthcare directives is a move towards people with capacity being able to plan for their future. The advance healthcare directive (AHD) is legally binding and details the person's wishes directly concerning specific treatment decisions in the context of an anticipated deterioration in their condition near their end of life. The AHD is in place in the event that the person has a loss of decision making ability to give consent to or refuse treatment and communicate them to others (Irish Hospice Foundation 2016).

Appropriate and positive risk-taking is essential when ensuring that a person's autonomy is promoted in a safe, supportive environment. The assessment of risk of the decision must be made with all available professional information, advice and evidence, as well as the person's own will and preference (HIQA 2016). Social care workers cannot become risk-averse in supporting vulnerable people with the decisions that they make; even if the decision is deemed to be unwise, we must assume capacity and provide support (HIQA 2019).

Ultimately, we need to leave our own personal preferences and biases aside and do the right thing for the people we support in the course of our work. Self-reflection can be used by social care professionals to enable them to consider and strike a balance with the competing ethical principles of respecting people's human rights, autonomy and 'do no harm'. This can help promote autonomy and safety for the social care worker and the people we support (HIQA 2016).

Tips for Practice Educators

1. Read Chapter 67 by Noelle Reilly and Denise Lyons and use the SKIP Model (Lyons & Reilly) categories of knowledge-informed practice to guide your discussion.
2. Write a new case study based on a fictional service user, ask the student to apply the FREDA principles to the dilemma and discuss.
3. Share how you make decisions with your service user, what evidence do you rely on to make decisions. Talk about situations that worked well and the evidence you used to make that decision.

References

Carolan, M. (2020) 'Intellectually disabled man challenges marriage ban and court wardship', *Irish Times*, 28 January.

Government of Ireland (2015) *Assisted Decision-making (Capacity) Act*. Dublin: Irish Statute Book.Healy, T. (2019) 'High Court blocks marriage of man with intellectual disabilities', *Irish Independent*, 20 June.

HIQA (Health Information and Quality Authority) (2016) *Supporting People's Autonomy: A Guidance Document*. Dublin: HIQA.

- (2019) *Guidance on a Human Rights-based Approach in Health and Social Care Services*. Dublin: HIQA.

HSE (Health Service Executive) (2017) *Assisted Decision-making (Capacity) Act Complaint Officer Workshop.* Dublin: HSE.

Inclusion Ireland (2018) *Capacity*. Dublin: Inclusion Ireland.

Irish Hospice Foundation (2016) *Advance Care Planning and Healthcare Directives for a Person with Dementia*. Dublin: Irish Hospice Foundation.

Law Reform Commission (2006) *Vulnerable Adults and the Law*. Dublin: LRC.

NSW (New South Wales) Government (2009) *Capacity Toolkit*. Sydney: Attorney General's Department, NSW.

SAGE, HSE and Nursing Homes Ireland (2015) *Empowerment Briefing Document.* Dublin: Third Age.

Social Care Ireland (2009) *What is Social Care Work?* [online]. Available at <www.socialcareireland.ie> [accessed 27 January 2020].

UN (United Nations) (2007) *Convention on the Rights of Persons with Disabilities*. New York: UN General Assembly.

Chapter 47 – Orla Dowling

Domain 3 Standard of Proficiency 7

Be able to prioritise and maintain the safety of both service users and those involved in their care.

KEY TERMS

Safety versus risk

Maintaining and prioritising safety

Proportionality

Positive risk management

Safety culture

Social care is … providing a safe and caring environment for service users, which includes the identification and control of risks to achieve effective, efficient and positive outcomes for service users and staff.

Introduction

The social care sector offers services to a broad client base who can experience challenges at different times in their lives (Lalor & Share 2013). Social care workers aim to enhance the well-being of and empower those we work with. It is a fulfilling profession that is ever evolving, and continuous professional development and openness to change is required. Social care workers provide services to those who might otherwise be at risk, and this can pose some challenges. We have a duty of care to those we work with to provide a safe and efficient service in all settings.

The examples in this chapter are based on my experience of working with children, young people and families who are at risk in their home or community.

TASK 1

Become familiar with the health and safety policy in your service.

Safety Versus Risk

A risk is the possibility of an event occurring that will have a harmful outcome. Social care workers complete risk assessments to ensure the safety of service users, themselves and the general public (Seden 2016). In social care, the risks for social care workers vary depending on the type of service and the service user's background. As social care workers we have a duty of care to the service users we work with and are expected to complete risk assessments daily. It is important that we are familiar with health and safety policies and reporting mechanisms.

Safety involves a risk being controlled or reduced to an acceptable level (Roeser *et al.* 2012). When we discuss safety, we consider both the physical and psychological safety of service users, staff members and members of the public. Physical safety can include the work environment,

hazards and equipment. Psychological safety is when a person feels respected, that they can apply themselves to a task without fear of consequences and is comfortable voicing opinions. The presence of psychological safety in a challenging work environment can help social care workers overcome barriers to change and learning (Edmondson *et al.* 2016).

What an acceptable risk level is will be established by each organisation; this can be found in the risk assessment policy. In social care we determine the level of risk by using a risk assessment.

TASK 2

Please read Chapter 50 on how to complete a risk assessment.

Please read Chapter 54 for a greater understanding of risk and safe environments.

Maintaining and Prioritising Safety

When discussions of safety arise, we consider the guiding legislation and policies, including the Health Act 2007; the Health and Social Care Professionals (Amendment) Act 2019; the Health, Safety and Welfare at Work Act (2005); the Equal Status Acts 2000-2008; the Safeguarding Vulnerable Adults at Risk of Abuse Policy and Procedure (2014); and the National Guidance for the Protection and Welfare of Children (2017).

Maintaining safety first involves the formal process of following guiding legislation and policies within organisations. These can include behaviour guidance, medications management, health and safety, and risk assessment. In these formal processes, best practice guidelines are provided to ensure safe environments are created in the social care setting. As social care workers we have a responsibility and duty to keep our knowledge of these policies up to date. Continuous training and development, supervision and discussions with colleagues are key to keeping up to date with relevant legislation.

Another aspect of maintaining safety involves knowledge of the service user we are working with. Access to care plans, behaviour support plans, daily logs and incident reports can equip us with the relevant knowledge to keep the service users and ourselves safe. These will provide us with details about the service users' likes, dislikes, triggers, emotional needs, coping mechanisms and overall support needs. This knowledge is invaluable; however, it will not on its own provide us with the expertise to maintain safety. Equally important is relationship-building with a service user. When key relationships are established, social care workers can be attuned to changes in a service user's demeanour. We rely on our communication skills, in particular non-verbal communication. Being aware of subtle changes in a service user's non-verbal cues can equip us to adjust our communication styles or plans to ensure safety for that service user and others. In practice these changes may be so subtle that others involved in a young person's care do not notice them.

Case Study 1

While engaging with a young male, Noah (pseudonym), aged 15 years, I noticed a subtle change in his non-verbal communication. I had been working with Noah for two years and we had developed a strong professional relationship. The goals for engagement that day included assisting Noah in meeting with his social worker. Noah had compiled a list of questions and had been working on remaining calm during the meeting. At the beginning of the meeting Noah expressed himself well and put forward his questions. After a few minutes, I noticed the right side of his jaw twitching, a very subtle change. I suggested that we take a break and went outside with Noah. Once outside Noah began to speak about his frustrations with the conversation and noted that he had felt himself becoming extremely angry, stating, 'I was about to pick my chair up and throw it at him.' An open discussion was had with Noah and he was soon able to return to baseline and recommence the meeting. Reflecting back on this experience, it was evident that the safety of Noah, the social worker and myself may have been in jeopardy. My ability to pick up on the subtle change in Noah's non-verbal communication was attributable to the relationship I had built with Noah and my ability to notice his triggers and provide a safe space for him to explore his emotions and return to baseline.

Effective teams can improve the overall efficiency of a service and promote psychological safety. Team meetings are opportunities for staff members to share their expertise, generate creative ideas and improve safe practices. They also provide a space for improving communication channels and developing staff relationships. In the social care sector, we rely on teams of people in all services. At times social care workers are faced with complex cases that are physically and psychologically demanding. Having a team who foster open communication, shared goals and practices will help reduce of stress or burnout. Team discussions should be open, with all members sharing ideas or highlighting concerns. Fostering a team-based approach allows social care workers a safe environment to discuss incidents or concerns, build self-awareness, develop creativity, reflect on incidents or events, and develop professional relationships.

Case Study 2

Georgina is a 20-year-old female who lives independently with support from social care workers for 55 hours per week. Georgina has been supported by the organisation for four years and has a staff team of five social care workers. Georgina has a diagnosis of mild learning disability, PTSD, and borderline personality disorder. At times Georgina struggles with emotional regulation and low mood. The staff team, along with a manager, have weekly team meetings, at which there are open discussions, and all members have the opportunity to share ideas, discuss concerns, develop procedures and provide input into actions. During the most recent team meeting two staff members noted the following changes in Georgia's demeanour; sitting in the dark (closing windows and doors), watching a movie on loop, sitting in a curled-up positions, needing prompting to engage in conversation. Other team members had not noted any change in Georgina's demeanour.

An open discussion was had by the team, and some noted that these changes are concerning. It was discussed that Georgina did not normally close the door as it made her feel trapped and caused flashbacks of previous traumatic experiences; and that Georgina usually greeted staff in an upbeat and friendly manner. But as prompting was needed it seemed as if she had withdrawn into herself, that fixating on one thing, the movie, signified that Georgina was stuck in her emotions and also that sitting in a curled-up position and hugging her knees implied that Georgina was in need of comforting. These behaviours had been noted previously and had resulted in Georgina engaging in risk-taking and self-harm behaviour.

The team agreed that these were early warning signs that Georgina's mood was low. The team agreed on a safety plan and put this in place immediately. The safety plan included contacting Georgina's psychologist, developing a safety procedure with Georgina in the event that she feels like harming herself, supporting Georgina in using her self-soothing toolkit, and procedures in the event of Georgina self-harming or exhibiting suicidal ideation.

The case study above outlines both the importance of buildings a trusting relationship with the service user and the value of effective team meetings. As some of the members were new to the team and were not aware of these early warning signs, the open team discussion was essential – without the knowledge provided by the rest of the team they might have approached the situation in a different manner. This could have led to Georgina's and the team's physical and psychological safety being compromised. For students on placement, observing other staff members' interactions and approaches to different service users will give you an insight into appropriate interactions or responses to situations. Attendance at team meetings and care plan reviews affords new staff members and students a comprehensive understanding of a service user. These opportunities should be afforded to all students.

The question of prioritising the safety needs of a service user and those involved in their care can seem a difficult and daunting task. Not all risks are equal; some can lead to more severe consequences than others. Risk prioritisation is a part of overall risk management and involves identifying the physical and psychological factors of safety. Once the risks are identified, control measures are put in place. The risks may still exist, but they are less likely to lead to serious illness or injury.

TASK 3

Review the case study below and explore the following questions.

- What are the safety concerns for the service user, social care worker and the public?
- How would you safely engage with George in a person-centred manner?
- What, if any, safety measure would you put in place?

The safety of service users and those involved in their care is deemed of equal importance. In the social care sector, we may assume that we are challenged to manage the risk of maintaining the safety of both service users and those involved in their care while also working in a person-centred manner. However, these should be done in conjunction; they are not contradictory.

Case Study 3

George, aged 17, has been referred to the organisation you work in. He is completing the last two weeks of an eight-month placement in a children's special care centre. The staff from the special centre report that he has engaged well in all the programmes and the level of incidents has decreased over the last month. George's referral notes his history, which includes drug and alcohol misuse, violent attacks on members of the public, and robbery. George's care plan involves sourcing independent accommodation and providing support in all areas of education and training, daily living skills and social networks.

In the above case example, we can easily note the safety concerns for all involved. In social care, we may fall into the trap of prioritising the safety of staff members and the public over the best interests of the service user. Therefore, in the above scenario it may seem justified to limit George's involvement in the community. However, putting in place safety measures can reduce the risk to an acceptable level while also promoting George's best interests. Some safety measures that could be put in place include increasing staffing levels to two staff to support George, a detailed risk assessment, a safety plan, regular team meetings, regular individual meetings with George, and implementing a behavioural guidance document with input from George. This would set the expectations for both George and staff members. An example of some expectations set out may include:

- Staff members to knock on George's bedroom door and wait to be invited in.
- George and staff members will show mutual respect.
- Staff members will not transport George if he presents under the influence of drugs or alcohol.
- George to inform staff members if he is feeling overwhelmed.

Proportionality

HIQA (2019) notes that social care services are moving towards a person-centred approach that involves empowering service users to participate in their own care. There are challenges to this, and when a person is deemed not to have the capacity to make some decision an intervention is required. This intervention involves social care workers weighing up the safety of the service user and the risks involved, for both the person in question and the public. This decision involves a balance between the service user's rights, choice, quality of life and personal growth and health and safety concerns.

Proportionality involves taking measures that restrict a service user's liberty in order to protect the public from harm (DoH 2020). Social care workers are responsible for meeting the needs of service users and preventing them harming themselves or others. At times this may lead to a dilemma about whether the service user's choices can be supported or if there are risks to themselves and others that require an intervention (Seden 2016). Kemshall (2013, cited in Seden 2016: 10) has identified some of the key components in assessing risk:

- Identification of the risk
- The likelihood or probability of the risk occurring
- The situation in which the risk may occur
- The impact of the risk
- The consequence of the risk and who it may affect.

Social care workers aim to manage safety by reducing risks. While working in the field we make 'defensible decisions' – decisions that are ethical and made with the information available (Seden 2016). The measures taken to reduce risks should be the least restrictive. It must be decided whether the interference with a person's rights is justified. When considering such a decision, consider: if the goal will be achieved; if there is no other less restrictive measure; if the measure is proportionate to the benefit; if not implementing the measure would result in significant harm. These measures should be assessed and reviewed regularly.

Positive Risk Management

Positive risk management relates to building a culture within a service where risk management and safety is openly discussed and proactively managed (HIQA 2019). In society, risk-taking is an accepted part of life; however, for some of the service users we work with it is often discouraged. In the case of people with a disability, taking positive risks may be avoided because of perceived fears in relation to ability or capacity. But safety considerations must be balanced with some risk-taking, as there are positive outcomes that benefit a person's quality of life.

Positive risk management involves identifying the risks, looking at potential benefits and developing actions to minimise the risk while helping a service user achieve the desired outcomes. It is also acknowledged that contingency planning should be put in place if the risk becomes unacceptable.

Case Study 4

Peter is an 8-year-old boy living in foster placement. Peter has been in care for two years and has had one previous placement. During his interactions Peter likes to take charge and becomes frustrated if he is not winning games or another individual is not following his lead. Peter's frustration is exhibited by shouting or hitting other children. Peter has expressed that he would like to join a local football team; however, his foster carers highlight that there are too many risks.

TASK 4

Look at the above case study and determine the following.

- The potential risks involved to Peter and the public
- Whose safety should be prioritised
- The potential benefits for Peter
- How the risks could be minimised.

When developing risk assessments in social care it is important to apply a human rights-based approach. This considers the risks and rights that could affect the person's or other people's safety or wellbeing. As social care workers we encounter complex situations where we need to consider a service user's preference and the risk of harm versus their right to autonomy. HIQA (2019) developed the FREDA principles as a guiding framework for ensuring human rights-based approaches to care. These five principles are fairness, respect, equality, dignity and autonomy.

TASK 5

Please read Chapter 5 to help you apply the FREDA principles to your practice.

Safety Culture

The culture of an organisation affects the beliefs and attitudes of the team, including health and safety performance. 'The safety culture of an organisation is the product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organisation's health and safety management' (HSL 2002: 6). The main components for safety culture are situational (policies, management systems), psychological (values, norms and attitudes) and behavioural (observations, reporting measures).

The level of management influences health and safety in various ways. A manager's attitudes and behaviour towards safety influences workers; this can include encouragement of safety ideas, reporting procedures and how safety is prioritised in policies and procedures. Staff who perceive their managers as being involved in safety and open to discussion around this are more likely to use coping strategies then those with less involved managers (HSL 2002). In the social care sector, having a manager who is open to discussion around safety, supports reflective practice and is open to change helps promote psychological safety.

Pidgeon and O'Leary (1994, cited in HSL 2002: 3) outline four factors which reflect a positive safety culture:

1. **Organisations learning through practice.** An organisation is transforming continuously as it learns from past experiences and best practice. This knowledge should be transferred throughout the organisation.
2. **Management's commitment to safety.** Managers who are perceived to have safety considerations at the forefront of their work influence the safety conditions on the ground. If a manager does not encourage safety practices or dismisses concerns, staff members will have greater exposure to risks.
3. **Shared concern and care for hazards.** Safety concerns are shared among the staff team, discussed openly at team meetings and agreed actions are followed by all. All staff members report concerns of hazards to managers.
4. **Realistic practices for controlling hazards.** As an organisation, putting in place control measure that are realistic or SMART contributes to the success of avoiding the hazard. Control measures should be more easily accessed by all staff members.

TASK 6

Review the case study below and explore the following questions.

- How would the different responses from management influence the safety culture in an organisation?
- How can you effectively maintain the safety of Gemma, Sonya and the public?
- What, if any, safety measures would you put in place?

Case Study 5

Sonya, an employee, has started on a new case with Gemma, an 8-year-old girl who has recently moved into a foster family. Gemma has experienced two previous placement breakdowns. Sonya is asked to work one-on-one with Gemma in the community assisting her with emotional regulation using therapeutic interventions. After her first session, Sonya outlines to her manager (Bill) that she feels the case should be two-on-one, for the following reasons.

- Gemma is sporadic in her movements in the community and not aware of her physical safety, e.g., running out in front of cars.
- Sonya noted that Gemma has previously made disclosures about a worker's misconduct.

The manager's (Bill's) possible responses:

A. Bill completed a risk assessment on the case, held a team meeting where an open discussion was had and safety measures agreed. He also sourced a second worker for the case. Bill then offered an opportunity for Sonya to attended supervision to reflect on the process.

B. Bill listened to Sonya's request and explained that the case was one-to-one and that this would not change. Bill also noted that the disclosures Gemma made related to misconduct, not to any form of abuse, and therefore were not of a concern to the organisation. Bill also sent Sonya some suggested activities that she could use to engage with Gemma.

Tips for Practice Educators

1. Provide the students with induction training and allow them time to review the service's policies and procedures, in particular those related to health and safety in the workplace, employees' and employers' rights and responsibilities.
2. Allow students the opportunity to review the organisation's risk assessment folders, health and safety policies, staff handbooks, behaviour guidance policies and behaviour intervention pans. If possible the student should also have the opportunity to view individual service users' care plans. This will assist the students to put this proficiency into practice.
3. Taking part in team meetings will give the student the opportunity to see some of the processes of developing and implementing safety procedures. This will equip them with an understanding of how informed decisions regarding a service user's capacity to maintain their own safety are reached.
4. Provide the student with a task of carrying out a risk assessment and safety plan. The student should be provided with all the relevant documentation needed. The student should be able to look at the risks and benefits and put in place any safety measures needed.
5. Students should be afforded the space to critically reflect. The time afforded may be used to unpack incidents and reflect on current safety procedures. This can be prompted through supervision. Give students the opportunity to articulate their concerns and reflect on their experiences in a supportive environment.

References

Curtice, M., Bashir, F., Khurmi, S., Crocombe, J., Hawkins, T. and Exworthy, T. (2011) 'The proportionality principle and what it means in practice', *The Psychiatrist* 35(3): 111-16.

DoH (Department of Health) (2020) 'Ethical framework of decision-making in a pandemic'. Available at <https://www.gov.ie/en/publication/dbf3fb-ethical-framework-for-decision-making-in-a-pandemic/#> [accessed 13 July 2021].

Edmondson, A.C., Higgins, M., Singer, S. and Weiner, J. (2016) 'Understanding psychological safety in health care and education organisations: A comparative perspective', *Research in Human Development* 13(1): 65-83.

HIQA (Health Information and Quality Authority) (2018) *National Standards for Children's Residential Centres*. Dublin: HIQA.

HIQA (Health Information and Quality Authority) (2019) *Background Document to Inform the Development of Guidance on a Human Rights-based Approach to Care and Support in Health and Social Care Settings*. Available at <https://www.hiqa.ie/sites/default/files/2019-06/Draft_Guidance_Human_Rights-Based_Approach_to_Care_Background_Document.pdf> [accessed 12 July 2021].

HSA (Health and Safety Authority) (2012) *Health and Safety at Work in Residential Care Facilities*. Available at <https://www.hsa.ie/eng/Publications_and_Forms/Publications/Healthcare_Sector/Residential_Care_Facilities.pdf> [accessed 13 July 2021].

HSL (Health and Safety Laboratory) (2002) *Safety Culture: A Review of the Literature.* Available at <https://www.hse.gov.uk/research/hsl_pdf/2002/hsl02-25.pdf> [accessed 13 July 2021].

Lalor, K. and Share, P. (2013) 'Understanding Social Care', in K. Lalor and P. Share (eds), *Applied Social Care: An Introduction for Students in Ireland* (pp. 3-18). Dublin: Gill and Macmillian.

Roeser, S., Hillerbrand, R., Sandin, P. and Peterson, M. (2012) *Handbook of Risk Theory: Epistemology, Decision Theory, Ethics and Social Implications of Risks.* New York: Springer.

Seden, J. (2106) 'Social work: Risks, needs and balanced assessments', *K216 Readings*. Milton Keynes: Open University.

Social Care Workers Registration Board (2017) Standards of proficiency for social care work. Dublin: CORU Health and Social Care Regulator.

Tusla (Child and Family Agency) (2016) *Proficiencies: Reflection Guide for Social Workers and Social Care Workers*. Dublin: Tusla.

Chapter 48 – Jacqui McCann

Domain 3 Standard of Proficiency 8

Be able to evaluate intervention plans using appropriate tools and recognised performance/ outcome measures along with service user responses to the interventions. Revise the plans as necessary and, where appropriate, in conjunction with the service user.

KEY TERMS

Strengths-based approach

Positive behaviour support

Opportunity and support

Hope

Motivation and role modelling

Reflective practice and learning

Social care is … a platform for providing care to adults and young people who need support to manage in their daily lives. It is the opportunity to enhance and develop an individual's needs which can in turn promote positive experiences and outcomes.

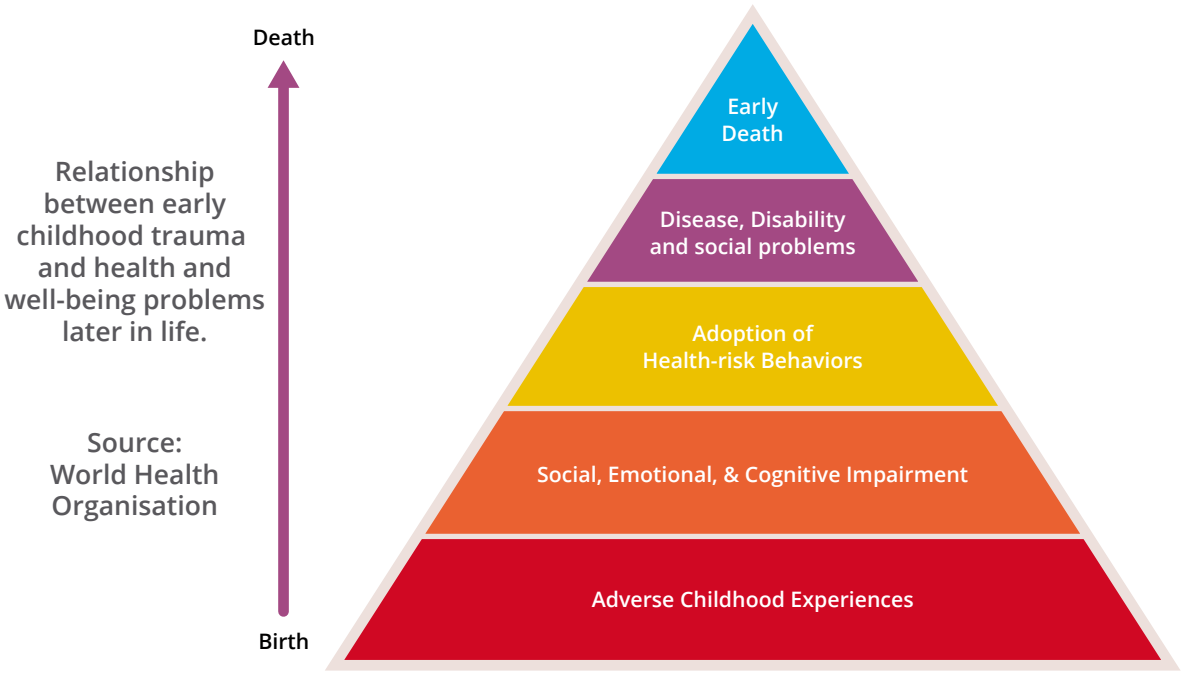
Social care practice has evolved to create many different pathways of working with individuals in their life space to respond to their care needs. At the forefront of this practice is a drive, not just to respond to these needs, but to 'do better 'and provide high-quality standards of care. In terms of the provision of residential care for young people in care in Ireland this drive to 'do better' has been led by the by the institutional scandals that demanded reform. Young people in care in Ireland, whether in foster, residential or special care, are united by the impact or effect of the trauma or abandonment that resulted in them being placed in care and the transitions between care placements that contribute to these effects.

In this chapter the provision of special care in Ireland as an intervention will be discussed along with the individual intervention plans that are adopted. Special care is a purpose-built secure facility for young people in care who are detained by a High Court order because they pose a risk to themselves or others. Special care is an intervention for young people who have experienced significant trauma and are presenting with extreme risk-taking and/or highly challenging behaviours. The chapter will also identify the core intervention plans that are designed and implemented to respond to the specific care planning needs of the young people. These include responding to risk; health and wellbeing; behavioural, therapeutic and relational needs. How the intervention plans are developed and reviewed will be explained, along with how the outcomes for the young people are measured.

The care system in Ireland has the unique role to provide for and respond to the needs of these young people at the fulcrum stage of their development 'during their childhood'. This is a critical period of our lives that shapes our adulthood. Young people who are placed in care have a complexity of needs. Alongside their primary emotional, physical, social and educational care needs, young people who have been placed in residential care, and specifically special care, also require intensive support

and intervention regarding risks associated with their behaviour. But how do we identify what they need and what to prioritise? How do we intervene and provide the care they need? How do we identify the outcome and impact? How can we keep them safe from harm?

Recent research into ACES (adverse childhood experiences) by the CDC-Kaiser Permanente ACE Study in the 1990s (CDC 1997) and, more recently, by Spratt *et al.* (2019) suggests that there is a direct link between the impact of trauma and maltreatment on children and outcomes in their adult life. This research recognises the importance of identification and early intervention for young people affected by adverse childhood experiences in relation to outcomes in their future.



ACES can be manifested and are incrementally identifiable through the presentation of behaviours of concern. Young people in care can start to develop and demonstrate these issues in the forms of unhealthy coping strategies. This helps explain the pathways that can lead to poor health outcomes in later life. For example, if they lack emotional intelligence they are more prone to act out their emotions, resulting in risky behaviour including aggression and violence, running away, self-harm and suicidal ideation, criminality or the use of substances that block their feelings. These are behaviours that young people who are placed in special care will present with. They require high-end, intensive and holistic interventions from specific qualified and trained staff.

What is Special Care?

Residential and special care, under the care provision system in Ireland, sets out specific intervention plans and strategies that accommodate and take into account the needs of the young people placed in these services. As part of this continuum of care, special care provides the highest level of intervention to those young people in care with the highest level of needs. Special care is the provision of care to young people (12-17 years of age) in a purpose-built secure facility. Young people with severe and complex emotional and behavioural needs and deemed a potential risk to themselves and/or others, are detained under a High Court order. The placement is a short-term intervention to support their return to a community-based placement, usually residential care or, in some circumstances, foster or familial care.

Currently in Ireland there are three special care centres, which at maximum capacity can accommodate 26 young people. Most of these young people have been exposed to significant trauma and abandonment throughout their childhood and adolescent years. Over the last three years in Crannóg Nua Special Care Service young people on average are 15 or 16 years old during their placement in special care. The short-term intervention of three to nine months aims to respond to the trauma or the effects of trauma from the young people's childhood years.

The purpose of special care as an intervention is to respond to a comparatively high threshold of need or risk. This should meet a sufficiently high threshold to justify the deprivation of the child's liberty. The potential benefit or gain of special care can be considered in terms of outcomes. (The term 'outcome' will have relevance later in this chapter.) However, my experience of working with these most vulnerable, at risk and emotionally dysregulated young people is that the interventions in special care provide them with safe and caring experiences that in turn will enable them to grow to progress positively into their future. This is achieved by promoting wellbeing and teaching young people to have hope.

Special Care as an Intervention

'The Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland. HIQA's role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered' (HIQA 2015).

In Ireland the programme of care for young people in special care is legislated for under the Health Care Act 2007, the National Standards (HIQA 2015) and the Special Care Regulations 2018. These documents set out the framework of expectation that young people will be provided with safe care that responds to their individual needs. Since 2018, special care centres in Ireland have been legally defined as 'designated centres'. There is a legal requirement for them to maintain 'registration' that deems them fit for purpose when inspected against the Special Care Regulations. These inspections are carried out by HIQA. There is a full inspection every three years with annual inspections carried out in related to targeted or identified regulations.

The Special Care Regulations comprise 25 regulations encompassing the different areas of the provision of special care that require compliance; and five related to administrative requirements, e.g., annual fees. Each regulation includes specific indicators of compliance. Some of the regulations and evidence-based intervention strategies provided for the young people in special care are:

- positive behaviour support
- risk management
- care practice – operational policies and procedures
- staff training
- programme of care and education
- individual needs
- religion, ethnicity, culture and language.

In all circumstances, the special care centre has a responsibility to provide evidence, including in care records (another regulation), which sets out how young people's records are maintained.

At a high level this framework of the legislation demonstrates how these elements within the care programme is designed to function as an intervention to young people during an extremely difficult period of their life. Under these high-level requirements there are three types of intervention designed and implemented locally within the individual special care centres to directly respond to the individual needs, risk and behaviours of the young people. They are: the placement plan (Welltree model of care and outcomes framework); the placement support plan; and the individual therapeutic plan. In addition, the individual education plan is designed by the school in the special care centre and is specific to the goals of education as per the curriculum provided. However, how education is supported and developed is included in the placement plan.

All these documented interventions provide guidance and direction to staff working with the young people. These plans overlap and complement each other and are co-ordinated to provide a consistency of approach. Staff working to these planned interventions provide consistency, which is key – it reassures young people and ensures that they are responded to in a positive way.

Risk Assessments

These intervention plans are also implemented and safeguarded through risk assessments. These are used daily in staff practice to ensure that staff consider areas of risk associated with elements of the young person's care, including activities, tasks, interactions or intervention responses. The idea is that if these risks are considered and planned for, taking into account the appropriate use of protective factors, the young person will have a better chance of engaging proactively and of having a positive experience. By using the strengths-based approach and completing work regarding their risk-taking behaviour, it is hoped that they will develop the capacity to manage these risks better.

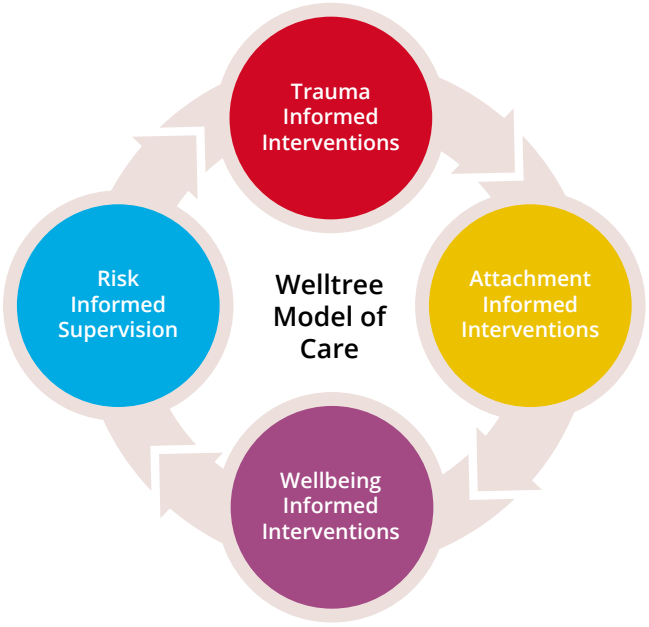
Case Study 1

One example of this is an intervention to support a young person who has a history of absconding from special care. The plan focuses on taking the young person off-site. On the first few occasions there may be safeguards in place, such as visiting different locations that are not known to the young person, introducing them to a specific activity, and ensuring that two staff are accompanying them and going on a weekday, rather than at the weekend. All these measures, it is hoped, will support the young person in having a positive experience and reducing the opportunity for them to abscond. Through review, these safeguards are reduced, and the young person can demonstrate their ability to safely manage their time off-site. These situations are all fluid and based on the circumstances related to the young person at the time.

Although all special care centres implement the intervention plans mentioned, this chapter will focus predominantly on my seventeen years' experience and the approach adopted in Crannóg Nua Special Care Service.

Placement Plan

All young people in special care have an individualised placement plan which includes the goals set out for their time in special care. Since 2018, special care has adopted the Welltree Model of Care. This was developed by Stuart Mulholland, a childcare consultant from Scotland who has worked closely with residential and special care in Ireland to drive and support the implementation of the model. The model is also applied in the UK and internationally. It aims to guide staff in their responses to the wide range of needs and risks presented by traumatised young people who display challenging behaviours that result in harm to themselves or others. The model is underpinned by and advocates adherence to the following principles.



The model focuses on trauma- and attachment-informed interventions being at the forefront of staff's approach to their engagement with the young person and the programme of care provided. This is promoted by the therapeutic alliance created by staff with the young person. This is how staff role model and engage the young people in a healthy and safe attachment to support the therapeutic development of the young person through their sense of physical, emotional and psychological safety. This model also applies a strengths-based approach through promoting the young person's wellbeing by providing knowledge and supporting their skill development.

The Welltree Wellbeing Outcomes Framework

The Welltree Wellbeing Outcomes Framework was developed to support and accompany the Welltree Model of Care. The framework provides a structure for identifying goals related to wellbeing for the young person and how to measure the outcomes achieved. It is based in Ireland on *Better Outcomes, Brighter Future: The National Policy Framework for Children and Young People 2014-2020*. This is a comprehensive statement that sets out how we intend to achieve the best for young people under five national outcomes that include identified aims.

VISION

Our vision is to make Ireland the best small country in the world in which to grow up and raise a family, and where the rights of all children and young people are respected, protected and fulfilled; where their voices are heard and where they are supported to realise their maximum potential now and in the future.

NATIONAL OUTCOMES

- Active & healthy, physical & mental wellbeing
- Achieving full potential in all areas of learning & development
- Safe & protected from harm
- Economic security & opportunity
- Connected, respected & contributing to their world

AIMS:

Children and young people are or have ...

1.1 Physically healthy and make positive health choices	2.1 Learning and developing from birth	3.1 Secure, stable, caring home environment	4.1 Protected from poverty and social exclusion	5.1 Sense of own identity, free from discrimination
1.2 Good mental health	2.2 Social and emotional wellbeing	3.2 Safe from abuse, neglect and exploitation	4.2 Living in child/youth-friendly sustainable communities	5.2 Part of positive networks of friends, family and community
1.3 Positive and respectful approach to relationships and sexual health	2.3 Engaged in learning	3.3 Protected from bullying and discrimination	4.3 Opportunities for ongoing education and training	5.3 Civically engaged, socially and environmentally conscious
1.4 Enjoying play, recreation, sport, arts, culture and nature	2.4 Achieving in education	3.4 Safe from crime and anti-social behaviour	4.4 Pathways to economic participation and independent living	5.4 Aware of rights, responsible and respectful of the law

Children and Young People have a voice and influence in all decisions affecting them

Source: *Department of Children and Youth Affairs, Better Outcomes, Brighter Future Policy Framework*

The Wellbeing Outcomes Framework uses the five domains from the National Outcomes and incorporates the aims within 33 indicators set out in the framework. Hope is an extra domain added to the framework because it has been proved to be of great importance in the development of wellbeing. Encouraging hope for the young person can effectively motivate them to have a positive attitude toward their future. It supports the young person to engage in setting out goals and developing their skill set in trying to achieve them. This concept is equally important for the optimism of staff in how they encourage young people in their placement in special care.

Welltree Wellbeing Outcomes Framework

National Outcomes

Active & healthy, physical & mental wellbeing	**Achieving full potential in all areas of learning & development**	**Safe & Nurtured**	**Economic security & opportunity to develop life skills**	**Connected, respected & contributing to the world**	**Hope**

Placement Plan Sub-Headings

Psychological/ Psychiatric/ Emotional	**Health**	**Activities/ Interests/Hobbies**	**Education/ Training/Work**	**Safety**	**Family Relation-ships/Contact**	**Preparation for Leaving Care**	**Independent Living Skills**	**Individual and Society**	**Social Skills**

Welltree Wellbeing Evaluation Tool

Scoring within this range indicates that the young person is still developing an understanding of the factors that could affect their wellbeing. They occasionally express or demonstrate evidence of wellbeing and require a high level of support.			**Scoring within this range indicates that the young person is consolidating their learning in relation to the factors that could affect their wellbeing. They often express or demonstrate evidence of wellbeing and require a moderate level of support.**		**Scoring within this range indicates that the young person is flourishing in terms of their wellbeing. They have achieved a good understanding of the factors that could affect their wellbeing, consistently express or demonstrate evidence of wellbeing and require a low level of support.**	
0	**1**	**2**	**3**	**4**	**5**	**6**

On admission, at the SCOAP (special care order application preparation) meeting, the baseline score for the young person under each outcome domain is identified. This is completed by the input of all professionals and the referral information provided. The placement plan is then designed, taking into account the priority of needs based under the domains of the outcomes framework.

In most circumstances, young people are on admission in the low developing stage in the Welltree outcomes framework. For young people to meet the criteria for special care there must be a risk to themselves or others, which is captured under the domains of 'active & healthy, physical & mental wellbeing' and/or 'safe & nurtured'. Therefore, during their placement in special care, it is these domains that we want to see an increase in, as this demonstrates that the young person is ready to move on from the security/detention of the special care service. The aim is that the young person's score has increased and in the 'consolidating stage', creating the opportunity for this progress and motivation to be continued in their placement in the community. This is achieved by engaging the young person in their placement plan goals and reviewing the outcomes of the plan.

How we engage the young person

Implementing the model has encouraged the centre to consider and plan for how we provide the principles set out in the model and framework. Staff have all received training so that we have a shared understanding of the language and goals and aims of the intervention; and so that we are educated on the effects of trauma and attachment. From admission, there is a shared understanding of the risks that have resulted in the young person being placed in special care, the requirement of the trauma- and attachment-informed interventions, and a clear plan for improving the young person's wellbeing. Staff are supported to understand how their relationships and interactions with the young person provide a therapeutic alliance. This is achieved by recognising why we intervene with the young person.

Young people with past experiences of trauma and attachment can be mistrustful in their interactions with staff and will act out their feelings. Therefore, staff need to provide consistent and safe responses that allow young people to feel cared for. Utilising risk management strategies alongside a strengths-based approach facilitates staff to provide multiple opportunities in the life space for young people to exercise choice, develop skills and achieve their potential. This is balanced against how the young person's wellbeing can be promoted in a careful assessment by staff. This helps to ensure that considerations of risk are weighed against the effects this may have on the short-, medium- and longer-term wellbeing of the young person. This is communicated to the young person to ensure that they develop the capacity to manage risk and promote their own wellbeing when they leave the special care environment. Carrying out this complex and extremely sensitive work demonstrates the skilled role social care staff have in using a relational and strengths-based approach to respond to the young people's high levels of risk and wellbeing needs.

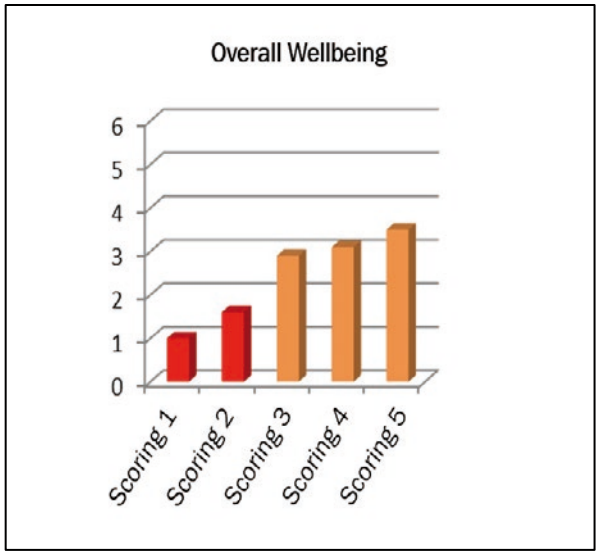
From admission, the young people are encouraged to be actively involved in their programme of care. The model also recognises the participation of key stakeholders in the young people's life, including family, social workers and other professionals, and how the integration of interventions will provide positive outcomes and support to the young person in their participation. The placement plan incorporates a holistic action plan to support the goals set out. There is careful consideration given to how young people are encouraged to achieve their placement goals. This could be through daily routine, creative ways for key-working or individual work, and behaviour management plans. The key workers meet with the young person monthly and identify with them the areas that they are going to focus on for the coming month. The key workers then also build structured individual work sessions into the young person's weekly plan for them to complete.

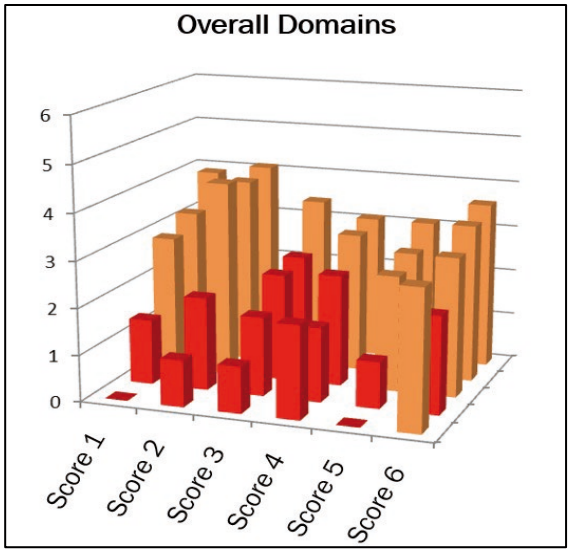
How do we evaluate and review?

At the end of each month, related to the placement plan, the keyworkers review the evidence of work completed by the young person in relation to the indicators set out. This is not solely restricted to the individual work, but all evidence of how the young person has managed in that aspect of care. For example, the goal may be related to the indicator 'learning & development' – *The young person understands the importance of education or training and demonstrates this through positive behaviour and attitude.* The evidence may be that the young person has engaged in structured individual work regarding the importance of attending school and demonstrates this understanding by having improved attendance at school as part of the programme. The following table is an example of the evidence for a score of 2, 'under-achieving full potential in all areas of learning & development'.

Achieving full potential in all areas of learning & development SCORE 2		
Reason for indicators chosen: A. Mary's educational attendance has historically been inconsistent and can often require support within Crannóg Nua B. Mary appears to manage her behaviour better when she is kept active and channels her energy in a positive way.		
2(a) The young person understands the importance of education or training and demonstrates this through their positive attitudes and behaviour		
Action needed	**Identified person required**	**Status**
• The staff team will continue to follow Mary's placement support plan, in relation to supporting her attendance in Crannóg Nua special care school. • Complete individual work (1) on the importance of education and future education goals.	Staff team	Action in progress
2(b) The young person understands the importance of hobbies/activities and demonstrates this through their positive attitudes and behaviour		
Action needed	**Identified person required**	**Status**
• Mary's assigned staff will continue to complete a daily plan with her. This will include identified pro-social activities, both on and off site – in keeping with her placement support plan. • Complete individual work (1) on interests/hobbies and the benefit of participating in these within the community. This individual work is to be related to transition visits with onward placement and the importance of positive engagement in these, prior to transitioning back to their centre.	Staff Team	Action in progress

The scoring is completed and reviewed by the multi-disciplinary team, based on the evidence provided. The framework adopts a strengths-based approach and it can be difficult to apply in practice, but we encourage the professional team not to draw on the negative behaviours. However, the framework does also avoid this by looking at how much of the time the young person has been successful in demonstrating the behaviour. The framework has also supported changing the perspective from how many significant events has the young person has: the approach now supports and recognises how the young person has engaged positively outside these periods and also how they have managed or responded when a significant event has occurred. The graphs demonstrate how the interventions implemented within special care are successful in improving these young people's wellbeing. There is a conscious effort to set out achievable goals to encourage the young people's participation and motivation to engage them and for them to be proactive in their overall placement plan. The scores of the outcomes are then included in graphs, which provide a visual aid in representing the improvements in the young person's wellbeing. If the young person is having difficulty, the scoring allows for a re-focus of the goals required and also for the multi-disciplinary team to review the cause of the deterioration.





Staff actively encourage young people to participate in their scoring to develop an understanding of what supports them in their progression towards their placement goals. What has also been highly beneficial is where the placement that the young person has come from, or is going to, uses the Welltree Model of Care. Previously, when the scoring was completed on admission of a young person, the score was in line with the scores of the residential placement. This also means that the goals can be set out and adapted to promote joint working between the services and support the transition for the young person back to their placement. The scores also provide feedback to the special care centre regarding the overall progress in each of the domains. It allows for analysis of how the special care unit is doing with regard to improving the overall wellbeing of the young people and also the individual domains. This is something which has not been available in the past in relation to providing data on the outcomes from the interventions provided in special care.

TASK 1

What does wellbeing mean to you? How have you promoted your own wellbeing? How has it been promoted by individuals in a social care setting where you have worked? What intervention plans support this?

Individual Therapeutic Plan

On admission to special care the therapeutic rationale of the placement is considered and agreed by the multi-disciplinary team. This takes into account the therapeutic needs of the young person based on their presenting risks and previous trauma. Each special care unit has an in-reach ACTS (Assessment Consultation Therapy Service) team. These are made up of multi-disciplinary clinicians including psychology, speech and language, social work and substance misuse. On admission, the identified ACTS clinicians will complete the AIM 40 from the Ambit Model which assists them in identifying the priority of therapeutic needs.

AMBIT is a whole-team approach designed for services who work with young people/service users presenting with multiple interacting problems where complexity is a feature. AMBIT was developed with a focus on those characterised as 'hard to reach' and for whom help seeking or using conventional forms of help can be particularly challenging. AMBIT offers a theoretical framework, specific tools and ways of working and is based on the core theory of mentalisation as a core concept of team working. It aims to address a wide range of aspects of the child's/family's life as opposed to focusing on a single target problem and there is a strong emphasis on goal setting, team working and local expertise, thus building on the expertise, knowledge and strengths of the existing team.

'Aim 40' is used to plan and sequence the intervention for the period of special care, to assist the team in gathering information from all the multi-disciplinary team involved and the young person to ascertain what they believe to be the key problems. It involves 40 questions which look at areas from daily living skills to clinical need. Typically, these young people/families are enmeshed in multiple services with multiple professionals involved and can be working towards different individual goals. The objective of 'aim 40' is to create alignment among the network of clinicians about the key problems and to focus the intervention with the young person on working towards agreed goals. This information informs the development of the individual therapeutic plan (ITP) for the young person. It will take into account any diagnosis, learning or mental health needs and effects of trauma that needs to be addressed. The ACTS team will work with the young person, their family, the staff team in special care and their identified onward placement as part of the AMBIT model that they implement. The ACTS psychologist or clinical team manager may also liaise with the community-based psychiatrist if the young person has significant mental health needs or is prescribed medication related to mental health. The ACTS team engages the young people with, for example, self-regulation, responding to self-harm and suicidal ideation, family work, speech and language/processing needs, responding to diagnoses such as ADHD/ADD/ASD and life story work. The ACTS team may also complete assessments based on the needs of or concerns for the young person.

How we engage the young person

As with all intervention plans multi-disciplinary engagement is critical if we are to achieve positive outcomes for the young person. This is ensured by having multi-disciplinary participation in all meetings pertaining to the young person's programme of care. Although ACTS retain ownership of the ITP, the other professional groups, including the staff team in the centre, can support how the young person is engaged to achieve the goals set out for them. For many reasons young people can struggle to engage with this therapeutic plan. This can be due to fear, stigma, not thinking there is something wrong with them, the formality of therapy and maintaining self-control. However, there are ways that this process can be assisted and supported for positive outcomes.

On admission to special care, it is crucial that there is a there is a culture promoting the benefits of the young person engaging in their therapeutic plan. Although young people should never be forced into therapy, it should have a similar weight of importance as education. When staff actively promote their therapeutic plan, it can be influential for the young person. This is certainly enhanced when the staff team have a positive and proactive working relationship with the ACTS team.

Young people in special care will generally have high levels of anxiety as a result of their adverse childhood experiences and in dealing with the whole process of the admission to special care. As part of this, young people are educated and informed regarding the role of ACTS through individual work and information captured in the young person's (information booklet) statement of purpose. Where a one-to-one session for the young person and their ACTS clinician is required, staff incorporate this into the young person's weekly plan so that they are aware when it is happening. The time of the day, where the meeting will happen and a fun activity after the session, are all considered to support the session. On occasion, if appropriate and requested by the young person, staff can remain with them as support. Staff can really demonstrate skill in supporting the most reluctant young people to attend these sessions – again, relationships and trust are key.

To further support the engagement of the young person in their ITP there are regular interactions between ACTS and the staff team. This can also help in circumstances where the young person won't engage directly with the ACTS clinicians. Staff may complete information required for assessments or complete planned individual work that supports the therapeutic goals, for example the 'Reduce the Use' programme for substance misuse, or self-regulation techniques for self-harm.

How do we evaluate and review?

The ITP is reviewed by ACTS every month. A representative attends the young person's child in care review or multi-disciplinary team meeting to provide feedback and support the update of the care plan. There is also an ACTS meeting every fortnight with staff and management to review the aims and progress of the ITP. Where difficulties have arisen, possibly relating to the young person's engagement or an escalation of behaviour, alternative strategies can be considered. There are also regular focused meetings between ACTS clinicians, the unit case manager and key workers. The ACTS team also attend staff meetings to provide information on how to support the young person. This is another example of the joint approach in responding to therapeutic needs.

Finally, ACTS complete workshops relating to the individual young people at intervals throughout their placement. They provide therapeutic support and understanding to the staff in relation to the young person's trauma/attachment and presentation of behaviours. They review the frequency of behaviours and also how to address and support risk management strategies on discharge. When the young person has an identified onward placement, the emphasis and priority is on a collaborative approach. Where appropriate the ACTS team support the young person and the team in the onward placement to support them managing successfully in the community.

1

Individual Work
This is direct work completed by staff with the young person. It is goal-oriented and documented and recorded as part of the programme of care. It can be planned as part of placement plan goals or can be opportunity led.

2

Emotional Intelligence
'If you are tuned out of your own emotions, you will be poor at reading them in other people' Goleman 2011).

Placement Support Plan

The placement support plan (PSP) is the document that sets out the behaviour management interventions for the young person in the context of therapeutic security. This is necessary because young people placed in special care demonstrate a range of extremely challenging behaviours that cannot be safely managed in the community. They might include substance misuse, exploitation, absconding behaviours, violence and aggression, self-harm, allegations of abuse and seeking medical treatment. There is a significant complexity in the behaviours presented by young people in special care and the needs that these behaviours meet. This is particularly challenging for staff when young people are placed together in special care units.

At an organisational level there are provisions relating to the application of therapeutic security principles in special care that support the daily implementation of positive behaviour support and behaviour management. The centres incorporate a number of safety features, including, among others, secure doors and windows, locked internal doors, CCTV, personal alarms for staff, and identified safe rooms. The centre is designed to be able to respond to significant high-end behaviour to support both staff and young people to be safe. As a balance to this focus on safety, the environment is decorated to provide a homely and warm feeling so that young people feel welcomed and comfortable. The young people are encouraged to participate in creating the décor of the centre, including how they decorate their own rooms.

In relation to staffing, there is a least a 1:1 staff to young person ratio, staff working night shifts, and all staff are trained in TCI (therapeutic crisis intervention). A significant part of this training is that staff are trained to physically restrain the young person if considered necessary to protect the young person from harming themselves. De-escalation techniques are the principal method employed by staff to assist the young person to regulate their behaviours. These are reviewed regularly by both internal and external professionals to ensure that practice is adhered to and developed in a manner that safeguards the young person's wellbeing. The optimum outcome of this training is that staff are confident to respond to challenging behaviour and the young people feel safe and secure. It also supports an understanding of the indicators of escalation in challenging behaviour to ensure that interventions are put in place earlier and with low-level responses that enhance the young person's own self-regulation. The PSP outlines how the young person can respond and react in times of difficulty. The intervention plan identifies the challenging behaviour that the young person may engage in, signs of triggering and/or escalation and the incremental stages of responses and de-escalation methods that can be implemented within the special care environment.

How we engage the young person

On admission, significant individual work is carried out with the young person. This includes their understanding of the rationale for their placement in special care, the expectations and routines of the centre and how they will be supported to manage their challenging behaviour. Staff work exceptionally hard and can develop relationships in a really quick time period. These relationships underpin how staff can support the young people to feel safe and secure and in turn promote appropriate coping mechanisms. Staff utilise all opportunities outside crisis cycles to proactively engage the young people in their wellbeing. This includes promoting good sleep hygiene and routine, attending school, eating a healthy diet, keeping physically active and having fun, all of which can reduce incidents and support the development of appropriate coping mechanisms.

Young people are made aware that they have a PSP. The aim of this intervention plan is to provide direction in how to respond to and manage challenging behaviour displayed by the young person. Where appropriate, the young person is supported to engage in developing or updating their PSP. The plans are all unique to each individual's needs, risks and cognitive ability. Many young people in special care have speech and language and/or language processing needs. This can mean that when they are emotionally heightened they are less likely to be able to communicate effectively or respond to verbal prompts or commands from staff.

As part of their placement plan, the at-risk behaviours that led to the young person being admitted to special care is a strong feature of the structured key working or individual work carried out by staff with the young person. This is an opportunity to discuss these issues in a planned and safe way when the young person is at baseline. It can also support engaging the young person around de-escalation techniques and self-regulation skills. An example of this is where occupational therapy guidance has been provided regarding their sensory issues. It can also include encouraging the young person to use sensory tools such as fidgets or soft balls to self-regulate instead of possibly resorting to self-harm.

One of the most significant parts of how we engage the young person in their intervention plan is conducting an LSI (life space interview) after an incident. This is part of the TCI model. It is a structured discussion with the young person after a significant event. It explores what happened, tries to identify the trigger, links the feelings to the behaviour and tries to consider alternative behaviour management strategies for the future. This empathic and relational approach allows the young person to address and reflect on their perspective of the incident and be supported by staff to explore alternative coping mechanisms for the future. It may also provide staff with learning or information, including possible triggers and/or responses that can be updated in the PSP.

How do we evaluate and review?

The evolution and development of special care has led to greater sophistication in how we review behaviour management and promote positive behaviour support. In my experience this is an area that has developed significantly and has benefited from reviewing systems that ensure best practice and positive outcomes. It is imperative that risk assessments, positive behaviour support and behaviour management remain live and are updated and reviewed as required. Staff in their practice are trained and guided in their responses to challenging behaviour. They are also prompted to take learning from each significant event and amend or update the PSP as required.

There are robust incremental reviewing systems within the service which feed into the PSP for the young person to support their individual needs. When an incident has occurred, the staff completing the significant event report will consider and include any learning or possible updates required for the PSP based on the event. This will also include anything pertinent raised by the young person in the LSI. The staff may also complete a shift review to discuss how the shift/incident was managed and this can also provide feedback or follow-up. The deputy social care manager will then review the significant event document and a 'manager review & response' form will be completed by the social care manager. This ensures that the PSP was followed in line with policies and procedures.

On some occasions there may be a response meeting following a significant event. This consists of the management team, social care leaders and some staff. The meeting reviews what has occurred and what is the response plan. Following the meeting, changes to the PSP may be required. A debrief meeting may be provided for the staff involved in the incident. This is usually facilitated by the person in charge or a manager to provide emotional support to the staff member by letting them discuss the incident in a structured and protected forum. It allows staff to gain clarity or discuss the actions or decisions made during the incident. It is also generally very productive in providing further learning and reflective practice.

In addition, there are higher-level reviews. A monthly centre SERG (significant event review group) is attended by a Tusla National Training Lead, a Welltree consultant and a health & safety representative. The centre's management team, including the director and PIC (person in charge), staff and ACTS attend. The previous month's significant events are reviewed based on level of restrictive practice used, a pattern or theme emerging, or on consideration of challenges or concerns in relation to the significant event. The group then review the incident or patterns of incidents. Not only is learning achieved, but there is also a recognition of the good practice that has been achieved. This forum is extremely effective and has been pivotal in supporting and responding to the challenges of significant events and high-risk behaviour in the centre. At national level, a SENRG (Significant Event National Review Group) is made up of representatives of senior management from each special care centre. High-end themes are reviewed and addressed at this meeting.

In the centre, in addition to the focused review of significant events, trend analysis is completed. This looks at the statistics related to the data on incidents and behaviours presented. Each month, quarter and year there is a review to provide information on the rationale or antecedents to behaviour and to identify where high-end service-level responses or strategies are required.

All of these reviewing mechanisms and reflective practice support the development and implementation of the intervention plan to promote positive outcomes. In special care, this top-level governance is required to ensure that the most appropriate and safest response is applied to the behaviour that occurs. Constant reflection and learning supports the young person's participation in the intervention plan. This is achieved through the consistent and competent actions of the staff in the form of trauma-/attachment-informed responses that promote wellbeing.

TASK 2

Using the ICMP (Individual Crisis Management Plan) template from TCI (Therapeutic Crisis Intervention), develop an intervention strategy for a service user in your placement.

Conclusion

Special care is one of the highest-end interventions that can be provided to a young person in the care system in Ireland. As outlined above, there are influential factors involved in how individual interventions are implemented and how young people are supported to have positive outcomes. The plans should all complement and work cohesively together to support the overall care plan of the young person so that they successfully step down from special care. In addition to the evidence and information provided, in my experience there are other elements that can be provided within the service to enhance the successful delivery of individual interventions.

In the first instance, the centre needs to be creative in how it reviews and maintains motivation in implementing the plans. Part of this is recognising how to engage the young people in the environment. In Crannóg Nua there is always consideration given to the environment, taking into account both the requirements of the intervention of special care, including safety and security, and also the need for the environment to be comfortable and inviting for the young people. This ensures that the centre is both safe and able to support responses to challenging behaviour and also a space that is pleasant and homely for young people so that they engage positively in the therapeutic programme.

After the centre re-opened as a special care service in 2017 it was evident that the building's acoustics were not supporting a trauma-informed approach. There were concerns regarding how the noise travelled and the effect of this on the young people, with doors banging, people shouting or talking and general echoes. Sound boards were installed, and the impact was immediate. There is now a pro-active approach to review how the environment can be developed to respond to the sensory needs of the young people to support their engagement in the intervention plans. Examples are using colour, creating texture and managing light with curtains, having different surfaces to sit on (sturdy couches, beanbags), taking account of the purpose of rooms, having blackboards to write on instead of graffiti and use of diffusers or air fresheners to scent the rooms. There is significant consideration given to making the young person's bedroom feel safe, comfortable and individual to their taste. These developments demonstrate to the young people that their needs and wishes are taken into account, which really helps to develop the relationship and therapeutic alliance.

The fulcrum of the service is the staff team. Interventions will only be as successful as the team that is working with them. The team need to be supported to become confident in implementing intervention plans. They need recognition and understanding to process the challenges in the special care environment. There should be a culture and drive to 'do better' and use reflective practice in all aspects of the care provided. This also includes staff accountability and places an emphasis on professional development. The leadership and culture of the centre will guide how this is received and achieved by the staff team.

The implementation of these interventions in special care supports the young person to progress within their programme of care. In the short term the outcomes for the young person can be measured, depending on how they progressed within special care and the placement that they stepped down to. However, there is currently no data or research on the outcomes for young people post-discharge from special care. Other than the contact that staff may maintain with the young people or information provided to staff or professionals, the young person's outcomes are unknown. This research and data would be very beneficial to support the ongoing development of the programme of care based on outcomes or feedback from the young people. In the absence of that, the best outcome or measure comes in providing the young people with what they feel is a positive period and opportunity of their life that they were kept safe and care for. And that there was **hope**.

Tips for Practice Educators

Special care is a unique environment that can provide a student on placement with a wealth of knowledge and experience. To support this, they need to be active and engaged in their approach and armed with the relevant information on the service prior to the placement

Beginning of placement: Ask the student to review a programme of care for a young person they are working with in the placement. While upholding confidentiality and data protection, ask them to identify the intervention goals set out in the intervention plans.

Middle of placement: This is the time for the student to immerse themselves in the progression of the intervention plans and understand how they are implemented, evaluated and reviewed. This will be supported by:

- Meeting with the identified key team and case manager and agree some individual work in line with Welltree outcomes framework goals that the student can complete with the young person in the company of a staff member.
- Attend key training provided in the centre, if available. This may include behaviour management, including TCI, and Welltree.

- Using the outcomes framework, complete a scoring for a young person with a key worker and young person, if appropriate.
- Attend a staff meeting, ACTS meeting and SERG to see how intervention plans are evaluated and reviewed.
- Attend a child in care review if appropriate. This will give the experience of multi-disciplinary working and how the full programme of care is reviewed to update the care plan.

End of Placement: Ask the student to identify any other evidence of practice by the staff, the programme or environmentally that supports the young people's responses to the interventions.

References

Anna Freud National Centre for Children and Families (2020) *Online AMBIT Manual*. Available at <https://manuals.annafreud.org/ambit/index.html> [accessed 24 June 2021].

CDC (Centers for Disease Control and Prevention) (1997) *CDC-Kaiser Permanente ACE Study*. Available at <https://www.cdc.gov/violenceprevention/aces/about.html> [accessed 24 June 2021].

Goleman, D. (2011) 'Emotional intelligence', interview with Daniel Goleman on Leadership and the Power of Emotional Intelligence, *Forbes*, 15 September. Available at <https://www.forbes.com/sites/danschawbel/2011/09/15/daniel-goleman-on-leadership-and-the-power-of-emotional-intelligence/?sh=7b3de5d76d2f> [accessed 24 June 2021].

HIQA (Health Information and Quality Authority) (2015) *National Standards for Special Care Units*. Available from <https://www.hiqa.ie/reports-and-publications/standard/national-standards-special-care-units> [accessed 24 June 2021].

Office of the Attorney General (2017), S.I. No. 634/2017 – Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017. Available at <http://www.irishstatutebook.ie/eli/2017/si/634/made/en/print> [accessed 24 June 2021].

Spratt, T., Devaney, J. and Frederick, J. (2019), 'Adverse childhood experiences: Beyond signs of safety; reimagining the organisation and practice of social work with children and families', *British Journal of Social Work* 49(8). Available at <https://academic.oup.com/bjsw/article/49/8/2042/5372389>.

Welltree (2020) *Developing the Welltree Model of Care*. Available at <https://socialcareireland.ie/wp-content/uploads/2020/11/Presentation-Social-Care-Ireland-2020-Copy.pdf> [accessed 24 June 2021].

Chapter 49 – Sheena O'Neill and Caroline Costello

Domain 3 Standard of Proficiency 9

Understand the need to monitor, evaluate and/or audit the quality of practice and be able to critically evaluate one's own practice against evidence-based standards and implement improvements based on the findings of these audits and reviews.

KEY TERMS

Quality of practice
Evidence-based standards
Monitoring and evaluation
Implementation

Social care is … safe, effective, individualised and person-centred support to vulnerable and marginalised people to enhance their quality of life.

Quality of Practice

Social care practice is dynamic, multidimensional and complex work. Social care workers are professional practitioners trained to provide safe, effective, individualised and person-centred support to vulnerable and marginalised people (SCI website) to enhance their quality of life. This support may be delivered over the short or long term. People who use social care services are entitled to high quality and purposeful care that meets the individual needs of the person (SCI website). This requires safe services and safe practices that take a person-centred approach to service provision while utilising best-practice approaches to provide quality care to people using services.

When we speak about best practice, it is sometimes assumed to be a commonly understood term, but, as we know, assumption of understanding can be dangerous. Best practice should not be considered as something we inherently know/understand but practice that has been developed from past failing, from knowledge (either evidence-informed or evidence-based) or from participatory approaches in care development.

In considering quality of practice, we must first have a clear understanding of the standards pertaining to our own practice. There are several stakeholders in the professional practice of social care, all with a multitude of roles and responsibilities. These stakeholders include: service users; social care workers; CORU; regulatory bodies; governance structures; and funding bodies. To ensure quality of practice it is important to consider each stakeholder's participation:

Figure 1 Definition of quality in the Irish healthcare system (HSE 2016)

- **Service user/person we support:** The service user/person we support is the most important stakeholder and must be supported/facilitated by using appropriate models of participation and be given the opportunity to have an input into relevant reports, for example programme planning and HIQA audits. It is important to ask ourselves, if we never ask someone about their experience of receiving a support service, how will we know if it is right for them? If persons providing support become familiar in their social care role or 'know' what needs to be done, it can be easy to stop asking and start assuming. The service user has as much of an essential role in ensuring quality of practice as the person who uses the service. Each person using a service has a right to reliability, transparency and consistency, both in service delivery and practice approach, where their own responsibility is defined, as well as all parties involved in their support. This reinforces working in partnership and enables monitoring and evaluation to be a shared process. Working in partnership is critical to enabling and supporting the service user to be a participant in all parts of their plan of support, including monitoring and evaluation of quality of practice. The service user's voice is vitally important as they will experience how the social care worker carries out their work, and they are directly impacted by it. It is critical that the service user's voice and their feedback are captured.
- **Social care workers:** Social care workers must be guided by organisational and national policy and national legislation. They are bound by CORU's Social Care Workers' Registration Board Code of Professional Conduct and Ethics and must register with the professional body. Policies and procedures set out what is expected of the worker and provide guidelines to follow to ensure safe, equitable, consistent, and quality practice. Examples of policies that guide practitioner practice include child protection, safeguarding vulnerable adults, policy and procedure, behaviour management, risk management, General Data Protection Regulation (GDPR), and health and Safety policy.
- **Funding bodies:** In Ireland social care provision is delivered through statutory bodies such as the Health Service Executive (HSE); Tusla, the Child and Family Agency; community and voluntary services such as youth services or family support projects; and private companies that run residential facilities for people of all ages. Where government funding is provided to non-statutory organisations there is a requirement to engage with providers via a memorandum of understanding (MOU) or service-level agreements. These funding agreements are built upon compliance with organisational and national policy, along with national legislation. Each of these policies is supported by evidence-based research and seeks to enhance public safety.

- **Governance/regulatory bodies:** These authority structures are established to verify that policies and processes are supported by evidence-based research and will enhance public safety. An example of this is CORU, Ireland's multi-profession health regulator. CORU's role is to 'protect the public through regulating the health and social care professions listed in the Health and Social Care Professionals Act 2005 (as amended)' (CORU website). CORU has a responsibility to safeguard the service user.

Evidenced-based Practice

Social care workers use evidence-based practice tools to enhance their practice. The Sicily Statement on Evidence-Based Practice (EVP) provides a commonly accepted definition: 'Evidence-Based Practice requires that decisions about health care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources' (Leen *et al.* 2014). Evidence-based practices are supported by research and apply social care values and ethics to practice, and the processes prepare students to think critically about their approach to their work (Parrish 2018). These approaches have been validified through research carried out in the health and social care fields. Using an evidence-based approach in social care, such as the task-centred approach/crisis intervention/ person-centred approach (Lishman 2015), facilitates a clear pathway for working with people who use services. Evidence-based approaches provide a strategic and purposeful way of working to include areas such as assessment, planning and implementing a programme of care for service users. These clear planning pathways lead to monitoring and evaluation of work being delivered, the achievement of goals/ outcomes/plans, as well as the quality of practice of the social care worker.

Using evidence-based practice approaches gives transparency, accountability and responsibility to all stakeholders in the person's plan of care and support. Additionally, it emphasises the need to evaluate the approaches used by the practitioner as well as the outcomes of the person at the centre of the care work (Parrish 2018). Stakeholders involved may include the person, family member, guardian, next of kin, social care worker, member of multidisciplinary team and the regulatory body (CORU).

Framing the Evidence

The *Framework for Improving Quality in Our Health Service* (HSE 2016) shares six drivers for quality improvement in health and social care services, and points to organisational culture as being critical to continuous quality improvement (HSE 2020). Positive organisational cultures enhance positive outcomes (Braithwaite *et al.* 2017). The social care worker has influence is all aspects of the quality improvement framework, as can be seen in the following examples (HSE 2016):

1. Leadership for quality: This requires committing to leadership strategies, and to seeking support and supervision for social care leaders. Within all levels in organisations there must be a common goal to seek to provide quality services. A meaningful focus on creating a positive culture within the organisation is essential. Mission statements and organisational values should not merely be something within a strategic plan, rather they should be embodied by all members of staff.

2. Person and family engagement: This involves the service user and, where appropriate, family members in all aspects of person-centred care. Services must encourage, promote and develop strategies for participation, for example facilitating an appropriate and inclusive communication strategy. Advocacy groups play a vital role representing the interests of service users. Examples of advocacy groups include EPIC, an organisation that engages 'with and for children and young adults who are currently in care or who have experience of being in care. This includes those in residential care, foster care, relative care, hostel, high support and special care units or facilities' (EPIC website). Sage Advocacy is a support and advocacy service for vulnerable adults, older people and healthcare patients.

When we speak about involving people in their care, we must demonstrate how this is facilitated. This may be achieved through a service user participation tool that is appropriate to the individual. It is equally essential to ensure that participation is meaningful. In youth work, the Lundy model of participation is used. This is a 'rights-based model which conceptualises Article 12 by showing what is needed to make young people's participation in decision-making meaningful for the young person' (Byrne & Seebach 2015: 10).

3. Staff engagement: It is essential that practitioners participate in all staff engagement strategies such as supervision, decision-making/problem-solving, continuous professional development and positive mental wellbeing. Once again, we must consider what this will look like in practice. It is of little benefit for staff to engage in, and supervisors to conduct, performance management and development interviews if they are meaningless. For example, if a staff team request training they feel will enhance the quality of practice, and the manager agrees to provide it, but the training is not provided, or staff rostering does not facilitate staff attending the training, then this engagement is meaningless. Communities of practice are an important structure for social care sectors as they encourage peer support networks and sharing of good practice.

4. Use of improvement methods: Examples include plan/do/study/act (PDSA), SMART goals (specific, measurable, attainable, realistic and theoretically sound (evidence-based) or timed), the improvement method, and Lean Six Sigma. 'Building measurement into all improvement initiatives is essential so that we know when improvements have occurred and when they have not' (HSE 2016). It is essential that all steps in planning improvement measures are clearly captured/recorded, that timescales are established, and clear roles (who does what) are set out. It is essential to build in monitoring and evaluation strategies so that achievement can be measured, and changes made in a timely fashion where required. In addition, what is learned should be shared across the staff teams and any identified improvements implemented in a timely fashion.

5. Measurement for quality: It is essential to collect and store relevant data, such as records, when working with service users to measure quality and progress; for example, the service user's experience and achievement of all outcomes. This can, for example, be monitored at regular intervals throughout the implementation of a plan and evaluated at its conclusion. This data will inform improvements at a point in time and/or moving forward in your practice. The data gathered should be data that is purposeful, and in line with the requirements of the organisation. The burden of additional staff workloads will only be embraced by staff where the measurements are seen as more than a tick box exercise, and there is a clear focus for improved outcomes. Plans/work practices must include clear measurement strategies: if we do not have clear indicators to measure quality of care, how will we know if this has been achieved?

6. Governance for quality: Social care workers ensure that they work in line with policies and procedures to ensure that their work is safe, effective and person-centred, and that they are accountable. Remember, policies and procedures are living documents and can always be developed and refined to ensure that the quality of care and the safety of all stakeholders is enshrined.

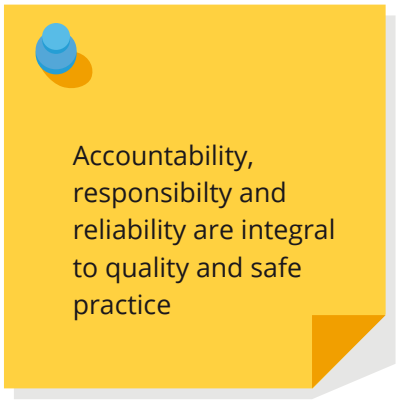
Social care workers play a key role in designing programmes of support and care that are individual to the needs of the person using their particular service, e.g., a support plan for a person with a mental health difficulty or intellectual disability, a risk management plan for an older person, an education/employment plan for a young person, after-care planning for a young person leaving care.

How a social care worker carries out their work has huge significance in the development, experience and outcomes of the service user. Work carried out with service users should have clear **purpose** and **process** to determine the best course of action for outcome achievement. It is important to set clear aims and objectives so that the service user is clearly understands what the expectation is and why.

In our experience many of the pieces of work facilitated by social care workers are not apparent to a non-professional observer. For example, the relationship-building component of engaging with a service user is the foundation to identifying the service user's support needs. Sometimes this relationship building may begin with a cup of tea, but this is only the first step in a clear process with an identified purpose as the end goal. What is unseen is the assessment that is being undertaken by the social care practitioner and the building of a relationship that is necessary to facilitate the enhancement of quality of life. If our focus and role as social care workers is not clear, it causes confusion for all stakeholders. 'Knowing as we go' in social care is unlikely to be purposeful and could create a dependency for sustained support among service users and families. Part of professional practice is to be transparent in terms of what practice is being undertaken and why. In this way it is important to follow the social care process to build the helping relationship using models such as the ASPIRE (assessment, planning, intervention, review and evaluation) model (Sutton 2006).

Monitoring and Evaluation

Best practice identifies that social care work must be delivered in collaboration with the service user, as their voice and wants are an integral part of the process. Assumption of a 'quality practice' being provided is not enough. Research has shown that effective and efficient practice requires monitoring and evaluation. Quality of practice and quality care requires a commitment to quality improvement. The pursuit of quality practice should be for ever evolving as workers strive for excellence. There are many examples of best practice and outcomes achieved with success. Unfortunately, there are also examples of service users' interests and safety not being prioritised, where adequate quality assurance processes were not in place and/or not utilised. This has resulted in wilful or circumstantial neglect/ abuse of service users and where legislation such as whistleblowing and protected disclosures were invoked to remedy these failings.



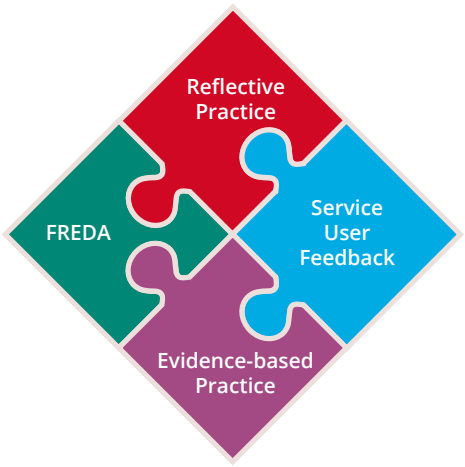
'To audit for quality improvement requires a systematic review and evaluation of current practice against research-based standards with a view to improving clinical care for service users' (HSE 2016).

Monitoring and evaluation are essential components of quality improvement. Their purpose, in the most basic sense, is to seek what works, what does not work, and what improvements can be made for immediate implementation and forward planning. If you consider the quality improvement framework provided earlier, monitoring and evaluation should take place for each individual driver. This process of monitoring and evaluation is central to auditing practice with a view to improving both the service and service user experience (HSE 2016).

'You need to prioritise time to evaluate your own practice, we (as social care workers) can become so focused on the ultimate outcome that we lose sight of all the steps along the journey.' (Lisa, a social care worker in a family and youth support service)

Planning with evaluation in mind helps to develop strategy in a focused and measured way. It also provides clarity to the social care worker's role in supporting the service user, and how they will go about their work. Monitoring promotes corrective action in a timely manner, taking account of what is not working and/or hindering progress. Planning one's own engagement practices throughout the body of social care work is equally essential for continuous professional development. As social care workers we know that our journey of education does not end when we graduate from our programme of study. This is our grounding in theory and application to practice. As a professional practitioner, each social care worker has a responsibility to engage in critical reflective practice to review their own practice and its effectiveness and impact. As we develop as practitioners and in a soon-to-be regulated profession, completing and maintaining a continuing professional development (CPD) portfolio is essential. We need to be available for training appropriate to our role which will enhance the quality of care we provide, as well as our capacity to care. Maintaining our CPD portfolio allows us to reflect on the new knowledge we have gained and enables us to plan how it will be integrated into our professional practice.

Evaluating one's own practice can be considered through a vision of co-production (SCIE 2020). At its core, co-production is a partnership approach to working with service users where the service user has input into all aspects of decision-making. Co-production elicits a collaborative working approach requiring the social care professional and the person using the service working as equals sharing power as they work toward identified goals. Co-production is intrinsic to good-quality practice. It speaks to the 'Nothing about me without me' approach to care. The front-line worker is a tool for change in a service user's life, and their voice should not take precedence. It is important to note that a social care worker's professional tools are not always obvious, so we must use opportunities such as self-care strategies, reflective practice and CPD to reboot and replenish.



We are required as practitioners to frequently monitor and evaluate personal practice; to identify and acknowledge good practice for its continued implementation, and knowledge gaps that have impacted care of the service users so that other resources and/or training and supervision can be sought; and to make timely changes. For quality assurance and a person-centred approach, the FREDA principles of human rights (fairness, respect, equality, dignity and autonomy) can be utilised as a focal point for monitoring and evaluation. The FREDA framework takes a rights-based approach to supporting people (HIQA 2019).

As previously addressed, best practice in social care work is underpinned by evidence-based and evidence-informed practice approaches. While experienced social care workers develop expertise in their roles, which naturally develops confidence, this can result in complacency within the role. Where this occurs, the structure of monitoring and evaluating practice can be under-prioritised and prevents practitioners asking questions such as Why are we doing this? or How could we enhance our practice? It is essential that all social care workers are aware of what is best practice for the sector that they are working in so that they can work in a way that best supports the service user and that is transparent and equitable. This supports consistency among the staff in responding to service user need. Where there is an absence of understanding of evidence-based practice this can lead to difficulty with providing best practice as well as adequate and appropriate service provision to the service user.

TASK 1

Describe an activity that makes you feel good. Write down your role in that activity and any contribution from another person. Now write down how you feel you could make it better.

For example, I really enjoy having a coffee in a fancy café. My role is to walk in, order my coffee and special extras such as a shot of syrup or oat milk. I usually meet a friendly barista who asks what my preferences are and tailors my coffee for me. They have listened to me and then provide this service. Sometimes I feel it may be too sweet and I know it is because I have not communicated my preferences such as a half shot of syrup, etc. The experience would be better if I communicated this preference, but I sometimes forget and would appreciate it if I had a choice about the quantity of the ingredients. I also feel that people are busy and forget to personalise the experience.

Tips for Practice Educators

For students to achieve this standard of proficiency they must have a clear understanding of the importance of critiquing their own practice, and why they should do it. It is important that the student understands the sequential pathway:

- How it is guided
- Whose voice is most important and
- What their role is.

- It is important that the student can see that any plan, intervention or outcome-based activity is not complete without evaluation and will not meet its full potential in the absence of monitoring. Even the best-laid plans, if unaudited, can go wrong.
- Speak to your student about their role in a service user's life. Give them the FREDA human rights framework when they are preparing a piece of work with a service user and ask them to keep it in mind as they progress through any plan they make with a service user.
- Get the student to ask the service user how they feel they could be best supported by them.
- It is important for the student to work with the service user in all aspects of planning and monitoring. Co-production requires effort and investment and marries well with quality practice.
- Discuss co-production with your student as an auditing tool for their practice. The student will be required to demonstrate service user involvement at all planning and delivery points. It is vital that the students can see that their role is not to make decisions for the person, and that to ensure quality they must take a partnership approach.
- Students must show a methodical and evidence-based approach to their work.
- Students must be aware of the standards guiding their practice in the sector they are engaged in. in. Ask your student to research the governing standards of your organisation and get them to identify one theme/standard. Get them to take some time to evaluate the current practice of the organisation and create some recommendations under their identified theme/standard. An example of a governing standard might be from HIQA, HSE or Tusla. This could be used to feed into a team meeting.
- An important question to consider with your student is: Does effective input ultimately lead to effective outcomes? No – the dynamic nature of working with people means that results will not always be as desired. Choosing a practice approach to facilitate growth and achievement is only a part of the work journey for a social care worker; monitoring and evaluating are essential to checking whether the chosen approach is working. In fact, an intervention may produce vastly different outcomes to what has been anticipated. As we cannot always predict how things might go, monitoring and evaluation must be planned and transparent. This too is true for taking responsibility to audit one's own professional practice. It demonstrates professional accountability. A social care worker and service user cannot always anticipate how things will proceed, and adaptation may be required to achieve success or the best possible outcome, in a timely manner.

Bibliography

Braithwaite, J., Herkes, J., Ludlow, K. *et al.* (2017) 'Association between organisational and workplace cultures, and patient outcomes: Systematic review', *BMJ Open* 2017.7: e017708. doi: 10.1136/bmjopen-2017-017708.

Byrne, S. and Seebach, M. (2015) *Youth Participation Policy: A Federal Policy for Whole Organisation Change* [ebook]. Youth Work Ireland. Available at <https://www.youthworkireland.ie/images/uploads/general/Youth_Work_Ireland_Participation_Policy_Fina.pdf> [accessed 1 February 2021].

CORU (website) 'What Is CORU?' <https://www.coru.ie/about-us/what-is-coru/>.

DCYA (Department of Children and Youth Affairs) (2015) *National Strategy on Children and Young People's Participation In Decision-Making 2015-2020.* Available at <https://assets.gov.ie/24462/48a6f98a921446ad85829585389e57de.pdf> [accessed 10 May 2020].

EPIC (Empowering People in Care) (2012) *'My Voice has to be Heard': Research on Outcomes for Young People Leaving Care in North Dublin.* Available at <https://www.epiconline.ie/wp-content/uploads/2020/04/My-Voice-has-to-be-Heard-EPIC-report-1.pdf> [accessed 25 May 2020].

- (website) *About Us.* Available at: <https://www.epiconline.ie/about-epic/> [accessed 22 March 2021].

HIQA (Health Information and Quality Authority) (2012) *National Standards for Safer, Better Healthcare.* Available at: <https://www.hiqa.ie/sites/default/files/2017-01/Safer-Better-Healthcare-Guide.pdf> [accessed 3 May 2020].

- (2019) *Guidance on a Human Rights-Based Approach in Health and Social Care Services.* Available at <https://www.hiqa.ie/sites/default/files/2019-11/Human-Rights-Based-Approach-Guide.PDF> [accessed 4 May 2020].

HSE (Health Service Executive) (2016) *Framework for Improving Quality in Our Health Service.* Available at <https://www.hse.ie/eng/about/who/qid/framework-for-quality-improvement/framework-for-improving-quality-2016.pdf> [accessed 2 May 2020].

- (2020) *By All, With All, For All: A Strategic Approach to Improving Quality 2020-2024.* Available at: https://www.hse.ie/eng/about/who/qid/strategic-plan-2019-2024/strategic-approach-2020-2024.pdf> [accessed 2 May 2020].

Leen, B., Bell, M. and Patricia, M. (2014) *Evidence-based Practice: A Practice Manual* [ebook]. Kilkenny: HSE. Available at <http://hdl.handle.net/10147/317326> [accessed 19 May 2020].

Lishman, J. (2015) *Handbook for Practice Learning in Social Work and Social Care: Knowledge and Theory.* London: Jessica Kingsley Publishers.

Parrish, D. (2018) 'Evidence-based practice: A common definition matters', *Journal of Social Work Education* 54(3): 407-11.

Proctor, E. and Khinduka, S. (2017) 'The pursuit of quality for social work practice: Three generations and counting. *Journal of the Society for Social Work and Research* 8(3): 335-53.

SCI (Social Care Ireland) (website) <https://socialcareireland.ie/> [accessed 2 May 2020].

SCIE (Social Care Institute for Excellence) (2015) *Co-production in Social Care: What it is*. Available at: <https://www.scie.org.uk/publications/guides/guide51/files/guide51-easyread.pdf> [accessed 10 May 2020].

- (2020) *Co-production in Social Care: What it is and how to do it.* Available at <https://www.scie.org.uk/publications/guides/guide51/practice-examples/you-in-mind.asp> [accessed 5 May 2020].

Sutton, C. (2006) *Helping Families with Troubled Children*. Chichester: John Wiley & Sons.

Youth Work Ireland (2015). *Youth Work Participation Policy: A Federal Policy for Whole Organisational Change.* Available at <https://www.youthworkireland.ie/images/uploads/general/Youth_Work_Ireland_Participation_Policy_Fina.pdf> [accessed 10 May 2020]

Chapter 50 – Claire Barry

Domain 3 Standard of Proficiency 10

Be able to recognise important risk factors and implement risk management strategies: be able to make reasoned decisions and/or provide guidance to others to initiate, continue, modify or cease interventions, techniques or courses of action and record decisions and concerns.

KEY TERMS

- Risk factors
- Risk management strategies
- Reasoned decisions
- Recording

Social care is … providing calm and considered interventions to support people.

TASK 1

Reflecting On Practice

As a social care worker (or a student in training), think of a time you supported another person to make a decision that involved an element of risk. How did you weigh up the benefits versus the risk? How did you support that person?

Introduction

Risk factors and risk management strategies are different in different care settings. This chapter is based on my experience as the manager of a day centre providing services to adults who have an intellectual disability.

Risk and risk management is an integral part of our work in human services. Good risk management enables the professional to support the individual, maximise their independence/opportunities whilst ensuring we are providing support to minimise risks. This can be a balancing act and the more complex the risk, the more delicate the balance. Risk can sometimes be subjective, so we benefit from having objective means to measure and evaluate risk. The risk management system supports us in this process.

Consider This

'Risk management … includes a broad range of responses that are often closely linked to the wider process of care planning. The activities may involve preventative, responsive and supportive measures to promote the potential benefits of taking appropriate risks and to reduce the potential negative consequences of risk' (HIQA 2014).

This chapter will use a case study to lead the student through the process of risk management.

To meet this proficiency, the skills of recognising risks, implementing a risk management strategy, making reasoned decisions and recording them is required. These steps are outlined in the diagram on the right. This chapter review these areas, after first discussing positive risk management.

Risk Management

Risk management strategies are all the strategies in place to manage risk. Ultimately, our aim is the best possible outcome for service users. Risk management should not be seen as an additional task outside the remit of a social care worker. Rather, it should be integral to our work. The Health Information and Quality Authority (HIQA), which assesses residential services for adults with an intellectual disability, has published a risk management guidance document to support organisations in their management of risk. This document proposes that managing risk should be seen as a cycle:

> 'The process of **risk management** involves a cycle of identifying risks (risks may be identified from complaints logs, individual risk assessments, incident reporting systems and observation), evaluating their potential consequences and determining the most effective methods of responding to them (i.e., of reducing the chances of them occurring and reducing the impact if they do occur). The cycle is completed by a system of regular monitoring and reporting' (HIQA 2014).

There are several strategies at each stage of this cycle to support the process of risk management. Some of these are specific to risk and managing safety; others are part of our everyday work with the aim of building and delivering high-quality services.

The importance of this proficiency is reflected in *New Directions*, the policy framework that guides the provision of HSE-funded day services. Services assess their competency against a number of themes. Theme 3.1.3 states that day services should ensure that:

> 'Risk assessment and management policies and procedures are in place which enable staff to support people to manage situations where they may be vulnerable. The approach to risk management supports responsible risk taking and informed decision making, as a means to enhancing the quality of life, competence, social skills and independence of people using the service' (HSE 2014).

Positive Risk-Taking

Risk management is intrinsically linked to quality. If we have a good-quality service where the person and their needs are at the centre of what we do, then we naturally support the person with risk-taking in line with their needs and preferences.

> 'HIQA acknowledges that promoting autonomy, and improving quality of life, may sometimes require a degree of risk. People who use health and social care services are entitled to the dignity and personal development associated with risk-taking. A positive approach to risk assessment acknowledges that risk-taking is part of a fulfilled life.
>
> Positive risk assessment considers possible harms, and focuses on individual strengths and collaborating with people to meet their individual needs. HIQA supports positive risk assessment in appropriate settings when person-centred planning and associated necessary safeguards are in place' (HIQA 2014).

Positive risk-taking or positive risk enablement is central to our work. We need to ensure that we are not overly protecting people. It can be very easy to fall into the habit of wrapping people in cotton wool. Part of the social care worker's role is to educate, inform, and advise those we work with. However, sometimes we can *over*-manage risk and try to eliminate it completely. As social care workers, we need to ensure that we give people the opportunity to make their own decisions. Sometimes they may not be the decisions we would choose. It is okay for people to fail and learn from mistakes. This process in turn helps the individual be more informed and be able to make better decisions in the future. This is extremely skilled work. Informed decision-making is very different from abandoning people to their choices. People need to be supported through the process. Social care workers should strive to ensure that each individual is engaging in **informed** decision-making. Sometimes it can be safer or easier to be risk-adverse and not take any risks at all. However, this does not allow for personal growth of the individual or skills/competency development of the staff. Ultimately, positive risk-taking focuses on the benefits to the service user of engaging in the risk. The potential loss to their quality of life is identified and prioritised.

'Positive risk management; persons with disabilities are afforded the "dignity of risk". A step by step approach enables the person to gradually build the skills necessary to take part in different tasks, activities and experiences' (Gadd & Cronin 2018).

Further suggested research into Positive Risk Taking:

- New Directions Interim Standards (HSE 2014)
- Assisted Decision-Making (Capacity) Act (2015)
- Research the 'dignity of risk'
- Supporting People's Autonomy: A Guidance Document (HIQA 2016)

TASK 2

You are key worker to Stephen, a 55-year-old gentleman with Down Syndrome. Stephen walks home after attending the day centre every day. On his way home he calls into the local shop, pops into his sister's house and meets various neighbours along the route. Stephen has just received a diagnosis of early-stage dementia and you are concerned about his safety. You are worried that the risks may be high for Stephen walking home independently, but the rewards and value he places on this activity are also high. You talk to Stephen and he tells you that it is important to him to continue walking home each day.

Question

Where can you record Stephen's comments to ensure they are documented and included in the management of risks?

Answer:

Stephen's opinions are recorded in his Person Centred Plan. Stephen decides he will share this information with his family. Stephen is asked his opinion about supports that will help him – this is also documented.

Risks	Benefits
• Getting lost • Having an accident • Losing his possessions • Being vulnerable	• Exercise, physical health • Social interaction with his sister and with others in the community • Independence/choice • Participating in his community • Having a role as a customer, brother

Making Reasoned Decisions

How a risk is perceived can be very individualistic. Two social care workers could have very different perceptions of risk – both in how they perceive the potential benefits and how they see the risks. As social care workers we require systems to prevent this process being *subjective*. Our systems should ensure our decisions are *objective* and fact-based. In our professional lives we need to have structures and systems to help us weigh up/balance the *risk* and the *reward* in a situation.

TASK 3

Returning to our case study, what additional risks and benefits can you think of?

Answer:

'Effective risk assessment involves communicating with individuals with disabilities and older people about making a judgement on any potential harm and measures to reduce this. Information gathered from the individuals can then inform decisions regarding their care in the light of their particular circumstances. Judgements made should not be influenced by an overly cautious or paternalistic approach to risk. However, potential risks should not be ignored as this may result in negative outcomes.' (HIQA 2014)

As can be seen from the case study, social care workers are required to evaluate information and make reasoned decisions. This decision-making process should be conducted with the service user and using the resources available. A social care worker who can implement decisions in their own professional practice is then in a position to assist, support and guide their colleagues.

TASK 4

If you have not already done so, read the site-specific **Safety Folder, Risk Register and Risk Assessments** for your service.

Recognising Risk Factors

In order to decide what management strategies we will use, we need to be very clear on the risks involved. So what is a risk? The HSA defines a risk as 'the likelihood that a person may be harmed or suffer adverse health effects if exposed to a hazard' (HSA *Hazard and Risk*).

The risk may be to the person themselves or to others. We have an obligation to guard against injury and adverse health effects not only to the people to whom we provide services directly, but also to all the people who may come in contact with our service: families, the staff team, visitors, auxiliary staff (including transport staff, cleaning staff), management and clinical staff, volunteers, students, contractors, etc.).

'Risk identification determines what might happen that could affect the objectives of an individual or a service, and how those things might happen. The identification of a risk involves a balanced approach, which looks at what is and is not an acceptable risk. It should be a view based on the aspirations of the individual with a disability or an older person that aims to support them to achieve the best quality of life for that person. The views of those who use services, their families, carers and/or advocates are all taken into account in identifying risk. It is important to be aware that not every situation or activity entails a risk that needs to be assessed or managed. The risk may be minimal and no greater for the person who uses the service than it would be for someone who is not using a service. Information gathering and sharing is an essential part of risk identification, assessment and management, and is also key to identifying a risk in the first place' (HIQA 2014).

Risk identification is not one single person's responsibility. A culture should be created where everyone feels involved in identification of risk. Some risks will be identified by a Social Care Worker based on their knowledge and judgement. For example, through the key working role someone may express a desire to undertake something new which will involve an element of risk. Equally, risk identification may come from other stakeholders (e.g. families, peers) or processes (Audits, Person Centred Planning, Incident Reports).

TASK 5

Gong back to our case study, what specific risk are you concerned about?

Answer:

You need to narrow down your concern to the specific risks involved.
Are you concerned that:

1. Stephen could get lost?
2. Stephen might lose his wallet in the shop?
3. Stephen could take longer to navigate the way home?
4. Stephen could have an accident crossing the road because of a loss of road safety skills?
5. Stephen could be vulnerable in the community?
6. Or something else?

In this case study, let's imagine that your concern is number 4 – Stephen could have an accident crossing the road.

Now that you have narrowed down the risk to a specific issue, you can start to analyse this risk and put supports in place.

Risk Assessment

An objective way to manage a risk is to use a risk assessment. This process enables you to think through the implications of a risk and what you can do about it. It can be done by one person or a team. Writing out a risk assessment gives you the written documentation to show how you made balanced and reasoned decisions.

'Risk assessment is the overall process of risk analysis and risk evaluation. Its purpose is to develop agreed priorities for the identified risks. It involves collecting information through observation, communication and investigation. It is an ongoing process that involves the management of relevant information' (HIQA 2014).

TASK 6

Watch this two-minute animated video from the HSA, which gives an overview of what is involved in undertaking a risk assessment: https://www.hsa.ie/eng/Small_Business/Getting_Started/Risk_Assessments_Made_Easy/

In our practice, completing a risk assessment form gives the social care worker a forum to **analyse** the **information gathered**. The main aspects are:

1. The **hazard** and who is at **risk**.
2. **Control measures** – the measures in place to try to limit any negative result from the risk.

Risk Assessment	
Your Name:	**Date:**
Task being assessed:	**Review Date:**

Hazard	Risk	Control Measures	Person Responsible	Risk Rating

RISK MATRIX	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare/Remote (1)	1	2	3	4	5

3. **The risk rating.** This looks at:
    a. the severity of the **impact of the risk**. For example: the potential injury from a trip hazard is low compared with the severity of impact of exposed electrical wiring
    b. the **likelihood** of the risk occurring.

The picture to the right is from the HSE's Risk Matrix (HSE 2017). The full detailed version is available on the HSE website.

TASK 7

Watch this five-minute animated video on YouTube called 'Risk and How to use a Risk Matrix': www.youtube.com/watch?v=-E-jfcoR2W0

When the **likelihood** and the **impact** are considered together, this gives us the **risk rating**.

4. If the risk rating is too high and it is at an unacceptable level of risk, we may have to go back to our control measures and add **additional controls**.
5. These additional measures may reduce the level of the risk, so we will assess the risk rating again.
6. **Review date.** All risks should be reviewed regularly.

TASK 8

Looking at Stephen's case, you are concerned that Stephen may have an accident due to a loss of road safety skills.

Question:

What are the controls (things you can do to minimise the risk) for Stephen?

Answer:

With Stephen and the other supports available to you, the controls decided on might include:

1. Walk through the route with Stephen and ensure/maximise his use of pedestrian crossings.
2. Identify if there are any particularly dangerous crossings – you may need specific measures for these.
3. Conduct road safety training and arrange a refresher date.
4. Conduct a task analysis for the journey home. This will help identify current skills and any changes in his skills.
5. Make sure Stephen wears a fluorescent jacket and has a light on his backpack on dark winter evenings.
6. Key worker ensures that Stephen's regular medical, sight and hearing tests are up to date to ensure he has no additional physical health obstacles.
7. Every three months: monitor task analysis and undertake refresher road safety skills.
8. Have alternative transport arrangements agreed for days when the weather is bad or Stephen feels unwell.

Monitor Courses of Action

When agreed actions (or controls) have been put in place in your risk assessment, you will need to decide on a review date. This date will depend on the individual circumstances. In some cases the social care worker might put a three-month review date in place; in other cases, a 12-month review date may be set. It is best practice that all risk assessments are reviewed at least annually.

Social care workers have a responsibility to monitor the impact of the interventions or techniques and assess their effect.

Should the risk increase or the agreed control measures be ineffective, you may need to recommence the risk assessment process with all the relevant stakeholders.

Record Decisions and Concerns

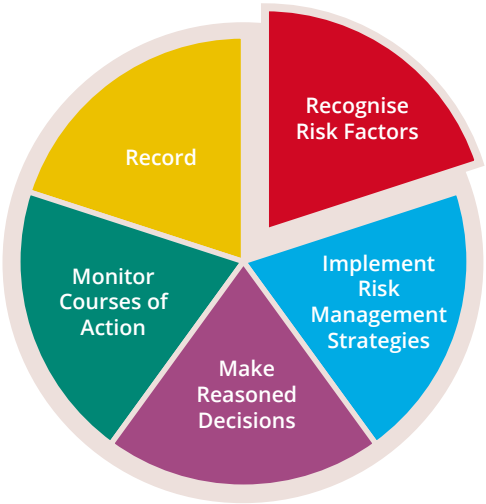
If, by implementing the measures, the risk has reduced significantly, there may be a case for considering closing the risk assessment and moving the recording of this information into another document, such as a care plan.

If the measures have been unable to be fully implemented this will need to be recorded and reported. For example, if there are resource issues (staff time, money), this will need to be highlighted to the line manager.

'Whereas all possible actions should be taken to reduce or mitigate risk, it is likely that it may not be possible to complete all actions identified as required. This may be due to resource or other constraints. What is important however is that as the Manager, you have acted to minimise risk in relation to any actions required that are within your span of control and that you have communicated appropriately actions that lie outside of your control. In circumstances where you can provide evidence that this has occurred, you have fulfilled your responsibility to your Manager (i.e., you cannot be held accountable for aspects of the risk which lie outside your control). It is legitimate for the organisation to "accept" a level of residual risk if this is done within the appropriate governance framework' (HSE 2017).

All documentation should be filed in the service user's individualised file. All risk assessments should be documented on the unit's risk register (if applicable to your service).

Conclusion



This chapter has discussed positive risk-taking and decision-making in the context of a risk management strategy. We then reviewed how to recognise risks; implementing and recording a risk management strategy was discussed.

A case study was used to demonstrate how a social care worker can work through each of these steps to effectively manage risk while keeping the wishes of the service users central to decision-making.

TASK 9

Sign up to HSELand (www.hseland.ie) and create your own account to access a range of free courses relevant to this proficiency. Certificates of completion are provided at the end of the course.

Tips for Practice Educators

Students should read the unit's safety folder, specifically the risk assessments. They should be encouraged to discuss the broader issues and understand how the specific controls for each situation were identified.

Students should be encouraged to discuss interventions they see occurring and consider the risk/benefit analysis.

Ideally, students on placement should learn about managing risk through practice rather than through theory alone.

Practice educators could consider facilitating the completion of the HSELanD task above during the student's workplace hours. Encourage students to spend time exploring this site for current and future learning.

Students in supervision should be encouraged to analyse situations and consider identifying risk factors. A team approach should be emphasised in identifying and resolving issues, with the social care worker taking a leadership role.

Depending on the level of experience of your student, consider supporting them to conduct a risk assessment.

Resources

ABC (Antecedents, Behaviour, Consequences) downloadable Form from the National Autistic Society. https://www.bexleyvoice.org.uk/uploads/3/9/0/4/3904704/abc_chart__1_.pdf

HIQA (Health Information and Quality Authority) – www.hiqa.ie

HSA (Health and Safety Authority) – www.hsa.ie. Resource for all aspects of health and safety.

HSA Risk Assessment Sample Template – https://www.hsa.ie/eng/Education/Managing_Safety_and_Health_in_Schools/Interactive_Risk_Assessments_-_Primary/No-69-Blank-Templates.pdf

HSE Online Training Courses – www.hseland.ie. Range of free social care-related courses. Certification of participation provided on completion.

References

Appuhamy, Ranil (n.d.) *Risk and How to use a Risk Matrix*. Let's Learn Public Health <https://www.youtube.com/watch?v=-E-jfcoR2W0>.

David, Miles (n.d.) sourced from Brainy Quote <https://www.brainyquote.com/quotes/miles_davis_130826> [accessed 4 January 2020].

Gadd, T. and Cronin, S. (2018) *National Framework for Person Centred Planning in Services for People with a Disability* (summary version). Report commissioned by the HSE on behalf of National New Directions Implementation Group. ACE Communication Ireland. Available at <https://www.hse.ie/eng/services/list/4/disability/newdirections/person-centred%20planning%20framework%20summary%20report.pdf>.

HIQA (Health Information and Quality Authority) (2014) *Guidance for Designated Centres: Risk Management*. Available at <https://www.hiqa.ie/sites/default/files/2017-01/Guidance-on-risk-management.pdf>.

- (2016) *Supporting People's Autonomy: A Guidance Document.* Available at <https://www.hiqa.ie/sites/default/files/2017-01/Supporting-Peoples-Autonomy.pdf>

HSA (Health and Safety Authority) (online) *Hazard and Risk*. Available at <https://www.hsa.ie/eng/Topics/Hazards/> [accessed 20 February 2020].

- (online) *Risk Assessments Made Easy* (instructional video) <https://www.hsa.ie/eng/Small_Business/Getting_Started/Risk_Assessments_Made_Easy/> [accessed 1 February 2020].

HSE (Health Service Executive) (n.d.) *Healthcare Records Documentation Requirements*. Available at <https://www.hse.ie/eng/about/who/qid/resourcespublications/tool-box-talks/healthcare-records-management.pdf>.

- (online) *Care Plans*. Available at <https://www.hse.ie/eng/services/list/4/mental-health-services/dsc/dubwestsouth/help/careplan.html> [accessed 1 February 2020].
- (online) *Multi-disciplinary Team*. Available at <https://www.hse.ie/eng/services/list/4/mental-health-services/dsc/communityservices/multidisciplinaryteam.html> [accessed 1 February 2020].
- (online) *Risk Management Documentation* <https://www.hse.ie/eng/about/qavd/riskmanagement/risk-management-documentation/> [accessed 1 February 2020].
- (online) *Risk Management Support Tools*. Available at <https://www.hse.ie/eng/about/qavd/riskmanagement/risk-management-documentation/risk%20management%20support%20tools.html> [accessed 1 February 2020].
- (2008) *Risk Assessment Tool and Guidance*. Available at <https://www.hse.ie/eng/about/who/oqr012-20081210-v4-risk-assessment-tool-and-guidance-incl-guidance-on.pdf>. [accessed 10 February 2020}.
- (2014) *Draft Interim Standards for New Directions, Services and Supports for Adults with Disabilities*. Available at <http://nda.ie/Good-practice/Standards/Interim-Standards-for-New-Directions-Services-and-Supports-for-Adults-with-Disabilities/Draft-Interim-Standards-for-New-Directions-Services-and-Supports-for-Adults-with-Disabilities.pdf> [accessed 5 February 2020>.
- (2016) *A Guide to Risk Assessments and Safety Statements*. HSA. Available at <https://www.hsa.ie/eng/Publications_and_Forms/Publications/Safety_and_Health_Management/Guide_to_Risk_Assessments_and_Safety_Statements.pdf>.
- (2017) *Integrated Risk Management Policy: Incorporating an Overview of the Risk Management Process*. Available at <https://www.hse.ie/eng/about/qavd/riskmanagement/risk-management-documentation/hse%20integrated%20risk%20management%20policy%202017.pdf>.

NHS (National Health Service) (UK) (2018) *Guide to Making Information Accessible for People with a Learning Disability*. Available at <https://www.england.nhs.uk/wp-content/uploads/2018/06/LearningDisabilityAccessCommsGuidance.pdf> [accessed 1 February 2020].

Social Care Workers Registration Board (2019) Social Care Workers Registration Board code of professional conduct and ethics. Dublin: CORU Health and Social Care Regulator. Available at https://coru.ie/files-codes-of-conduct/scwrb-code-of-professional-conduct-and-ethics-for-social-care-workers.pdf.

Tanner, Robert (2015) *Management is a Journey* (General Patton Quotation) <www.managementisajourney.com/saturdays-quote-general-george-patton-on-risk-taking/> [accessed 4 January 2020].

Chapter 51 – Michael McCarthy

Domain 3 Standard of Proficiency 11

Understand the principles of quality assurance and quality improvement.

KEY TERMS

Quality in social care

Quality framework: interdisciplinary and inter-agency planning

Quality assurance in social care

Quality improvement in social care

Social care is … not usually voluntary work, though it can be. It is normally paid professional work, which distinguishes it from the equally valuable care and solidarity provided by Irish people on an informal basis across the country in looking after loved ones who may be incapacitated or have a particular illness.

Quality in Social Care

Professions such as social care, social work, community development and healthcare fall under the umbrella term 'human services' (Dalrymple & Burke 1995; Healy 2005; Banks 2006; Molly 2019). The field of human services approaches the goal of meeting human needs through a multidisciplinary knowledge base which focuses on the prevention and remediation of issues in order to work towards improving the quality of life of people who require service provision (Banks 2006; Lundy 2004).

Quality as a proficiency in social care work addresses some of the most complex and uncompromising human and social issues (McCann *et al.* 2009). Problems include poverty, child abuse, domestic abuse and homelessness. Social care work takes place in many settings including residential, in wet shelters, in hospitals, in nursing homes, in the prison service and in addiction services (Fanning & Rush 2006). Social care work is not an ordinary job but a profession which requires specific knowledge and skills.

Quality Social Care Frameworks

Social care is much more than care giving and the role of social care workers is to plan and provide for the care of marginalised individuals and groups in society of all ages and backgrounds (Molly 2019). This refers to building relationships with service users based on trust and positive mutual regard. It concerns working as part of a team and adopting a working in partnership approach to care, which leads to liaising, planning and co-ordinating services and service provision alongside other agencies (Walsh *et al.* 1998). This is what we mean by inter-agency working. For example, Table 1 illustrates various services that service users may need in addition to their existing support needs.

Table 1 Quality support planning

SUPPORT NEEDS	INTER-AGENCY REFERRAL
Child protection and welfare concerns	Tusla Child and Family Agency
Vulnerable persons at risk of homelessness	Relevant local authority, advice and information centres
Individuals with significant mental health issues	GP/appropriate mental health service team
Domestic abuse	Citizens Information Centre / Women's Aid / Men's Aid Ireland / Aoibhneas women's and children's refuge / Immigrant Council of Ireland (for advice on migrant women's rights and domestic violence) / HSE information line for elder abuse / national counselling services
Bereavement and trauma	Counselling services, e.g., Barnardos children's service / grief counselling services
Medical card referral	HSE
Addiction support	HSE
Education/training/employment	Several pathways available
Registering a social housing need	Relevant local authority
Registering as homeless	Relevant local authority

Support planning as part of a quality assurance framework enables the social care worker to explore in depth the needs and wants of the individual. In this respect, a support plan covers a wide array of needs including: housing, finances, mental and physical health, addiction issues, education, training and employment and life skills development (Powell 1992; Share & Lalor 2013).

In striving for quality improvement, what do we do to advance support plans, aftercare plans or any other type of support mechanism in helping vulnerable individuals and groups to reach their goals and full potential?

It is necessary, apart from the relational aspects of social care work, to have quality administrative systems in place. This is paramount in order to be able to stand over work that is evidence-based and person-centred, and to ensure that all social care workers are accountable for their words and actions. In the next section we will discuss quality assurance in social care and what this means in practical terms and we will differentiate between quality assurance and quality improvement.

What is the difference between quality assurance and quality improvement in social care?

Quality assurance measures compliance with standards and policies based on service user safety, quality of life, the rights of service users, ensuring that service users are treated with dignity and respect at all times and in employing an appropriate balance of interdisciplinary working[2] and inter-agency working[3] when required (HIQA 2018).

Quality improvement focuses on processes and systems utilised to improve both the quality of social care work and accountability (Loshin 2007). For example, systems used to enhance employee growth, potential and career advancement, performance management tools, annual employee appraisals, regular supervision of staff and management and the use of in-house databases to safely store and record relevant, concise and factual information regarding daily service user interactions (HIQA 2017).

Quality improvement systems that capture service user experience and daily interactions with social care workers should be case noted in a timely fashion. This provides a history of the work and will also be useful to relief staff members or new staff members joining the organisation. This is because they will be able, following a detailed handover from the team or their predecessor, to get a full picture of how the work has been progressing and it will assist them in mapping progress made and work yet to be done. As part of any quality improvement process this is essential for quality evidence-based practice.

In residential services any quality-based interventions or related quality-approved organisational incident or accident reports should be compiled as soon as possible after an event in order to ensure accuracy of the information. If a particular incident has been traumatic for an employee or a number of employees and service users; seeking support from a peer mentor or member of the team is important. Social care leaders should ensure that if an employee is upset post-incident, that they can have time off if required, access to counselling supports, and informal supervision should be provided between formally scheduled supervision meetings.

In the aftermath of a challenging behaviour incident, the service user should be given an opportunity to discuss their concerns and what occurred from their point of view (Wood & Long 1974; Tolan & Guerra 1993; Smith & Kirby 2004).

Post Challenging Behaviour Incidents instead of After Challenging behaviour Incident
1. Actively listening to the service user's perspectives.
2. Allowing the service user to drain off emotion as part of emotional first aid.
3. Supporting the management of an overflow of emotions.
4. Keeping the service user engaged and talking to avoid them moving away or leaving the room. This is achievable by listening and caring gestures and by showing genuineness.
5. Calmly remind the service user of the rules of the service, while acknowledging their feelings.
6. Allow the service user time for reflection and follow up with the person to see how they are feeling in the coming hours or days.
7. Provide a handover to the social care team and to any other relevant support workers involved in their care.

2 Interdisciplinary working is a team approach to care whereby the social care team within an organisation provides supports and services to individuals through shared decision-making. It demonstrates accountability and shared leadership and adopts a holistic and inclusive way of working with marginalised individuals or groups.

3 Inter-agency working refers to information-sharing and working in a partnership approach to care between different services outside your own organisation. It is sometimes referred to as inter-agency collaboration.

Depending on the organisation, as part of quality in training, therapeutic crisis intervention techniques may be employed as part of quality in training (TCI 2021). Such training may be useful in helping service users to identify and reflect on what triggered their behaviour, as follows:

- In remediating the situation.
- In returning the person to their normal state prior to the event (base line) and in helping to avoid further emotional or violent outbursts or situations in which challenging behaviour is more or less likely to occur.
- This will be dependent on all potential triggers (music, loud noises, a history of violence, not getting along with other service users and staff members) or circumstances based on emerging or known patterns of behaviour and the service user's support needs.
- Improving quality is about making social care practice safe, client-centred, effective, efficient and fair.

All significant incidents should be discussed by the team in order to put a plan in place, for example if a service user self-harms or attempts suicide. This can be traumatic and upsetting for the person, their family and for their key worker and other members of the staff team.

As part of quality assurance, a safety plan would need to be devised or updated depending on the history of events and level of risk management involved (Webb 2006). A social care team may need to take advice and direction from the person's mental health team as part of this process (Francis & Armstrong 2003). Risk assessments as part of safety planning are very important when working with vulnerable individuals and groups (Bostock *et al.* 2005). Lone working risk assessments are also crucial because they set out what is appropriate and what is not acceptable when visiting people in their own homes or in their own accommodation within social care settings (HSA 2021).

Discussion: What quality assurance processes are in place in social care when there is an incident? How are incidents resulting in emotional outbursts or violence reported? What follow-up is there post-incident?

Lone Working Risk Management

A good-quality lone working risk assessment should point to the following:

- Potential hazards, which include threatening, abusive or potentially violent situations which may lead to social care worker injury.
- Allegations made against social care workers by their service users in lone working situations of a verbal, physical or sexual nature.
- Objects, things or even animals used to carry out threats against a social care worker.
- Risk of infection from service user pets if they are untreated for flees.
- Risk of needlestick injuries.
- Blood splashes from a service user who has self-harmed.
- Effects of passive smoking on social care workers.

Note: If a social care worker is ill, they should cancel any pre-arranged meetings with service users and should not attend in person in case the service user contracts their cold or flu or vomiting bug. Cancelled meetings should be rearranged and where possible another social care worker should be given a handover in case they need to attend an appointment with a service user (HSA 2021).

TASK 1

Identify other lone working risks not mentioned here. How would you prepare for dealing with potential risks?

Having a good quality assurance structure embedded in the organisational culture is significant because it can also help to reduce anti-oppressive practice (Hughes & Wearing 2007). This may be overwhelmingly positive if the correct practice is put into action and power differentials do not get in the way because it puts all service users first in any given situation (Payne 2005).

On the other hand, difficulties may arise when implementing quality anti-oppressive practice strategies because our training and work-based culture has become guided by national policy frameworks which in some cases may prevent social care workers from making common-sense decisions because of fear of reprisal (Healy 2005; Banks 2006).

This suggests that, due to a lack of personal autonomy, it is easier to look for consensus, reach for the standard operating procedure and consult the local policy rather than taking immediate action in the best interest of the service user (Rose & Palattiyil 2018). All social care workers need to be mindful of this.

As part of our duty of care we need to use our common sense, our general intelligence (IQ) and, most important, our emotional intelligence in order to be able to identify what is going on for an individual (Robinson & Clore 2002). This involves being able to read the emotions of the person and the environment. If one's own emotions become heightened in a difficult situation the following self-assessment may help improve the situation:

A. Reflect in the moment/self-acknowledgement of the atmosphere and potential risks in order to be able to remain calm.
B. Scan and assess the situation quickly.
C. Follow through with decisions that are logical and relevant to the situation.
D. Offer support to work colleagues and service users.

Quality in planning and delivering policy

Quality improvement is not just about service provision; it is about planning and devising policies and procedures that social care workers can familiarise themselves with through regular training and supervision (Schön 2017). When there is consistency and people are working to the same high-quality standards in order to ensure best practice, it will help to remediate problems and will prepare social care workers to act with conviction when faced with difficult situations.

Quality improvement requires core social care training, such as child protection training and first aid training, being put in place. Planning for quality structures requires social care workers to develop and regularly utilise specific skills, such as active listening, emotional intelligence, resilience, empathy, tolerance and good organisational skills (Ruch *et al.* 2010).

Discussion: What does quality planning and delivery look like in your social care setting?

Quality assurance in social care: how progress is measured and captured

Quality assurance in social care is about providing quality care and additional supports as required in assessing the quality of services provided. For instance, advocating on behalf of service users, attending appointments or accompanying service users to appointments or court appearances. It may mean sourcing appropriate referrals to other agencies in relation to the specific support needs of the service user at that time.

To measure outcomes, social care managers will collect weekly, fortnightly or monthly reports from social care workers (HIQA 2012). These will capture information regarding service users who are being supported depending on their specific needs through an actionable support plan. For example, housing is one of the main support needs of young adults who have left the care of the state. A young person will need assistance with move-on options and life skills development (finance, budgeting, apartment checks, education, training or employment) to get ready for eventual independent living. Other measures to assess the quality of service provision include risk assessments/safety plans that are in place for service users who may require mental health supports, and appropriate referrals are placed in liaison with the young person's after-care worker and any other outside agencies that may need to be contacted for support purposes (Batini *et al.* 2009).

The quality of the key working process is another factor that can be assessed in terms of service users' level of need and level of engagement with the supports offered (Share & Lalor 2013). Key performance indicator information[4] is then forwarded by local managers to the service manager or their equivalent (Parmenter 2007). For example, in a residential service, key performance indicator's (KPIs) can keep track of service user 'move-ins' to the service and of successful outcomes in terms of service user 'move-outs' from the placement to longer-term stable accommodation.

Quality in the Provision of Social Care

Quality care can be provided on a one-to-one basis or with smaller or larger groups of people in a social care setting. This requires using interpersonal skills, which is why it is relevant to have a good understanding of group dynamics (Kelly 2017). Essential as it is to get to know your service user group, it is just as imperative to foster and build good relationships with other social care workers and leaders who you work closely with in your organisation.

After all, how you as a social care worker develop quality practices in your vocation/career depends on the following:

1. The Quality of Education

- CORU (the Health and Social Care Professions Council) is the body responsible for regulating health and social care professions established under the Health and Social Care Professionals Act 2005. CORU's role is to protect the public by promoting high standards of professional conduct, professional education, training and competence among health and social care professionals.
- In Ireland, the minimum requisite qualification to practice as a social care worker in the publicly funded health sector is a three-year Level 7 degree. Many social care professionals will complete a Level 8 undergraduate degree in social care and some will go on to do a Level 9 master's in a related human services field.
- When a social care worker gains employment in their chosen area of social care the accessibility of good supervision, training and continuing professional development is crucial.

4 Key performance indicators in health and social care practice promote accountability to service users in terms of assessing service user goals and targets and in determining the allocation of resources and service budgets comparable with other organisations.

- Hands-on practical experience, education and training will help develop a person into a social care practitioner who is well rounded and balanced in their approach to care. This will aid the development of additional skills such as case management proficiency and the capacity to carry out the necessary administrative tasks to a high standard.

2. The quality and regularity of good supervision

- A social care leader is responsible for organising good supervision with their supervisee (Munsen 2002). A good supervision model guarantees the collective reassurance that CORU values, ethical codes and guidelines are uniformly adopted and explored as part of the supervision process (SCWRB 2019).
- Good supervision should not just be a line management exercise in which each service user's case is discussed, problems identified or solutions offered. It should be much more than that; it should boost reflective practice.
- High-quality supervision practice should convey how excellent supervision identifies with employee satisfaction, commitment to continuing personal development and employee retention.
- Quality supervision should facilitate conversations that the social care worker might like to have not only in relation to the work but also in relation to their feelings or personal matters outside the professional sphere that might be presenting issues for them (Lynch & Happell 2008). For example, the break-up of a relationship can be emotional for an employee and they may need time off. At times when childminding is an issue, patience and understanding should be shown by the supervisor and a plan put in place until the matter has been resolved.
- Conflict with other social care workers may arise from time to time and supervision offers a unique opportunity for a supervisee to feel listened to and valued and to have their perspective on the situation understood (Matthew 2009).

3. The organisational culture and personal growth

- The organisation's culture in relation to the perspectives of work colleagues about the nature of the work, individual and group case work and about their feelings and relationships with service users and their families (Schein 1993).
- The capacity to self-reflect and to develop as a competent social care worker through a process of self-awareness and reflective practice.
- To learn and demonstrate a willingness to accept constructive feedback that has been delivered in a respectful manner and to use this feedback positively in order to drive change.
- To become the best advocate you can be for the service user.

Quality Improvement and Task Fulfilment

The following key tasks/tools are useful in identifying how quality improvement works in practice.

- **Case management:** This may require holding a caseload of a number of service users, e.g., fifteen to twenty cases. The author previously worked in the family homeless action team assisting families who were living in emergency accommodation. As a case manager the work was both challenging and rewarding. To ensure that all service users' needs were adequately met a joined-up case management approach was adopted. This involved carrying out family assessments and holding initial key working meetings in order to identify family support needs.
- **Information gathering:** Gathering and recording information in line with GDPR (General Data Protection Regulation) in order to understand what led to families becoming homeless; an understanding of the family dynamic; the needs of the children and the overall support needs of the family as a unit.
- **Role fulfilment:** Carrying out risk assessments, putting in place service user-driven support plans, arranging regular scheduling and attendance of key working meetings and assisting families in securing long-term stable accommodation.
- In this context, building good relationships with local authority staff is important, particularly as they are not coming at the work from the point of view of a social care worker. It is our role to highlight and explain the issues to workers in other agencies in order to advocate for our service user's best interests. For example, helping a family or a young person to register their housing need, helping them to understand how the private rented housing assistant scheme works, preparing individuals to attend property viewings, advocating on their behalf with approved housing bodies or making referrals on their behalf to access courses, education, training, employment skills, family welfare supports or child support worker provision when required.
- Another example of case management is social care workers who work with young people over the age of eighteen who have previously been looked after by the state residential care system or through the Irish foster care system. This type of social care support is provided by after-care workers who may be employed by Tusla or by one of the NGOs that are funded by Tusla. Similarly, after-care workers will carry a varied caseload which will be assigned to them by their aftercare manager.
- **Autonomy and accountability:** Local policies as part of a quality standard framework should emphasise the need for social care workers to practise safely within ethical and legal professional boundaries (SCWRB 2019). This involves being able to identify the limitations of their role and to seek advice from their colleagues and managers when required. This is imperative in order that they can act in the best interests of service users by taking their views and perspectives into account and in allowing them to be involved at all times in decisions affecting their lives.
- **Quality improvement:** This will only succeed and be effective when local policies in line with national policy legislation are adhered to at the organisational level (SCWRB 2019). For example, candour and disclosure when somebody is at risk to themselves or others or the steps to take when there is a death in-service.
- **Quality communication:** This means being able to assess and manage situations in such a way that the process is clear to the service user. Communication styles may need to be modified from time to time (verbal and non-verbal communication) to suit the specific needs of the service user at the time.

- **Cultural competence:** Social care workers should also think carefully about language barriers, the culture of non-Irish service users or members of the Travelling community and the various physical and mental health needs of service users. Social care workers should be able to comprehend the importance of building and sustaining professional relationships with other workers on the team and to contribute to decision-making within an interdisciplinary team environment.

Quality assurance tools for developing culturally competent social care practice (Lum 2007; Sakamoto 2007):

- Take time getting to know each person from a different cultural background.
- Be aware of the social care values that you have trained in as part of your education and the organisational ethos and training.
- Critically self-reflect by thinking about your own personal cultural values and beliefs or potential biases.
- Be cognisant at all times that the person is the expert on their unique background, culture, language and heritage experience. Be prepared to adopt a position of 'not knowing' but being prepared and ready to learn. Seek advice on getting an approved interpreter on board if necessary.
- Reflection on the power of language is something to be aware of. It is often stated that language empowers people but remember that it may also leave a person wounded.
- Never make assumptions about person(s) just because they are perceived as coming from a similar background to another person you are working with.

- **Empowerment:** Social care workers should endeavour to empower service users to reach their goals and to manage their own wellbeing as much as possible (Anuradha 2004).
- **Quality managerial frameworks:** Social care workers should be able to produce documentation that is concise, factual and objective (HIQA 2018). This will involve applying digital literacy skills or other technologies such as the use of email or synchronised online meeting forums such as Zoom or Microsoft Teams. These are particularly pertinent in the current COVID-19 climate.
- **Quality safety measures:** Social care workers should have the capacity to gather all relevant background information regarding service users' history, health and wellbeing. For example, conducting needs assessments; seeking a social history or placement reports.
- **Assessment techniques:** Social care workers should be able to implement assessment techniques and to subsequently record a detailed assessment. For instance, family assessments for homeless families before they secure long-term, stable emergency accommodation. This is essential for building relationships with families who are only able initially to access emergency accommodation on a night-by-night basis. In this regard, advocating with the relevant local authority is essential in order to have their assessment and required paperwork finalised as part of their local authority assessment. At the point where it has been accepted that they are homeless, the family is eventually placed in longer-term emergency accommodation in which they will gain access to a dedicated case worker or child support worker if required.
- **Risk factors:** Social care workers should be able to recognise significant risk factors and to use this information to devise a quality-based risk management strategy in order to arrive at reasoned decisions when making interventions or when discontinuing interventions in favour of something new if previous strategies have failed to yield positive results.

- **Quality of practice:** Social care leaders need to comprehend the absolute necessity to monitor and evaluate the quality of social care worker practice through quarterly in-house audits in preparation for HIQA or Tusla audits. This is useful in order for social care workers to be able to critically evaluate their own individual practice as a case worker/key worker/after-care worker/team leader against evidence-based standards. This is further advantageous in terms of implementing changes and improvements to both standardised tools and relational-based practice based on the results and findings of review meetings and audits.
- **Health and safety:** Social care workers should be able to carry out and participate in and engage service users in fire safety checks at least twice a year. They should also carry out regular building checks to mitigate against possible damage that may be caused by hazards in the workplace. This also involves doing regular room or apartment checks in residential services to ensure the safety of both service users, visitors to projects and to employees.

Case Study 1

Supporting a young person transitioning from the care system to an aftercare residential service.

Background:

M will turn eighteen years of age in 2021. He was placed in voluntary care in May 2011 due to his single mother not being able to look after him. M's mother had a history of drug abuse. Her allocated social worker and other family members had reported neglect (poor boundaries and supervision of children, very little food in the house, children presenting as being unkempt and hungry in school, children not attending school regularly, and poor attachment with their mother). Following a family welfare conference, it was recommended and agreed that M and his siblings would be placed in care. M was placed with maternal relative foster carers (Barry and Jane) in 2011. M fitted in well to the family home and initially got on well with their younger child. The plan was to help M's mother with her addiction issues and to work towards reuniting the family.

Sadly, M's mother deteriorated further into her drug use and died a couple of months later from a drugs overdose. After a couple of months M presented with behavioural issues at home and in school. The foster family updated the child in care team who came to visit for review purposes that M often told lies as a way of getting attention. M ran away regularly, which was a cause for concern. M argued a lot with Barry and Jane, would refuse to wash himself or to hand over his clothing for washing, would shout at Barry and 'get up in his face', and similar incidents were reported by his teacher in school. M had visits from a youth worker who would come a couple of times a week, and from other professionals, which Barry and Jane found difficult because it meant their own child had no access to the living area. This made them frustrated, even though they wanted M to have the support he needed. M's views were always taken into account and he often spoke about the sadness he felt at the passing of his mother. M did not know his father, who had left when he was very young.

In 2017 things had not improved and the situation in the foster home was becoming increasingly difficult to contain due to frequent outbursts of anger from M. A strategy meeting was convened by Tusla and the fostering agency. Various plans to help the family had not been successful. Interventions included counselling for M and psychological support for Barry and Jane, respite for M to allow for time away from the family and time alone for his foster parents. M was often 'missing in care' and the Gardaí and social work department worked with the family each time until he came home. M was missing a lot of school and his foster parents continued to find his behaviour challenging and at times threatening. In late 2017 M was moved to another foster family but this broke down quickly. M's social worker tried to work with his previous relative foster carers to see if they would agree to give the relationship another chance, but they were unable to agree to this.

Move on, Interventions and Outcomes:

In early 2018, M moved to a residential placement for under 18s. It was a difficult adjustment moving from foster care to a residential service. M had to get used to living with other young people and had to adjust to 24/7 social care cover. Over time, through the consistency of the staff team in explaining the rules of the service and the rights and expectations on both sides, M began to settle in well to the placement and the staff generally found him to be pleasant. Prior to moving in a needs assessment and a social history was forwarded to the social care manager, who reviewed the information. The team met with M and his allocated social worker and he was assigned a key worker. His key worker, Jake, slowly built a relationship with M. This involved developing trust and maintaining professional boundaries at all times whilst balancing this with showing due respect and care to M's needs. An after-care plan was started in order to prepare M for leaving care as part of the national after-care policy for leaving care based on the principles contained in the Child Care Amendment Act 2015, the UN Convention on the Rights of the Child and the Child and Family Agency Act 2013.

The service M moved to aimed to work on better outcomes for M by preparing him to develop necessary life skills and social skills. M was encouraged to remain in school and his attendance began to improve. M was helped with his homework, which was not always done, but because his attendance improved he developed better relationships with his teachers, which was helped by staff advocacy. M can remain in this placement until he turns 18. Staff are confident that they can secure him an after-care placement to bridge the gap between leaving care and becoming a young adult. M will have a dedicated after-care worker and if he successfully transitions to an after-care placement he will have a dedicated key worker, and will retain his after-care worker and can maintain his after-care supports (up to the age of 21 or the age of 23 if he remains in education).

Based on the case study, here are some of the quality improvement principles in preparing young people for a life after care:

- Recognition that all young people have the right to be supported in their transition to adulthood.
- Preparation for leaving the care system commences upon entry to care.
- Planning is imperative to help achieve positive outcomes for young people leaving care who are engaged in the process of transitioning to independence.
- Tusla will work collaboratively with other organisations and NGOs that provide after-care accommodation and supports (statutory and voluntary services).
- Proper service planning and development will ensure that contingency planning is in place at all times, in case a placement breaks down, as a component of local services planning.
- Each young person like M will have a holistic needs assessment subject to regular updating and reviews in consultation with the young person (person-centred assessment).

TASK 2

Can you think of what quality assurance measures are followed when a young person goes missing in care? How would you prepare a young person for leaving care? Based on M's traumatic social history, outline the factors that have led to a positive outcome following years of trauma and years in care.

References

Anuradha, K. (2004) 'Empowering families with mentally ill members: A strengths perspective', *International Journal for the Advancement of Counselling* 26(4), 383-91.

Banks, S. (2006) *Ethics and Values in Social Work.* Basingtoke: Palgrave Macmillan.

Batini, C., Cappiello, C., Francalanci, C. and Maurino, A. (2006) 'Methodologies for data quality assessment and improvement', *ACM Computing Surveys (CSUR)* 41(3): 16-18.

Bostock, L., Bairstow, S., Fish, S. and Macleod, F. (2005) *Managing Risks and Minimising Mistakes in Services to Children and Families*, SCIE Report 6. London: Social Care Institute for Excellence.

Dalrymple, J. and Burke, B. (1995) *Anti-Oppressive Practice: Social Care and the Law.* Milton Keynes: Open University Press.

Fanning, B. and Rush, M. (2006) *Care and Social Change in the Irish Welfare Economy*. Dublin: University College Dublin Press.

Francis, R. and Armstrong, A. (2003) 'Ethics as a risk management strategy: The Australian experience', *Journal of Business Ethics* 45(4): 375-85.

Healy, K. (2005) *Social Work Theories in Context: Creating Frameworks for Practice.* London: Palgrave Macmillan.

HIQA (Health Information and Quality Authority) (2012) 'What you should know about data quality: a guide for health and social care staff' in *Guidance on a Data Quality Framework for Health and Social Care.* Dublin: HIQA. Available at <https://www.hiqa.ie/sites/default/files/2017-01/Data-Quality-Guide.pdf>.

- (2017) *Information Management Standards for National Health and Social Care Data Collections*. Available at <https://www.hiqa.ie/sites/default/files/2017-02/Information-management-standards-for-national-health-and-social-care-data-collections.pdf>.
- (2018) *Guidance on a Data Quality Framework for Health and Social Care.* Dublin: HIQA.

HSA (Health and Safety Authority) (2021) *Lone Workers.* Available at <https://www.hsa.ie/eng/Topics/Hazards/Lone_Workers/>.

Hughes, M. and Wearing, M. (2017) *Organisations and Management in Social Work*. London: Sage Publications.

Kelly, B. (2017) *Group Sork in Health Care Settings.* London: Guilford Publications.

Loshin, D. (2007) *Developing a Data Quality Strategy*. Available at <http://www.beye-network.com/view/3816>.

Lum, D. (2007) *Culturally Competent Practice: A Framework for Understanding Diverse Groups and Justice Issues.* Belmont, CA: Thomson Brooks/Cole.

Lundy, C. (2004) *Social Work and Social Justice: A Structural Approach to Practice.* Ontario, Canada: Broadview Press.

Lynch, L. and Happell, B. (2008) 'Implementing clinical supervision: Laying the groundwork', *International Journal of Mental Health Nursing* 17(1): 57-64.

McCann, J., Roiste, A. and McHugh, J. (2009) *Social Care Practice in Ireland: An Integrated Perspective.* Dublin: Gill & Macmillan.

Matthew, F. (2009) 'Leadership and organisational strategy', *Public Sector Innovation Journal* 14(1): 3-14.

Molly, M. (2019) 'An exploration of social care workers' experiences of emotional labour and professional burnout in domestic violence refuges', *Journal of Social Care* 2(2): 1-23.

Munsen, C.E. (2002). *Handbook of Clinical Supervision.* New York: Howorth Social Work Practice Press.

Parmenter, D. (2007) *Key Performance Indicators: Developing, Implementing and Using KPIs*. New York: John Wiley & Sons.

Payne, M. (2005) *Modern Social Work Theory 3rd Edition*. London: Lyceum.

Powell, F.W. (1992) *The Politics of Irish Social Policy.* New York: Edwin Mellin Press.

Robinson, M.D. and Clore, G.L. (2002) 'Belief and feeling: Evidence for an accessibility model of emotional self-report', *Psychological Bulletin* 128(6): 934-60.

Rose, S. and Palattiyil, G. (2018) 'Surviving or thriving? Enhancing the emotional resilience of social workers in their organisational settings', *Journal of Social Work* 1(2): 1-20, doi.org/10.1177.

Ruch, G., Turney, D. and Ward, A. (2010) *Relationship-based Social Work: Getting to the Heart of Practice*. London: Jessica Kingsley.

Sakamoto, I. (2007) 'An anti-oppressive approach to cultural competence', *Canadian Social Work Review* 24(2): 105-14.

Schein, E. H. (1993) *Organizational Culture and Leadership.* San Francisco, CA: Jossey-Bass.

Schön, D. (2017) *The Reflective Practitioner*. London: Sage Publications.

Share, P. and Lalor, K. (2013) *Applied Social Care: An Introduction for Students in Ireland* (2nd edn). Dublin: Gill & Macmillan.

Smith, C. and Kirby, L. (2004) 'Appraisal as a pervasive determinant of anger', *Emotion* 4(2): 133-8. *TCI Trainer Manual Activity Guide: System Overview* (2021). New York: Cornell University.

Social Care Workers Registration Board (2019) Social Care Workers Registration Board code of professional conduct and ethics. Dublin: CORU Health and Social Care Regulator. Available at https://coru.ie/files-codes-of-conduct/scwrb-code-of-professional-conduct-and-ethics-for-social-care-workers.pdf.

Tolan, T. and Guerra, N. (1993) *What Works in Reducing Adolescent Violence: An Empirical View of the Field*. Chicago, IL: University of Chicago Press.

Walsh, J., Craig, S. and McCarthy, D. (1998) *Local Partnerships for Social Inclusion.* Dublin: Combat Poverty Agency.

Webb, S.A. (2006) 'Risk', *Social Work and Society* 4(2): 379-82.

Wood, M. and Long, N. (1974) *Life Space Crisis Intervention.* Austin, TX: Pro-Ed.

Chapter 52 – Grace O'Flynn

Domain 3 Standard of Proficiency 12

Be able to carry out and document a risk analysis and implement effective risk management controls and strategies; be able to clearly communicate any identified risk, adverse events or near misses in line with current legislation/guidelines.

KEY TERMS

Risk analysis
Effective risk management
Communication
Positive risk-taking
Staff-associated risks

Social care is … managing risk to ensure that we can support the people in our care to exercise choice, engage in activities and live a full life.

Tip

Remember: Risks can have both positive and negative outcomes. Exposure to certain risks can give people the opportunity to grow and develop.

Risk analysis

Risk analysis is a process of identifying risk or potential hazards (HIQA 2014: 7). A **hazard** is something that could cause harm to someone. **Risk** refers to the likelihood of this happening (HSA online).

When assessing risk, it is important to ask:

- What is the hazard/hazardous activity?
- Who is at risk?
- Why are they at risk?
- Where are they at risk? (In specific environments?)
- When are they at risk? (At particular times, e.g., at night?)

The person identifying and assessing the risk is called the assessor. In social care, risks are measured using a scale. This scale is usually calculated by assessing the **likelihood of the risk occurring**, multiplied by the **impact of harm caused by the risk**. The HSE risk matrix (2018) enables the social care worker to objectively review the risk, helping them and the team to support the service user to make a safe decision.

Likelihood x Impact = Risk Rating

Likelihood (3) x Impact (4)

= Risk Rating 12

Sample risk matrix from HSE (2018)

RISK MATRIX	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare/Remote (1)	1	2	3	4	5

To successfully identify a risk and complete a risk analysis there are steps a social care worker should take.

1. **Build a relationship with the person.**
2. **Observe behaviours.**
3. **Gather information.**
4. **Communicate with relevant people e.g. the person, staff, parents/ guardians.**
5. **Investigate.**
6. **Record details.**
7. **Implement a plan.**

Risk assessments should be unique to the individual. A person-centred approach should be taken. A risk assessment may be necessary for one person you support, but not another.

Remember: Not every activity must be risk assessed.

Effective Risk Management

Managing risk can be a challenge for social care workers. It is a key aspect of our work as it enables us to provide safe and effective care to those we support (HIQA 2014: 4). It is important to acknowledge that not all risks can be eliminated. Despite some of our best efforts, there are always levels of risk associated with certain activities. It is our role to establish the best way to minimise or reduce this risk while supporting the person to carry out the activity. If minimising the risk is not possible, we may look at ways to educate the person we are supporting about the risk and make them more aware of the level of harm associated with the activity.

There are two approaches to risk management; preventive and reactive. Social care workers may aim to take a proactive and preventive approach by putting supports in place **before** the activity or action occurs (HIQA 2014: 4). For example, if a person you are supporting has decided to take up a new hobby or start a new job, you may look at the risks associated with this action. If there are evident risks, it is your role to put adequate supports in place to minimise this risk. This is a preventive measure. Before the person begins doing the activity, you have clearly identified the hazards and provided additional measures to reduce the level or likelihood of harm.

PREVENTIVE = BEFORE

In contrast, reactive risk management refers to a **response** to an adverse event or incident that has occurred (HIQA 2014: 4). If an accident or incident arose, it is your role to review why and how this happened. It may be apparent that there is a level of risk associated with an activity that you were unaware of. On reflection and analysis of the event, it may be possible to identify the areas of support required to reduce the likelihood of the risk recurring. Alternatively, a response may be to put supports in place to reduce the impact of the risk. For example, a person you are supporting falls off their bike and bangs their head. On investigating and analysing why the event occurred, you may become aware that the individual removes their helmet as soon as they turn the corner away from the service. In order to manage this risk effectively and to support the person to carry out the activity safely, you may look at control measures that can be utilised for the future. This might look at educating the person on the benefits of wearing a helmet when cycling and the possible consequences of not wearing it. These measures are implemented in response to the incident (**after**); therefore it is termed reactive risk management.

REACTIVE = AFTER

A key aspect of risk management is involving the individual you are supporting in the process. Remember in disability services, you cannot stop someone doing an activity just because there are risks associated with it. **It is their choice.** You must weigh up the positives and negatives associated with the risk. As a social care worker, you have a duty of care to keep people you support safe. However, this must not impact on their human rights. They have a choice to make poor choices, or decisions that you may not agree with or see as 'in their best interest'. People make choices every day that others may deem as poor, but this is ultimately their choice. Your duty of care lies with educating the person about the harm associated with an activity and supporting them to look at alternative or safer ways to engage in it; but you should not infringe on their human rights.

Tip

Refer to HIQA's Guidance on a Human Rights-based Approach in Health and Social Care Services.

Communication

Communication is a key aspect of risk management. It is essential for identifying what hazards and harm can be caused to a person. By communicating with the individual themselves, and with other relevant parties, risks can be identified and acknowledged. Communication is used for establishing ways in which the risk can be managed. It supports creative thinking, perhaps by brainstorming about the supports that can be put in place to reduce the risk, and creates continuity of care. Plans for intervention communicated effectively to the individual and staff team allow for smooth application in practice and can lead to better outcomes. Communication supports continuous learning and growth as we reflect on where things may have gone wrong when adverse events occur or areas of support that worked well.

One example of communication is how to document the risk you are assessing or monitoring or the incident you have witnessed.

Documenting risk assessments

Written communication is essential for effective management of risks. Having successfully identified hazards and likelihood of harm, a social care worker must document their findings. Always refer to your organisation's policy on risk management for guidance. By noting why an activity is hazardous, when, where and who could be affected, you are providing knowledge to others involved in the person's care. Setting out the agreed control measures and supports shows how the risk will be managed. This process demonstrates action and the response to the duty of care we have for people we support. Inserting the risk rating highlights the priority of the risk. The risk assessment document as a whole shows the rationale for identifying the risk and provides context to the intervention or supports that are required for managing it. Clear recording of the risk and control measures provide all relevant parties with the information they require to support a person to do an activity safely. It also communicates how the person themselves likes to be supported to engage in this activity.

Recording accidents and incidents

Adverse events or near misses can happen when learning and developing ways to manage risks. Despite putting interventions and supports in place, sometimes harm can be caused to a person. This may be due to circumstances that are out of our control. Often it is not possible to highlight every hazard and eventuality and implement effective control measures. In line with current legislation and guidelines, you are required to compile a report of accidents, incidents and near misses and may be obliged to report them to the inspectorate of your service (e.g. HIQA/Tusla) within a specific timeframe (HIQA 2014: 10). Recording these events are critical for reflection and growth. Social care workers should record adverse events factually and objectively. Providing the facts and details that resulted in the harm caused to the person enables us to review, reflect and rethink our approach. There may be a clear reason why the risk caused harm and there may be a simple solution. Not correctly documenting the details of the event hinders our ability to analyse the risk and reduce it for the future.

Reviewing and monitoring risks

This is another integral part of effective risk management. It is important to review accident and incidents reports regularly to determine whether the control measures are effective. If the risk is occurring regularly, further investigation and additional control measures may be required. The intervention in place may not be sufficient. By regularly reviewing the risks assessments, social care workers aim to adapt the approach to suit the needs of the individual. There may be a change in circumstance which has led to an increase in the likelihood or impact of harm associated with the risk. Risk assessments should be reviewed in line with legislation and organisational policies.

Risk register

In addition to recording adverse events and documenting individual risk assessments, services often use a risk register. This is a list of all the identified risks associated with that service. They may include a record of all the risks identified with the people we support and staff- or service-associated risks of working in that environment. The register will often rank the risks from high to low, placing the priority on those that have the highest risk rating. Colour coding is often used to indicate the priority, for example a traffic light system of red = high risk rating, orange = medium risk rating and green= low risk rating.

Recap

Case Study 1

Mark

Mark is a 30-year-old man with an acquired brain injury. He lives in an assisted living service in Dundrum. Mark really enjoys going out with his friends to the cinema on Friday nights. They go to the Savoy on O'Connell Street. As a result of his brain injury, Mark has short-term memory difficulties and requires a rollator to mobilise but is very reluctant to use it. When accessing public transport independently, Mark can forget which bus stop to get off at and can become disoriented. Mark has a history of ending up in unfamiliar places and has difficulty navigating his way back home. Mark is a film fanatic and organises his week around catching up with friends and seeing the latest film release. Marks' parents dislike him travelling independently due to the possibility that he may get lost.

As a social care worker, your role is to support Mark to do this activity safely. In order to successfully support Mark, you must establish:

1. What is the risk?	Getting lost while travelling independently
2. Who is at risk?	Mark
3. Why is Mark at risk?	His short-term memory loss and becoming disorientated
4. Where and when is he at risk?	When getting the bus to and from the cinema on Friday nights

After building a relationship with Mark and understanding the importance of this activity to him, social care workers must identify the areas of support that are required. The social care worker should chat to Mark about going to town weekly, acknowledge the meaningful relationships he has with his friends, and the enjoyment he gets from the activity. They could discuss the concerns that have arisen during past trips and ask if he has any worries in relation to completing the journey independently. The social care worker must ask Mark about the possibility of accompanying him on the route to town to identify his skills when completing the trip and to establish the hazards. The most important element is to explain how support at this point could increase Mark's independence in the long run and enable him to travel independently with reduced risks. The social care worker **must obtain consent** before proceeding with further support.

Having completed the journey, the social care worker must communicate and document the identified hazards. This will support them to calculate the risk rating before control measures are in place.

Remember: Likelihood of the risk x impact of the risk = risk rating

On accompanying Mark on the journey, you may notice that Mark is unsure of the route from the house to the bus stop and often takes a wrong turn. You may get to the bus stop and realise that Mark is unsure of when the bus is due and has to wait for long periods in the dark on his own. You may notice that Mark has difficulty seeing the number on the bus and often leaves it too late to put out his arm to notify the bus driver that he wants to get that bus. Mark may have difficulty mobilising with the rollator to his seat on the bus. The jerking motions of the bus moving away from the stop can cause him to lose his balance. Due to Mark's infrequent use of his rollator, he may have not developed the skills to use it to benefit him. Several times on the journey, Mark may require prompts from you to use his brakes when mobilising on a slope or to engage the brakes when stopped.

The journey helps you as the social care worker to identify the areas of support Mark requires and his areas of strength. You must then effectively communicate the risks to Mark and the team. This is where you might consult Mark and others to brainstorm on control measures or strategies that could be implemented to support him. It is evident that Mark requires travel training to establish the route and to become aware of the relevant bus stops. Mark has a great interest in history and often identifies areas with monuments and historical events. By identifying places of significance for Mark, he may be able to remember the route clearly. This may include identifying memorable monuments such as the Spire. You could provide Mark with a list of written directions of the route to the bus stop that he can keep in his pocket and refer to if he is lost. During travel training, you could encourage Mark to contact staff when he has reached his destination and when he is returning so they have an idea of the timeframe associated with his return. Mark loves technology and this intervention will give him opportunities to use his smartphone. He might need support with downloading and utilising the Dublin Bus application onto his phone to enable him to time the bus effectively and prevent him from waiting for long periods for the bus to arrive. Mark may need an eye test to establish if he requires glasses to see long distances and the number of the bus. You as a social care worker could link in with the community physiotherapist to arrange rollator training for Mark to assist him to use of his walker safely.

Tip

Careful consideration must be given to Mark's strengths and skills during the process. These skills will play a role in reducing the risk and acting as a control measure.

It is important at this point to create a list of potential control measures and communicate them in a way that is understood by all. The use of goal setting, visual aids and social stories may be required for Mark, all team members and his family to understand and implement the plan. You must ensure that Mark consents to the sharing of information with relevant others and is willing to engage in the strategies of support (HIQA 2014: 6). You will then reassess the risk. This means looking at the original hazards and assessing if they are still an issue, having implemented the control measures.

- Are the hazards that were identified initially still present?
- Has the likelihood and impact of the risks occurring reduced?
- Have any new risks been identified?

It may be that the activity is still considered high risk and the risk rating has not reduced significantly. This is where **positive risk-taking** may come into play.

Positive Risk-taking

Positive risk-taking refers to weighing up the advantages of carrying out an action versus the level of harm associated with the action (HIQA 2016: 7) The activity may provide an opportunity for growth and development. If we as social care workers decided that this risk was too high and said that Mark could not engage in this activity, not only are we restricting him, we are also infringing on his human rights. The activity allows Mark to maintain positive meaningful relationships, and provides opportunities to plan and organise activities, develop his area of interest, and support time management and money management skills. It provides time to utilise assistive aids and acknowledge that they can enhance his independence. It also allows him the opportunity to design and implement problem-solving skills. If this activity were removed from his weekly plan on account of the level of harm associated with it, Mark would have reduced opportunities to learn and grow.

The positives outweigh the negatives in this scenario. Mark travels independently to town every Friday to meet his friends and go to the cinema. He gets off at the wrong bus stop one in ten times and often seeks support from staff via the telephone to redirect him. Mark highlights the nearest monument/ road sign to staff and is supported to get back on the bus to get to the correct place. Mark is still at risk of becoming lost but has established problem-solving skills that support him to continuously engage in the activity independently. The impact of getting lost has reduced as Mark has developed ways to rectify the issue and get back on track. While the risk level may still be considered 'likely', the level of harm associated with it has reduced as Mark has developed the skills to return home without becoming lost.

Generic Risk Assessment Form (HSE Website)

Risk Assessment Form	
Division: HSCP	Source of Risk: External activity
HG/CHO/NAS/Function: CHO 7	Primary Impact Category: minor
Hospital Site/Service: ABII Assisted Living Service	Risk Type: Community access
Dept/Service Site: Dundrum	Name of Risk Owner (BLOCKS): MARK MURRAY
Date of Assessment: 01/01/2021	Signature of Risk Owner:
Unique ID No: 1234	Risk Co-Ordinator
	*Risk Assessor (s): Grace O'Flynn

HAZARD AND RISK DESCRIPTION	EXISTING CONTROL MEASURES	ADDITIONAL CONTROLS REQUIRED	ACTION OWNER (i.e., the Person responsible for the action)	DUE DATE
Mark may become lost when travelling independently to and from the Savoy Cinema on Friday night. Mark has short-term memory loss as a result of his acquired brain injury.	Mark brings his phone with him when travelling independently.	• Mark to complete travel training with Dublin Bus. • Staff to provide Mark with a list of written directions including landmarks & monuments to refer to when lost. • Mark to download the Dublin Bus application on his phone to time the buses. • Staff to support Mark to get an eye test to establish whether glasses are required. • Mark to engage in rollator training with community physiotherapist to increase rollator skills. • Mark to phone staff when he reaches his destination and when he is running home to establish a timeframe. • Staff to redirect Mark back to the bus stop by using familiar landmarks.	Mark & staff	

INITIAL RISK		Risk Status			
Likelihood	**Impact**	**Initial Risk Rating**	**Open**	**Monitor**	**Closed**
4	3	12	3	2	6

Staff-associated Risks

Risk analysis and effective risk management do not only refer to people we support. Risk assessments can be created to protect staff while engaging in practice, for example lone-working in a residential service. These risk assessments are the responsibility of the social care leader/manager and play a vital role in providing safe services. The same principles of risk management are applied.

The assessor aims to answer the following questions:

1. **What is the risk?** Lone-working.
2. **Who is at risk?** Staff and people we support.
3. **Why are they at risk?** Staff are at risk of false allegations. People we support are at risk of abuse/misconduct of the staff member.
4. **Where and when are they at risk?** Staff when working alone and people we support when living in a service where staff are lone-working.

Then the process of reducing the risk is investigated. The social care leader/manager may look at the control measures that can be put in place. These may include: an on-call manager system for staff if issues arise; training for staff on lone-working, safeguarding, first aid, etc.; training and information sharing for the people we support e.g., types of abuse, complaints procedures, advocacy information, etc. This form of risk management reduces the likelihood of risk but does not eliminate it entirely.

Tips for Practice Educators

1. Provide a history of the risk assessments taken in your service for the different people in the centre. Give examples of the steps taken, the preventive and reactive strategies used, the positive steps forward and the times when you needed to reassess the risk.
2. Teaching the documentation. When assessing the risk involved in a new activity or event, allow the student to assess the risk using the HSE risk matrix, compare their results with your own and discuss the difference between the two assessments.

Resources:

- Risk management support tools and explanation of risk rating scoring can be found at www.hse.ie. The following link has useful guides and templates for practitioners to utilise: www.hse.ie/eng/about/qavd/riskmanagement/risk-management-documentation/risk%20management%20support%20tools.html.
- Refer to the HSA (Health and Safety Authority) website for the latest policy and legislation guidelines: www.hsa.ie/eng/.

References

HIQA (Health Information and Quality Authority) (2014) *Guidance for Designated Centres: Risk Management*. Available at: <https://www.hiqa.ie/sites/default/files/2017-01/Guidance-on-risk-management.pdf>.

(2016) *Supporting People's Autonomy: A Guidance Document*. Available at <https://www.hiqa.ie/sites/default/files/2017-01/Supporting-Peoples-Autonomy.pdf>.

HSA (Health and Safety Authority) (online) 'Hazard and Risk' <https://www.hsa.ie/eng/Topics/Hazards/>.

HSE (Health Service Executive) (2018) *Risk Assessment Tool*. Available at <https://www.hse.ie/eng/about/qavd/riskmanagement/risk-management-documentation/hse%20risk%20assessment%20tool.pdf>.

Chapter 53 – Dawn Murtagh

Domain 3 Standard of Proficiency 13

Be able to comply with relevant and current health and safety legislation and guidelines and be able to access recommendations and findings of inquiries, investigations and associated reports relevant to social care.

KEY TERMS

Compliance
Health and safety legislation
Inquiry reports
Accessing reports and recommendations

Social care is … about providing the best quality of care possible, treating the people we work with as we would like our own family members to be treated. Social care involves promoting independence, encouraging people to reach their full potential and achieve their goals. Advocating for people while also providing them with the skills to advocate for themselves. Focusing on the positives even in times when this may seem difficult. Providing a person-centred approach, recognising that every person is different with their own individual needs and strengths.

Introduction

This standard of proficiency has two main elements. First, it requires social care workers to comply with relevant and current health and safety legislation and guidelines. Second, social care workers must be able to access the recommendations and findings of inquiries, investigations and associated reports relevant to social care. Utilising my research and experience with young people in residential and disability services, this chapter will explore what it means to comply with current health and safety legislation and guidelines in social care, explained through practical tips and links on how to access findings and recommendations of relevant reports.

Compliance

What it means to comply

Compliance is the process of following rules and regulations in relation to practice.

Compliance is the process of adapting, following or acting in accordance with rules and guidelines that relate to best practice (Dunbar 2021). It can be understood as behaviours fitting to how one should or should not act in accordance with regulations, standards or legislation (Dunbar 2021; Etienne 2012). In order for there to be a willingness to comply, it must be understood why compliance is important. Compliance with regulations, policies and legislation is vital for safe practice, to enable the smooth running of an organisation and to guarantee that everyone understands what is expected of them, as well as ensuring that everyone follows correct procedures.

Complying with standards in social care helps organisations to improve and maintain a high quality of care. For example, when preparing meals in a residential setting, compliance with food safety regulations ensures that food is handled, stored and prepared correctly, preventing cross-contamination and food poisoning. Complying with hygiene regulations prevents the spread of illness or infection.

TASK 1

Check out the Health and Safety Authority website (http://hsa.ie) and find out their role in health and safety in the workplace.

Everything we do in social care encompasses health and safety legislation and guidelines. These play a vital role in the provision of social care, protecting the safety and wellbeing of service users, staff, volunteers and anyone involved in a service. Health and safety regulations help identify potential hazards, therefore reducing and preventing the occurance of accidents, injury or fatality. But first what is the difference between legislation and guidelines? Legislation is an Act or law that has been set out by government. It is legally binding and therefore must be adhered to (Furlong 2014; Kenneally & Tully 2013). Guidelines interpret legislation and advise how to comply with the legislation, but they are not enforced by law.

TASK 2

Read Chapter 9 to learn about the role of policies and systems in protecting the health, safety and welfare of staff, service users and volunteers.

Health and Safety Legislation

One of the main pieces of legislation governing occupational health in Ireland is the Safety, Health and Welfare at Work Act 2005. This legislation applies to all places of work and has a major influence on our day-to-day practice in social care. Its purpose is to guarantee the health, safety and welfare of people at work. It places a duty of care on employers to manage work activities as much as reasonably practicable to prevent injury and ill-health and ensure the safety and welfare of employees. Under the Act employees are required to take reasonable care for their own safety and the health and safety of anyone impacted by their work.

TASK 3

Have a look around your home and see if you can identify any potential hazards that could cause harm. Who could they harm and how? How likely is this to happen? How serious could it be? What could be put in place to prevent or reduce the risk of harm?

Risk Assessments

TASK 4

Read Chapter 52 by Grace O'Flynn to learn more about risk analysis and risk management.

Section 19 of the Safety, Health and Welfare at Work Act 2005 requires that all organisations must conduct risk assessments which must be reviewed on a regular basis and amended where necessary. It is the duty of all social care workers to conduct risk assessments.

STEPS INVOLVED IN CONDUCTING RISK ASSESSMENTS
(i) Identify hazards. A hazard can be construed as anything that can cause harm. These include physical hazards, such as manual handling, using vehicles, slips and falls, chemical hazards (e.g. cleaning products), biological hazards (e.g. infection or allergies) and psychological hazards such as bullying or aggressive behaviour.
(ii) Assess the risk. This entails deciding who is at risk of harm due to the identified hazards. It also must be considered how probable it is for harm to occur and the extent of the impact of that harm.
(iii) Put measures in place to eliminate or prevent harm from occurring as much as reasonably practicable (HSA 2012; Safety, Health and Welfare at Work Act 2005).

Case Study 1

Mary has recently been referred to a residential care facility. During her initial assessment Mary's parents notified staff that Mary has an allergy to nuts. Before Mary attends the facility, a risk assessment was carried out and safety procedures put in place. The hazard identified in this case is nuts and any food products containing nuts. Assessing the risk identified that the person at risk from this hazard is Mary. No other staff or service users are deemed at risk because none of them has a nut allergy. Due to Mary's allergy, it is highly probable that she will experience harm or adverse reaction if she comes into contact with nuts. The extent of the impact is high: Mary could experience a severe allergic reaction, anaphylactic shock leading to fatality, depending on the severity of her allergy. Measures that could be put in place to prevent/reduce harm include enforcing a 'no nuts' policy in the residential centre. Other residents and families must be told not to bring nut products into the centre. Nuts must not be used in the preparation of meals and labels must be checked when shopping. Staff are trained in the use of an EpiPen in the case of anaphylaxis. An emergency protocol must be put in place to follow in the event of an adverse reaction.

Safety Statements

Section 20 of the Safety, Health and Welfare at Work Act 2005 requires every organisation and employer to have a written safety statement specifying all identified hazards and risks which have been assessed. The safety statement must outline staff duties and measures taken to protect their health, safety and welfare at the place of work. Additionally, it must include emergency and evacuation procedures.

TASK 5

When on placement read your organisation's safety statement. It is important to be aware of any emergency procedures and the duties involved to ensure safety.

Additionally, the Act sets out fines and penalties for breaches of health and safety legislation. The Safety, Health and Welfare at Work (General Application) Regulations 2007 provide more extensive detail on specific topics, for instance pregnancy at work, manual handling, the physical environment such as electricity and signage, workplace and personal protective equipment, first aid, training, night work and shift work and the protection of children, etc.

Slips, trips and falls are very common causes of injury in the workplace. Organisations are required to maintain a safe environment to prevent slip or trip hazards (HSA 2012). This is particularly important when working with people with visual impairments, mobility issues or physical disabilities. Floor space and exits must be kept clear at all times. Where I work, doors are painted a highly contrasted colour to walls to make them clearly visible. Steps and stairs are fitted with hand rails and high-visibility strips. A cleaning protocol is in place for staff to follow. Floors must be cleaned when there is little to no traffic. Spills must be cleaned immediately. Bright and even lighting is installed throughout the house. A policy is in place for reporting accidents.

There can be some drawbacks to health and safety guidelines. For instance, the requirement for emergency exit lights and safety signs in disability and residential care facilities can create a cold, clinical look in a place that is supposed to be inviting and homely for young people. This has become more evident during the COVID-19 pandemic as services have been required to display social distancing graphics and COVID-19 information posters.

The nature of service provided and the needs of the people we work with must be taken into consideration when implementing health and safety regulations as, on occasion, the implementation of a safety requirement can create risk in itself. For example, in relation to fire safety, it is a requirement under the Health Act 2007 (as amended) for residential houses to have automatic closing fire doors (HIQA 2021). While these are vital in the event of a fire for preventing its spread and allowing time for evacuation, they can be hazardous. These doors are expected to be kept closed when not in use. Fire doors are very heavy, which creates an obstacle for people with physical disabilities. Measures need to be put in place to eliminate impediments or dangers. For instance, a hold-open device can be installed to ensure that the fire door does not create a barrier for people with disabilities or mobility issues. When a fire alarm goes off these doors will close automatically. This poses a difficulty for the students with visual impairments I work with, as they are unable to see that the doors are closing. To ensure students don't collide with the doors, they are reminded during regular fire drills to take care when approaching the doors as they will be swinging closed. Personal emergency evacuation plans are in place that take into consideration the needs of each individual when evacuating a building.

National Standards

Both the National Standards for Children's Residential Centres (2018) and the National Standards for Residential Services for Children and Adults with Disabilities (2013) set out by the Health Information and Quality Authority (HIQA) emphasise the provision of safe care, and protecting people from harm, neglect or abuse. The standards mandate that all incidents that occur are managed and scrutinised to inform practice and prevent future harm. Additionally, the standards require the promotion of wellbeing and ensure that people's individual health needs are met. The Children First Act 2015 was aimed to make better provision for the protection of children. Under the Act, all children's services are required to have a safeguarding statement. The act enforces the obligation of mandated persons to report any concerns to Tusla, the Child and Family Agency. Furthermore, the Act provided the legal basis for *Children First: National Guidance for the Protection and Welfare of Children* (2017). This document establishes clear guidelines for recognising and reporting abuse and neglect. It describes the four main types of abuse and how to identify them. It highlights the steps involved in reporting concerns. The role and responsibilities of a mandated person are established, along with protocols for social workers working in Tusla.

To promote safety and protect young people (3.1 of National Standards for Residential Services for Children with Disabilities) and comply with the Children First Act, the organisation I work with put the following protocols in place.

As part of the recruitment process all staff must provide references and be fully Garda vetted. It is mandatory for all staff to undertake Children First training.

The organisation has drawn up policies pertaining to confidentiality and reporting abuse/concerns, which are read and adhered to by all staff.

There is a designated organisational child protection officer appointed to take the lead on safeguarding and child protection.

Each residential house has a visitor log in order to record all people who visit and when.

At least two staff members are required to be present during sleepovers.

All Irish legislation can be found at: http://www.irishstatutebook.ie/

European legislation can be found at: https://europa.eu/european-union/law/find-legislation_en

Introduction to Children First training can be accessed here:

https://www.tusla.ie/children-first/children-first-e-learning-programme/

Case Study 2

The following case study is an example of how an organisation practises in line with national standards. This is a fictional scenario, not based on real events.

4.1 promoting the health and development of each child:

Jack is a 14-year-old boy who has recently started living in a residential house for students with visual impairments. He lives in the house from Sunday to Friday, attends school and goes home at the weekends. At home, he lives with his parents and older brother. Jack has recently lost the majority of his vision. Before attending the service, Jack's needs were assessed in order to put an individualised plan in place to address these needs, establish goals to work towards and provide meaningful care and support. The service provided Jack with an ophthalmology exam to assess his vision and eye health. A personal medical care plan will be written to address Jack's medical needs. Access to nurses, dental screening, occupational therapy or physiotherapy will be available to if desired. Jack takes medication for high blood pressure. All staff have received medication training. Two staff must be present and medication administration protocol must be followed when giving Jack his medication. Jack will be supported to self-administer his medication. Medication audits are carried out on a regular basis to guarantee that proper procedure is being followed. If a medication error occurs this must be reported immediately, the nursing team must be informed to provide medical advice and an error form is to be filled out.

As Jack has recently lost vision, he is receiving orientation and mobility training to gain the skills necessary to navigate his surroundings without accident or injury. Jack has expressed an interest in learning how to access local shops and parks and travelling to school independently. These objectives will be added to his care plan and an orientation and mobility specialist will work with Jack to achieve his goals.

Jack will learn new independent living skills in order to adapt to his vision loss. For example, a programme will be put in place to safely teach Jack how to pour liquids or make hot drinks safely. Adaptions are made to appliances, such as tactile stickers, so that Jack can use them independently without sight.

Staff are building positive relationships with Jack. He is provided with the opportunity to express his opinions and make his own choices regarding all aspects of his care. He has a say in what activities he would like to partake in, meal choices, etc. This can be achieved on a daily basis and through link sessions with his key/link worker. Jack's grandmother, to whom he was very close, has recently passed away. During link sessions, Jack is provided with a safe space to express his emotions. He is reassured that all staff are there to support and listen to him whenever he needs. Jack's link worker offered to source counselling for Jack if he wishes.

It has been observed that Jack's favourite foods are Chinese takeaway and burgers and chips. He eats very little fruit or vegetables and drinks a lot of fizzy drinks. Jack seems to have very little awareness about nutrition and healthy eating. After discussion Jack has agreed to partake in an education programme to learn about healthy eating, nutrition and exercise. Jack expressed an interest in learning how to prepare his own snacks and lunch for school. Staff will teach Jack kitchen safety. He will be supervised and given the skills necessary to use sharp knives, handle hot objects and use appliances such as microwave, oven or toaster.

Inquiries, Reports and Recommendations

As we know, a plethora of inquiries and reports have had a major influence in shaping the landscape of social care practice in Ireland. These reports include the Kennedy Report (1970), the Madonna House Report (1996), the Newtown House Report (2001), the Ryan Report (2009) and the Child in Care Death Report (2012). The recommendations of these reports, along with others, have brought about significant change leading to improvements in the provision of care for the people we work with. Inquiries help establish what happened in the past and learn from mistakes (LRC 2005). However, many have criticised the effectiveness of reports (Burgess 2009, 2011; Mackie 2012; Stutz 2005). Burgess (2009) has claimed that inquiry reports have been ineffective, overly time-consuming, expensive and ineffective. He also argued that these reports placed too much focus on laying blame and introduced too many regulations without considering possible consequences. Howard (2012) has debated that while regulation and maintaining records is vital for transparency and accountability, over-regulation and excessive recording of information can often take the humanity out of care. Professionals often work in fear of allegations being made against them and have to balance the conflict between meeting the demands of paperwork and caring for the people they work with. Young people are acutely aware of the level of recording conducted. 'Are you going to write that in my daily log?' and 'What are you going to write about me?' are questions I have regularly been asked by young people I work with. We must consider how this makes them feel. The Ombudsman for Children (Muldoon 2017) says, 'It is important that Tusla operates in a way that protects the child rather than the system.' From their research, Buckley and O'Nolan (2013) advised that future inquiries should limit their recommendations and place emphasis on key learning points which could be integrated into future practice across all organisations.

HIQA, which was established under the 2007 Health Act, is an independent authority whose purpose is to set standards to promote a safe, high quality of care by health and social care services. It monitors and inspects services to ensure these standards are being met and that services provide safe, effective care that meets the needs of service users (Health Act 2007). When carrying out inspections HIQA determines a service's level of compliance, or non-compliance, with the national standards.

Accessing HIQA inspection Reports

Go to https://www.hiqa.ie/

Select 'inspection reports' at the top of the webpage.

A list of recent inspection reports will appear. From here you will be able to search for inspection reports of any service monitored by HIQA.

Select the type of service (e.g. disability, children's residential), the year, location, or any relevant key words to refine your search.

TASK 6

Practise this by looking up inspection reports for the service where you are on placement.

Tips for Practice Educators

- Inform students of legislative material and guidelines regarding health and safety relevant to social care.
- Discuss the role of inspections and provide information on some of the main inquiry reports that have had a major influence on the landscape of social care.
- Allow students the opportunity to practise accessing inspections and reports.

References

Buckley, H., and O'Nolan, C. (2013) *An examination of recommendations from inquiries into events in families and their interactions with state services, and their impact on policy and procedure.* Dublin: Government Publications.

Burgess, A. (2011) 'The changing character of public inquiries in the (risk) regulatory state', *British Politics*, 6(1): 3-29.

Burgess, A. (2009) *Public Inquiries and the Management of Public Risk, Report commissioned by the Risk and Regulation Advisory Council*. London: Risk and Regulation Advisory Council.

Children First Act (2015) Dublin: Stationery Office.

Department of Health (1996) *Report on the Inquiry into the Operation of Madonna House.* Dublin: Stationery Office.

Dunbar, P., Browne, J.P. and O'Connor, L., (2021) Determinants of regulatory compliance in health and social care services: a systematic review protocol. *HRB Open Research*, *4*(13) Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8258703.3/

Etienne, J., (2011) Compliance theory: A goal framing approach. *Law & Policy*, *33*(3): 305-333.

Furlong, J., (2014) Free and Easy: A Guide for Occasional Users for the Irish Legal System and Resources Legal Information Management. 14: 276-282.

Health Act, (2007) Dublin: Stationery Office.

Health Information and Quality Authority, (2018) *The National Standards for Children's Residential Centres*. Dublin: Stationery Office.

Health Information and Quality Authority, (2013) *The National Standards for Residential Services for Children and Adults with Disabilities*. Dublin: Stationery Office.

Health and Safety Authority, (2012) *Health and Safety at Work in Residential Care Facilities.* Available at https://www.hsa.ie/eng/Publications_and_Forms/Publications/Healthcare_Sector/Health_and_Safety_at_Work_In_Residential_Care_Facilities1.html.

HIQA (Health Information and Quality Authority) (2021) *Fire Safety Handbook: A Guide for Providers and Staff of Designated Centres*. Dublin. Available at <https://www.hiqa.ie/sites/default/files/2021-02/Fire-Safety-Handbook-a-guide-for-providers-and-staff-of-designated-centres.pdf> [accessed 10 August 2021].

Kenneally, A. and Tully, J. (2013) The Irish Legal System. Ireland: Clarus Press.

Kennedy, E. (1970) *Reformatory and Industrial Schools System Report.* Dublin: Stationery Office.

Law Reform Commission (2005) *Report on Public Inquiries including Tribunals of Inquiry.* Dublin: Law Reform Commission.

Mackie, K. (2012) *Public Inquiries – Proposals for a Design Rethink. Inquiry into Public Inquiries Consultation Draft 2 December 2012*. London: Centre for Effective Dispute Resolution

OECD (organisation for Economic Co-operation and Development' (2002) *Reducing the Risk of Policy Failure: Challenges for Regulatory Compliance.* Available at https://www.oecd.org/regreform/regulatory-policy/1910833.pdf

Office of the Minister for Children and Youth Affairs. (2009) Report of the Commission to Inquire into Child Abuse, 2009 Implementation Plan. Dublin: Stationery Office.

Safety, Health and Welfare at Work Act (2005) Dublin: Stationery Office.

Safety, Health and Welfare at Work (General Application) Regulations (2007) Dublin: Stationery Office.

Shannon, G. and Gibbons, N. (2012) *Report of the Independent Child Death Review Group*. Dublin: Government Publications.

Social Services Inspectorate (2001) *Newtown House High Support Unit Inspection Report.* Dublin: Stationery Office.

Stutz, J.R. (2005) 'What gets done and why: Implementing the recommendations of public inquiries'. *Canadian Public Administration*, 51(3): 501-21.

Chapter 54 – Marie Nolan

Domain 3 Standard of Proficiency 14

Be able to establish safe environments for practice which minimises risks to service users, those treating them and others including the use of infection prevention and control strategies.

KEY TERMS

Safe environments

Minimising risk

Infection prevention and control

Social care is … a vocation. It is a discipline that represents a better future, determination, vision and change for vulnerable and marginalised groups in society.

Before embarking on a career in social care, you must be willing to commit to a challenging but rewarding journey. Social care services require professionals who are open-minded, non-judgemental, positive, empathic and driven. The social care sector is ever-evolving, so you also need to be resilient and resourceful in your approach. Working in social care provides a great sense of purpose, and the dedication invested is reciprocated in the small successes achieved daily.

Risk and Safe Environments

Establishing safe environments in social care practice is very important, especially when some service users may not have the capacity to be accountable for their own safety. In social care settings, the responsibility to provide a safe environment lies with both the employers and employees. The social care sector is driven by a changing legislative and practice framework. Guiding policies include the Health Act 2007, the Health and Social Care Professionals (Amendment) Act 2019, and the Equal Status Acts 2000-2018. Social care workers are faced with the challenge of maintaining a safe working environment that is consistent with changing policies, procedures and legislation. For example, the understanding of risk is influenced by the litigation that shapes it.

Factors to consider when developing a risk assessment in social care settings include:

- a knowledge of potential hazards
- an openness to reflect and learn from mistakes
- adherence to legislation through the application of relevant policies and procedures
- the provision of appropriate information and training to staff and service users such as manual handling, and
- the development of risk assessments, as required. (OCR 2012)

The term 'risk' is commonly used in association with an action that has an element of danger or potential loss. We are involved in the process of assessing risk when we ask ourselves the question, 'Is this too risky?' Some people choose to take more risks in their everyday lives than others. Equally, some people choose to take actions without considering any risks at all (Anderson *et al.* 2014). However, in the professional context of social care, frontline staff are expected, and have a duty of care, to undertake risk assessment and risk management every day. All services that provide care to

vulnerable groups are regulated by a relevant statutory body, such as the Health Information and Quality Authority (HIQA), Tusla or the Mental Health Commission. These bodies' mandatory monitoring systems place a legal obligation on organisations to implement and adhere to policies and procedures that promote safe environments for service users. These policies include medication management, risk management, fire safety, finance management, safeguarding of vulnerable persons, and health and safety. It is therefore vitally important that all employees who are new to a service should receive an induction on and become familiar with all relevant guiding documents adapted to that service before they begin work.

There are other, less formal, contributing factors to establishing a safe working environment. Possessing an in-depth knowledge and understanding of the individuals being supported can be significant in the delivery of safe and effective services. Social care workers need to be aware of the environment in which they work. In context, it is imperative that, as a social care worker, you are tuned in to the environment in which you work and alert to the needs of the individuals you support. One way this can be achieved is through a consistency within the team approach to care in your service. Maintaining a familiar and regular staff team is an integral factor in building trusting relationships with service users and their families. Additionally, being familiar with personal files such as person-centred support plans and behaviour support plans will provide important information on individuals' interests, preferences, physical, mental and social health care needs. However, knowing relevant care plans is not sufficient on its own to promote a safe environment for service users and support staff. The application of non-verbal communication skills such as active listening, eye contact, empathy and close observation maximises understanding in care staff, and in turn promotes safety and trust for service users.

Minimising Risk

A risk assessment can be developed either orally with a colleague or written on a relevant template. Risk assessments should be based on the premise of creating opportunities for an individual rather than used as evidence to prohibit an activity taking place. The format of a typical risk assessment includes the identification of the risk/hazard; a description of the control measures put in place to minimise the risk; further considerations and an action plan; benefits to the individual of accessing the risk; and a review date.

Control measures are the steps that are introduced to avoid or minimise any potential risk associated with the activity for those involved. Which types of control measures are decided on depend solely on the nature of the risk identified. For example:

- **Physical hazards:** Considerations may include access to buildings, such as ramps; availability of assistive equipment such as hoists, wheelchairs, support bars.
- **Educational requirements:** Teaching the person about healthy eating, money management, infection control.
- **Behaviour support plan:** If the risk is due to behavioural issues or concerns, the control measures may incorporate elements of the individual's behaviour support plan, such as proactive and reactive strategies implemented to identify and manage behaviours of concern.

When developing risk assessments, ethical considerations of the rights of the individual involved should be given priority. Any control measures implemented should never intentionally infringe on the human rights of that individual. HIQA use the acronym FREDA as a guide to a human rights-based approach to care in health and social care settings:

- **F**airness: The individual's wishes are known and any decision made is communicated to the service user in a way in which they understand how it impacts them personally.
- **R**espect: The service user is respected and any actions implemented are reflective of the individual's values and beliefs, and are respectful of their personal belongings such as their property.
- **E**quality: Any decision or plan should not infringe any of the nine grounds of discrimination as set out in legislation (Equal Status Acts 2000-2018) such as age, i.e., activities should be age-appropriate and should offer opportunity on an equal par with a typical citizen of the same age/gender in society.
- **D**ignity: Always endeavour to support the service user in a dignified manner. This involves putting appropriate measures in place which aim to empower the person in terms of their image and competency.
- **A**utonomy: Ensuring that the person is informed by providing information and education in an accessible manner. Encouraging service users to be as independent as possible in all activities of daily living. (HIQA 2019). Illustration included with permission.

TASK 1

Review a risk assessment in your workplace and determine whether human rights are being promoted in the risk management process. Explore ways in which the control measures can be re-evaluated to promote a rights-based approach.

On identifying control measures that are achievable and that all involved agree to, a risk rating must be determined, i.e., whether the risk is deemed high (e.g. 'risk of injury to others'); medium (e.g. 'risk associated with medical conditions such as asthma/epilepsy'); or low (e.g. 'risk of injury due to use of equipment for work'). At this point, further considerations may be developed as additional measures, such as qualified assessments as needed, training schedules, and/or contingency plans (HSA 2020).

A review date is required so that the information is kept up to date and relevant. A regular review also ensures that the risk rating is maintained or, ideally, minimised due to the progress or success of implemented strategies.

It is important to be mindful that taking risks should not be viewed wholly as a negative experience: engaging in risk-taking has been found to enhance resilience (Coleman & Hagell 2007).

Case Study 1

A man with an intellectual disability chooses to live in a home of his own. Previously, he has resided in a group residential home setting. He is supported to move to an individualised set-up, which is a one-bedroom bungalow in a location of his choice. However, after transition he has expressed his wish to only have staff supporting him during the day, and would like to stay on his own independently at night.

Identified risk	Risk of injury/harm due to associated factors of living on own and unsupported by Staff such as sudden illness, fire safety, burglary.
Control measures	*Option 1:* Minimises risk but infringes human rights × Night staff rostered, as per former living arrangement, as risk is deemed too high × Service user's wishes denied in the interests of his own safety
	Option 2: Minimises risk but promotes opportunity ✓ Explore local resources such as community police programmes and fire brigade to engage in basic training for the service user in neighbourhood watch and fire safety ✓ Staff to provide skills teaching in use of mobile phone to emergency numbers and use of personal alarm, and provide education on self-sufficiency skills for independent living ✓ Staff to role-play about stranger-danger and managing unexpected visitors **Risk rating: Medium-High**
Further considerations/action plan	• Provide minimal support until relevant training is completed • Trial independent living at night for three months with regular weekly reviews **Risk rating: Low-Medium**
Benefits to the individual	• The individual's wish to live on his own at night is upheld and respected • Human rights are exercised • Any potential risk identified is minimised

Discussion

Note that both control measure options minimise any potential risk for the service user; however, the latter option creates opportunity in doing so. Due to the nature of the work involved in the social care sector, the urge to protect and shield those cared for is almost unavoidable. However, all vulnerable persons using services have the right to exercise will and preference. Therefore, social care workers have a duty to support and advocate for service users in their quest. The process of risk assessment and risk management, when used appropriately, achieves a desirable balance between risk and opportunity.

Infection Prevention and Control

Infection prevention and control is the process of preventing infectious disease, in the first instance by exercising proactive measures; and, if a disease is contracted, by controlling the spread of infection by suppressing or eliminating the disease through the implementation of an appropriate action plan.

From December 2019, when the coronavirus pandemic began to spread globally, social care services had to develop new infection prevention and control policies. COVID-19, a new illness caused by the virus, is an infectious and contagious disease causing severe acute respiratory syndrome. The disease is spread through ingesting the virus, either directly, by inhaling airborne droplets; or indirectly, by coming into contact with contaminated surfaces. According to the World Health Organisation (WHO), COVID-19 is more contagious than many other common infectious diseases, such as influenza, spreading more easily and more quickly. It has a high mortality risk, and those who recover can experience long-term health problems due to the impact of the virus on vital organs such as heart and lungs. While research and development on a vaccine continued, the general population had to adapt to a new way of living with the virus (WHO 2020).

In response to the onset of the pandemic in Ireland from March 2020, there was a requirement at service level to implement comprehensive risk assessments, protocols and robust systems to reflect guidelines from the government, the National Public Health Emergency Team (NPHET) and the Health Service Executive (HSE) guidelines. The restrictions undoubtedly impacted on service users' routines and constricted the dynamics of service provision. For example, something as common as facilitating visits from family and friends became a formality. This was part of the early introduction of *infection prevention* measures to keep the virus out of services.

The pressure of the COVID-19 pandemic was also felt greatly by social care workers. Individuals availing of service provision fell into the categories of those most vulnerable to contracting COVID-19 due to age, underlying health conditions and socioeconomic status (HPSC 2020a). In the early and unfamiliar phases of the pandemic, frontline workers ran tirelessly and dutifully in an effort to protect service users from contracting the disease. Unfortunately, it seemed at the time that their efforts went unnoticed publicly, in contrast to their colleagues at a multidisciplinary level – nurses, doctors and paramedics. Social care workers felt like the unsung heroes of the pandemic; but perhaps that is a perception that will change when the registration of social care workers as healthcare professionals has been completed (CORU 2020).

TASK 2

HSELanD (www.hseland.ie) is an online resource for free training that is available to employees in health and social care services. The course catalogue includes modules on Breaking the Chain of Infection; Infection Prevention and Control; National Standards for Infection Prevention and Control in Community Settings: Putting the Standards into Practice (module developed by HIQA); and Do the Right Thing: HSE Risk and Incident Management. Completion of relevant modules in advance of employment is recommended.

In emergency circumstances such as an unprecedented global pandemic, it is important that services implement the process of infection control promptly and efficiently. Exercising and embedding standard infection control precautions is significant in minimising contamination and spread of a virus.

Standard precautions include:
• A focus on education and training for frontline staff in infection prevention and control and cross-contamination
• Provision of relevant information to staff and service users in relation to specific infection
• Access and information on available vaccines and supports
• Providing and wearing appropriate personal protective equipment (PPE), including putting it on and taking it off correctly
• Maintaining clean and disinfected working environments and equipment
• Setting up the work environment with clear systems/protocols in place to guide staff in safe practice
• Prompt execution of effective reactive strategies.

The HSE is a reliable advocate and resource for guidance on infection prevention and control. However, it does warn that local protocols and procedures should be developed without implementing 'unnecessary barriers to care as barriers to care can be as harmful as infection' (AMRIC 2020). Once again, this demonstrates the importance of developing risk assessments that balance minimising risk and upholding autonomy.

At the onset of the pandemic and to respond to the pressures it presented to social care providers, the Department of Health published the 'Ethical framework for decision-making in a pandemic' in March 2020. The framework is aimed at assisting frontline workers, management and policymakers in health and social care settings with decision-making in difficult circumstances. It identifies seven ethical principles that should be considered when planning for and responding to decisions in crises. Two of the principles – minimising harm and proportionality – are relevant when considering infection prevention and control:

1. The principle on *minimising harm* reiterates the point that health and social care workers have a duty of care to inform and support service users in engaging in certain behaviours that reduce potential risks associated with the spread of infection; for example, supporting service users to avail of vaccinations.

2. However, the principle on *proportionality* advises that restrictions to one's liberty, as a result of control measures introduced to minimise risk, should not exceed what is required to address the actual level of risk to those whom the restrictions are designed to protect. For example, during a national lockdown, the highest level of restrictions should not be maintained longer than necessary just because it is felt that this is in the best interests of the individuals supported. Hence, government advice should be interpreted consistently with typical citizens of society, albeit occurring in a more strategic manner (DoH 2020).

TASK 3

Download and read the 'Ethical framework of decision-making in a pandemic' from https://www.gov.ie/en/publication/dbf3fb-ethical-framework-for-decision-making-in-a-pandemic/. Examine the seven key principles of decision-making during a pandemic. Consider how these principles might positively influence decisions impacting service users in relation to the introduction of infection prevention and control strategies.

In the unfortunate circumstances that an infectious disease is contracted in a care setting, an appropriate response plan is required to manage the spread of infection. Systems such as contingency-plans and risk assessments on cleaning, laundry and waste management should be considered. Standard precautions should be intensified. Maintaining a calm approach and clear communication with service users, staff and family is key to collectively overcoming a potential outbreak.

Tips for Practice Educators

In supporting students to achieve proficiency 14 under domain 3, it is helpful to commence placements by identifying risk assessments that are currently in place, and by providing information on any relevant policies and procedures present. The risk assessment folder contains significant information on safety and can be useful as a starting point for students to become familiar with the work environment and service users. As available, provide any inspection reports for the service which highlight areas of compliance in providing a safe environment; for example, HIQA inspection reports and annual audits. This will help students put the proficiency into perspective from a frontline point of view. If possible, protected time should be provided at induction stage, i.e., time allocated just to read files and interpret new information.

Students should be provided with the appropriate means to perform high standards of infection control practices while on placement. For example, they should know how to access PPE such as gloves/masks when needed; be informed about current systems pertaining to infection control procedures, e.g., COVID-19 management plans; be aware of any potential risks associated with infectious diseases such as hepatitis B for which they require additional protection; and be familiar with any cleaning procedures necessary.

When setting placement goals, it would be beneficial for the student to be assigned a goal specifically to develop a risk assessment. It is important that students can apply current risk assessments to their work practice but are also able to identify an activity that requires a new risk assessment or a review of an existing one. Practice educators could arrange for the student to assist planning an activity which requires a risk assessment in advance. Assess whether the student can identify potential hazards, determine the level of risk involved, accurately record findings and identify control measures that either minimise or eliminate the risk, while taking consideration of practical use of available resources, local policies and procedures and possible modifications of activity as required. On completion of the activity, the student should be given the opportunity to reflect on what worked and what could have gone better, and how the risk assessment impacted on the success of the activity.

Relevant training is required and beneficial for specific roles. As most training programmes are accessible online on HSELanD or via other online resources, an achievable training plan should be developed at the outset to help the student fulfil their role while on placement as best as possible.

References

AMRIC (Antimicrobial Resistance and Infection Control Team, HSE) (2020) *Infection Prevention and Control: Guidance for Resumption of Healthcare Services* (PowerPoint slides) <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/webinarresourcesforipc/IPC%20guiding%20framework%20webinar.pdf>.

Anderson, T.J., Garvey, M. and Roggi, O. (2014) *Managing Risk and Opportunity: The Governance of Strategic Risk-taking*. Oxford: Oxford University Press.

Coleman, J. and Hagell, A. (eds) (2007) *Adolescence, Risk and Resilience: Against the Odds*. West Sussex: John Wiley & Sons.

CORU (2020) *Social Care Workers Registration Board*. Available at: <https://www.coru.ie/about-us/registration-boards/social-care-workers-registration-board> [accessed 25 December 2020].

DoH (Department of Health) (2020) 'Ethical framework of decision-making in a pandemic'. Available at: <https://www.gov.ie/en/publication/dbf3fb-ethical-framework-for-decision-making-in-a-pandemic/#> [accessed 28 October 2020].

HIQA (Health Information and Quality Authority) (2019). *Background document to inform the development of guidance on a human rights-based approach to care and support in health and social care settings*. Available at: <https://www.hiqa.ie/sites/default/files/2019-06/Draft_Guidance_Human_Rights-Based_Approach_to_Care_Background_Document.pdf> [accessed 29 September 2020].

HPSC (Health Protection Surveillance Centre, HSE) (2020a) *COVID-19 Guidance for International Protection Accommodation Service (IPAS) Settings* (V5 01/10/2020). Available at: <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/vulnerablegroupsguidance/Guidance%20for%20IPAS.pdf> [accessed 29 October 2020].

HPSC (2020b) *Epidemiology of COVID-19 Outbreaks/Clusters in Ireland*. Available at: <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/surveillance/covid-19outbreaksclustersinireland/COVID-19%20Weekly%20Outbreak%20Highlights_Week392020_web%20version_v1.0_28092020.pdf> [accessed 5 October 2020].

HSA (Health and Safety Authority) (2020) *Risk Assessments Made Easy*. Available at: <https://www.hsa.ie/eng/supports_for_business/getting_started/risk_assessments_made_easy/> [accessed 30 September 2020].

OCR (Oxford, Cambridge and RSA) (2012). *Ensuring Safe Environments in Health and Social Care* (Level 2, Unit 4). Available at: <https://ocr.org.uk/Images/139857-ensuring-safe-environments-in-health-and-social-care.pdf> [accessed 22 November 2020].

WHO (World Health Organisation) (2020) *Considerations for Public Health and Social Measures in the Workplace in the Context of Covid-19*. Available at: <https://www.who.int/publications/i/item/considerations-for-public-health-and-social-measures-in-the-workplace-in-the-context-of-covid-19> [accessed 13 October 2020].

Chapter 55 – Deborah Brady and Fiona Brannelly

Domain 3 Standard of Proficiency 15

Be able to identify and document the unmet needs of individual service users and demonstrate an ability to select the appropriate escalation route working with colleagues and the service user to resolve the gap in care.

KEY TERMS

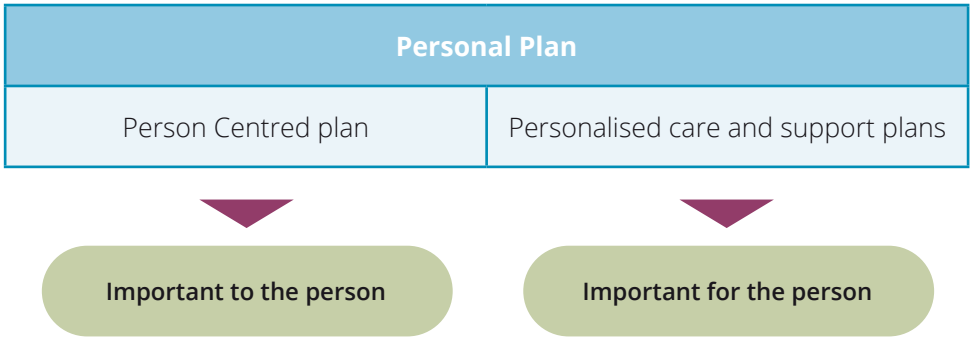
- Unmet needs
- Communication and needs
- Documenting needs
- Escalation routes for addressing unmet needs
- Complaints procedures

Social care is … advocating for the rights of people to have the life according to their will and preference by being innovative and creative in eliminating barriers.

Unmet Needs

Unmet needs occur when supports and services are unavailable or inadequate to meet a service user's will and preference, irrespective of the service. This chapter is written from our many years' experience as social care workers in disability services. People with disabilities are at a greater risk of their rights and needs not being identified and addressed. These unmet needs can relate to issues such as inadequate access to food sources, exposure and lack of protection from abuse and neglect, inadequate access to housing and respite, and limited family and social relationships, to name a few. In some situations, service users have the skills and abilities necessary to identify and communicate their will and preferences with their family or social care worker (SCW). For a service to meet the needs of the service user they need to gain in-depth information of 'what is important to the person and what is important for the person', which is usually contained in their personal plan (HSE 2018: 13).

Personal Plan Diagram (A National Framework for Person Centred Planning in Services for Persons with a Disability 2018: 13)



This approach puts what matters most to the service-user at the centre of the service in relation to the quality of care and support they access and what needs to happen to ensure they have the life they want. As an SCW you may be appointed as a key worker with responsibility for ensuring that these plans are updated and maintained to reflect the needs of the person you are supporting. These plans should be reviewed regularly and updated to highlight the changing needs of the person. This is done by the SCW, with the service user, their staff team and family/carers to ensure that the service they are receiving meets their current needs. These plans address not only the care and support the person requires but also their will and preference, hopes and dreams.

In the past we have seen many cases and reports of abuse in care such as the Áras Attracta Swinford Review Group 2016 report, which provides evidence of the negative impact of what can happen when the needs of people with disabilities are not addressed and how it can impact on the culture of an organisation. People with disabilities want nothing more than to have a say in their own lives and to gain access to the supports they need to be included in their communities to live an ordinary life (HSE 2018). For years people with disabilities were, based on their cognitive impairment, denied their legal capacity to make their own decisions. This had detrimental effects (Davidson *et al.* 2018), making them very vulnerable to exploitation and abuse as they were deemed incapable of expressing their wishes or lacking capacity to make their own decisions (Killeen 2016). Decisions were made by professionals and families in their 'best interest', not taking into account their will and preference (Carolan 2018). Examples of this range from lack of the service user's consent in relation to medical treatments, the services they received, and where or with whom they lived. To ensure a quality service that is meeting the individual's needs, personal plans are developed with that individual, their families and/or carers which contain valuable information about the individual to ensure that they will receive the service they want. If these plans consistently highlight needs that are not being met, there are different avenues you can take to rectify this. We have used fictional case studies in this chapter to illustrate how we identify and document unmet needs within our sector.

Case Study 1

Identifying Unmet Needs

Social care worker John has been Mary's key worker for the past three years. Mary has a hearing impairment and is non-verbal with a moderate intellectual disability. She uses a hearing aid and a picture exchange communication system (PECS) to communicate.

One day Mary came into her day service from her home and didn't follow her usual routine. It is important to note that when someone cannot communicate verbally, staff awareness of the individual's body language and routines are heightened, as changes in these can be an indication that something is not okay. Mary had a cup of tea but then went up to the physiotherapy bed and lay down. Mary is very inquisitive and likes to be in the company of staff members, so for her to do this is out of character to those who know her well. There was a locum staff working that morning and a permanent staff member who was with another service user. John was at a meeting and afterwards came into the kitchen, where staff drew his attention to Mary. They told him that she may have had a late night and was tired. However, John, who knows Mary very well, became very concerned. He went up to the physiotherapy area and asked Mary if she was okay. When he looked at her he knew she was seriously ill. John quickly informed staff of his concerns and made the decision that he needed to get Mary to hospital and there wasn't time to wait for an ambulance. He instructed staff to get Mary's hospital passport and list of medications while he organised transport. John brought Mary to the hospital and even though Mary could not communicate her illness and appeared well to the nurse, John advocated for her to be seen straight away – sometimes service users like Mary do not present symptoms of illness in the same way as the general population.

Mary was diagnosed with sepsis from an untreated urinary tract infection and ended up spending two weeks in hospital. On discharge, a care plan was drawn up for Mary by her service team that included regular urine tests and a referral to urology. A historical search of Marys medical files showed a history of UTIs which was not noted in her recent medical notes, so this was added to her current care plans. Additionally, her communication passport was updated to acknowledge the importance of knowing Mary's routine and body language.

To be able to identify an unmet need for service users who cannot communicate verbally, you need to have a good knowledge of the person's will and preference, which is reflected in their normal routines and behaviour. The ability to identify an unmet need early and act on it quickly is an important part of the role of a social care worker.

1. On reflection, what are the key issues you identified in this case study and how would you as a SCW address them?
2. What strategies and documentation would you have in place to prevent this situation from reoccurring?

Communication and Needs

Needs can be communicated through verbal language, objects of reference, picture exchange communication (PEC) or other communication devices or aids. Consequently, it is vital that family and SCWs have received the necessary training in communication tools and assistive technology. However, in the disability field, we frequently support people with limited communication abilities that can lead to difficulty in identifying and addressing a person's unmet needs. Therefore, in such circumstances it important that staff are familiar and have a relationship with the people they are supporting. It is also essential to have the necessary training and skills to enable SCWs to decipher the subtle cues (body language, facial expressions, different vocal tones) that service users use to communicate. It is sometimes through these subtle communication cues that we as SCWs can identify and understand a person's will and preference and thus identify their unmet needs.

Case Study 2

Staff were working with Ann for a number of years. Ann was non-verbal and although social care staff, along with the speech and language team, trialled several communication methods including objects of reference and PECS (through verbal communication and record keeping), Ann would not engage with the process. Consequently, staff would have to rely on their knowledge of Ann and her body language and facial expressions as cues. Several staff recorded that there were several incidents when Ann would stand while on transport. This was a new occurrence, so staff called a meeting as it was a health and safety issue.

TASK 1

What are the key issues you identify in this case study and how would you as an SCW address them?

After the meeting it was decided that we would seek the support of the behaviour specialist. We investigated any changes on the bus: Had the other people on the bus recently changed from where they would usually sit? Was there conflict between service users? Did this happen all the time or only when certain people were on the bus? We also investigated if there was anything from a medical perspective that we needed to address. The staff team are aware that all behaviour is communication, and medical issues/pain can present in many forms in the disability service. After routine blood tests and a scan, it was determined that Ann had gallstones. The appropriate medication was administered, and she were placed on a waiting list for surgery. Since the administration of pain medication, there have been no additional recorded incidents of Ann standing while on transport.

Documenting Needs

To ensure that a person's unmet needs are addressed, it is vital that SCWs, staff teams and family establish a clear and open communication process. This communication process is supported through the use of written reports and care plans. As part of our duty of care, we are legally obliged to keep written records and these records must be safely stored in line with legislation. Report writing and record keeping are two important elements of the SCW's professional role in line with current best practice and legislative requirements. It enables SCWs and their co-workers to provide safe and effective services and a continuum of care, while ensuring accountability. In order to ensure that our reports are written to a professional standard there are a few key points you should note.

How to Write an Effective Report
Report writing must:
• Be understandable, clear and concise.
• Use objective and neutral language. Reports should not include emotive language or abbreviations.
• Be completed in a timely manner.
The Benefits of Quality Report Writing
• Report writing allows us as SCWs to provide chronological facts based on practice evidence which support and inform our provision of care and promotes accountability
• Reports provide effective communication between staff and the multi-disciplinary team.
• They ensure continuity of care and assist in the detection of risk/complications.
• They facilitate collaboration between service user and professionals (Parr 2013).

In line with 'a person-centred approach' to service delivery, written records are maintained which contributes to a quality continuum of care for service-users and families. These records are important for the service user and their family and, under the Freedom of Information Act 2014, can be accessed by them. Records can be maintained in a variety of formats, e.g., written notes, emails and documents on iPads, etc. As SCWs it is important that we safeguard the service users' personal information. The European Union General Data Protection Regulation (GDPR) and the Irish Data Protection Act 2018 provide the framework for record management. One key principle of record keeping is knowing what information to keep, why we require this information, how it may be used, where it came from, how long it should it be kept for and where it should be filed/stored. As SCWs we have a legal obligation to store this information securely. Record keeping is central to accountability, provides the basis for interventions, a context and reasons for decisions made and allows practices to be monitored. Overall, records should provide clear evidence of the care and support that the service user receives and requires. They should also include their will and preference, their hopes and dreams, changes identified, and that the information is shared with the appropriate individuals. This has clear benefits for early detection and can address potential unmet needs for the person, which in turn may prevent behaviours of challenge or highlight the lack of resources such as speech and language therapy or physiotherapy.

Escalation Routes for Addressing Unmet Needs

When an unmet need has been identified by an SCW from the documentation (such as individual notes, team meeting minutes, monthly progress updates, personal plans, etc.) there are different ways to address the issue. The SCW brings this information to the attention of their social care leader (SCL) individually or at a team meeting where each individual's progress is discussed. Team meetings should happen regularly, and at these meetings information is shared and concerns are highlighted on each person in the service, to ensure that they are supported by each member of the team.

Taking on board the nature of the unmet need, the SCL will then identify the most appropriate escalation route to address these concerns. This can mean a referral to a member of the multi-disciplinary team (MDT) or, if the individual is already receiving input from a variety of professionals, an MDT review can be called. The MDT will include a number of professionals such as psychologist, behaviour support specialist, occupational therapist, social worker, speech and language therapist and physiotherapist who work together to assess, plan and provide support to the service user and their staff team. SCWs are an integral part of the MDT as they work directly with the service user and can advocate, on behalf of the service user, for unmet needs to be addressed. At an MDT review, a SCW can highlight their concerns, with the support of the SCL. Additionally, if the unmet need is a restriction to the service user's rights, there will need to be a referral to the human rights committee or social worker in the organisation or externally through an independent advocate from the National Advocacy Service (https://advocacy.ie). Alternatively, the SCL/SCW can support the service user to go directly to their area manager to highlight the unmet need, especially if there is a gap in resources to support the person. A huge part of an SCW's role is to promote self-advocacy and empower the person to communicate their own unmet needs. Advocacy can be provided through different forums; individually, or part as a group in the person's day or residential centre, which then can feed into a larger advocacy group where senior management will meet with the group regularly throughout the year. Access to self-advocacy and advocacy supports in general is very important for service users. Taking into account everyone's input, the manager will then seek resources through completing a business plan for the HSE to attain additional funds to meet those needs. (If there isn't currently an advocacy group in your service, you can contact the National Advocacy Service.)

Complaint Procedures

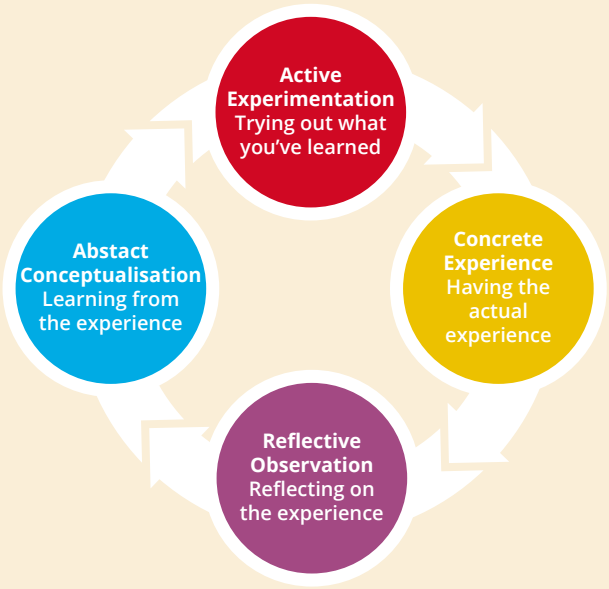
If the unmet need is not rectified at a local level, the person can be supported by the SCW to make a complaint. These complaints can be heard and addressed either internally or externally. Most services have an accessible complaints form which can be completed by the person themselves or with support from their family or SCW and forwarded to the local manager and/or complaints officer. Every service should have a complaints procedure in place and SCWs need to be familiar with the correct procedures and policies in their service. These complaints have to be addressed in a timely manner. However, if you are still not happy or if your service does not have an accessible complaints route, then there are different avenues to report their concern such as the HSE's 'Your service your say' complaints process (https://www2.hse.ie/services/hse-complaints-and-feedback/your-service-your-say.html). Or there is also the confidential recipient Leigh Gath, who deals with concerns of abuse, negligence, mistreatment and poor care practices (https://www2.hse.ie/services/hse-complaints-and-feedback/report-a-concern-about-a-vulnerable-adult-in-care-to-the-confidential-recipient.html).

It is important to remember that the service user's quality of life should not be based on the resources of the service. As an employee of a service, you have many routes to go through to highlight an unmet need (e.g. local or senior management, MDT, advocacy, etc.). However, if you have exhausted all available avenues, there are alternative options outside the service to support people with a disability, such as an independent advocate. Just remember that if the person is not at the centre of the service, they will continue to live a life of someone else's choosing through the lens of 'best interests' until systems are put in place to support and protect their expression of will and preference and their rights (Croucher 2016). As an SCW, you are in an influential position to empower the person you are supporting to advocate for the life they want.

Tips for Practice Educators

An important requirement to assist the student in achieving this proficiency lies within the practice educator's ability to assess at what stage of professional development the student is currently practising.

For this reason, it is important that educators are knowledgeable and have an understanding of the 'student development model'. One familiar model is the Kolb reflective cycle (see diagram below). Other well-known models are Artur Chickering's seven vectors of identity development and William Perry's theory of intellectual development.



One useful tool that practice educators can use in assessing the student's stage of professional development is regular support and supervision. When the student's stage of development has been established, the student and practice educator can set learning goals to help them achieve this proficiency. There are several key steps in doing this.

First, throughout the practice placements and on-site learning, students should be exposed to the various ways in which service-users communicate. As mentioned, communication routes can include direct verbal communication, use of PECs, objects of references, Lámh, etc. Each service user may have their own unique way of communicating and it is important that students are exposed to these and have training in communication and different types of assistive technology if required. Training of record keeping and GDPR would also be very beneficial.

Second, students should be encouraged and given opportunities to link in with the staff team to discuss the experiences of staff and how they identified and addressed service users' unmet needs through past experiences. Students could also read the service user's personal profile to observe the recording of unmet needs and how this was rectified; however, this will depend on the organisational policies relating to GDPR and consent given by the service user.

Third, the practice educator and student could use a supervision session to discuss a hypothetical unmet need. During this session the student and educator could discuss what tools were used to identify the unmet need, how it would be recorded, the escalation routes used to address the unmet need and what organisational policies and process they should follow. It would also be useful to discuss and explore what national and international legislative laws within which we are bound to practice as SCWs, for example the Assisted Decision-Making Act 2015 and the UN Convention on the Rights of Persons with Disabilities (CRPD).

Finally, the student should be encouraged and given the opportunity to participate in an active case where the staff team are currently working together in supporting a service user to identify and address an unmet need. This is important to enable and enhance the professional growth of the student. The student should be encouraged to participate and offer solutions. Students, where possible, should attend team meetings and MDTs and have sufficient access to the necessary paperwork. The practice educator should encourage the student, along with the staff team, to discuss how the unmet need was addressed, acknowledge the positives and discuss any learning or further training that may be required to ensure future unmet needs can be appropriately and timely addressed.

Suggested Reading:

- HSE, *New Directions – Day Services for Adults with Disabilities*: https://www.hse.ie/eng/services/list/4/disability/newdirections/newdirections.html.
- HIQA, *National Standards for Residential Services for Children and Adults with Disabilities*: https://www.hiqa.ie/sites/default/files/2017-02/Standards-Disabilities-Children-Adults.pdf.
- Assisted Decision Making (Capacity) Act (ADMA) 2015: https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/assisteddecisionmaking/assisted-decision-making.html.
- HSE, *Time to Move on from Congregated Settings*: https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/.
- Department of Health, *Value for Money and Policy Review of Disability Services*: https://www.gov.ie/en/publication/ed3564-value-for-money-and-policy-review-of-disability-services-in-ireland/?referrer=/wp-content/uploads/.
- HSE, *National Consent Policy – Quality Improvement Progammes*: https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/.
- United Nations Convention on the Rights of Persons with Disabilities (UNCRPD): https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html.
- HSE, *A National Framework for Person-centred Planning in Services for Persons with a Disability*: https://www.hse.ie/eng/services/list/4/disability/newdirections/framework-person-centred-planning-services-for-persons-with-a-disability.pdf.
- National Resource Center for Supported Decision-making (USA): http://www.supporteddecisionmaking.org/.

- Decision Support Service Ireland: https://decisionsupportservice.ie/.
- Data Protection Act 2018: http://www.irishstatutebook.ie/eli/2018/act/7/enacted/en/html
- HSE, Data Protection Policy: https://www.hse.ie/eng/gdpr/hse-data-protection-policy/hse-data-protection-policy.pdf
- HSE Privacy Notice – Patients and Service Users: https://www.hse.ie/eng/gdpr/hse-data-protection-policy/hse-privacynotice-service-users.pdf

References

Áras Attracta Swinford Review Group (2016) *What Matters Most: Report of the Áras Attracta Swinford Review Group*. HSE. Available at <https://www.hse.ie/eng/services/publications/disability/aasrgwhatmattersmost.pdf> [accessed 11 September 2020].

Carolan, M. (2018) 'Ward of court system does not protect vulnerable adults – HSE', *Irish Times*, 16 January.

Croucher, R.F. (2016) 'Modelling Supported Decision-making in Commonwealth Laws', ARLC 2014 Report, *Making It Work*, AGAC 2016 National Conference, Sydney, 18 October 2016.

Davidson, G., Edge, R., Falls, D., Keenan, F., Kelly, B., Mc Laughlin, A., Montgomery, L., Mulvenna, C., Norris, B., Owens, A., Shea Irvine, R. and Webb, P. (2018) *Supported Decision-making: Experiences, Approaches and Preferences*. Belfast: Praxis Care, Mencap and Queen's University Belfast.

HSE (Health Service Executive) (2018) *A National Framework for Person-Centred Planning in Services for Persons with a Disability*. Available at <https://www.hse.ie/eng/services/list/4/disability/newdirections/framework-person-centred-planning-services-for-persons-with-a-disability.pdf> [accessed 5 March 2020].

Keeling, Chapman, Williams, Keeling, June, Chapman, Hazel M., and Williams, Julie. *How to Write Well: A Guide for Health and Social Care Students*. Maidenhead, Berkshire: Open UP, 2013. Web.

Killeen, J. (2016) 'Supported decision-making: Learning from Australia', Winston Churchill Memorial Trust. Available at <https://www.wcmt.org.uk/sites/default/files/report-documents/Killeen%20J%20Report%202016%20Final.pdf> [accessed 20 November 2018].

Parr, T. (2013) 'Record Keeping' in A. Worsley, T. Mann, A. Olsen and E. Mason-Whitehead, *Key Concepts in Social Work Practice*. London: Sage.