# Scotland

# **Care Work** with Older People

Dundee College

Education and Culture
Leonardo da Vinci
FIN-00-B-P-PP-126556

"This project has been carried out with the support of the European Community. The content of this project does not necessarily reflect the position of the European Community or the National Agency, nor does it involve any responsibility on the part." The expansion of the transnational module and development of the work placement supervising. The ETM-pilot project 2000-2003 FIN-00-B-P-PP-126556

# Content

# Introduction

*Dear Student,*

*The aim of this handbook is to assist you when you are preparing for foreign work based training with older people in Finland.*

*Chapter One deals with EU and its normative basis and obligations to Member States.*

*Chapter Two describes generally how social protection is organised in Scotland.*

*In Chapter Three you have information on older people in Scotland and the important aspects when planning care fro them.*

*Chapter Four gives you a short, perhaps too short, overview on history and development of services available for older people and on future challenges. In this chapter you will also find a general presentation of the most important services for older people.*

*Chapter Five gives a brief view on the older person's income security.*

*Chapter Six and Seven are the essential ones when preparing for work based training with the older adult in Scotland. The four different care settings chosen are aimed to reflect the practical nurse's working day and relate to some of the main services introduced in chapters 4.2 - 4.9. The aim of these descriptions is to assist your preparations for actual practical training, and your learning in the workplace more concrete.*

*Chapter Eight and Nine give broader information on the sectors vocational training and labour market.*

*Please also refer to the Appendices as they are linked to the chapters and contain important information.*

*Most pictures can be opened up to full-screen size by double clicking the picture.*
*The following was written by an old lady who had a great sense of humour. She had many complaints associated with her age as did her friends, so she wrote this as a way of cheering them all up.*

**What are Senior Citizens Worth?**

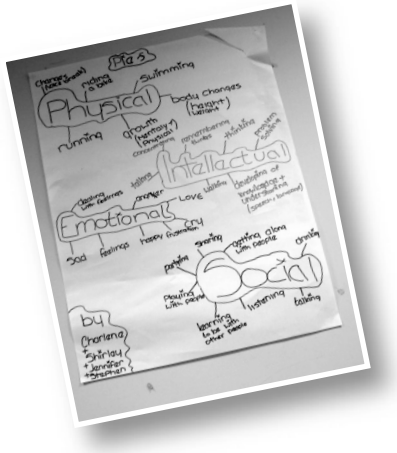
*Remember old folks are worth a fortune with silver in their hair, gold in their teeth, stones in their kidneys, lead in their feet and gas in their stomachs.*

*I have become a little older since I saw you last and a few changes have come into my life: Frankly I have become a frivolous old gal!*

*I am seeing 6 gentlemen every day. As soon as I wake up, Will Power helps me out of bed. Then I go and see Johnny Loo. Next Charlie Cramp comes along and when he's here he takes up a lot of my attention. When he leaves Arthur Ritis shows up and stays around all day. He doesn't like to stay in one place very long so he takes me from joint to joint. After such a busy day I'm really tired and glad to get to bed with Johnny Walker. What a life! Oh yes I'm also forgetting Al Zheimer.*

*PS*

*The minister came to call the other day. He said that I should be thinking about the Hereafter. I told him I do all the time. On my way home, in the parlour, upstairs, in the kitchen or down in the basement. I say to myself, 'Now what am I hereafter?'*



# 1. United Nations, European Union and Social Policy

## 1.1. United Nations' Second World Assembly on Ageing, 2002: Building a Society for all Ages

Ageing within a population is a challenge to all societies. Global guidelines and principles are drawn to secure and enable older persons' integration as full citizens in different societies. As an example of such global aims, the following UN- document presents UN-decided principles that are rephrased on EU-level as well.

To address the challenges associated with this momentous demographic shift taking place, the United Nations General Assembly decided to convene the Second World Assembly on Ageing form 8 - 12 April 2002 in Madrid, Spain.

### International Action Plan as an Answer to the Fact of Ageing 2002-12-15 (Passed on April 12 2002)

The international action plan is the logical and practical turnover of the decisions of the:

- UNO plenary assembly 1982 (action plan)
  and
- UNO plenary assembly 1991 (passing)

**Article 1** of the now presented action plan does express as a political statement.

'We, the representatives of the government meeting at the second world assembly in Madrid, to answer the fact of ageing, have decided to pass an international action plan to answer the fact of ageing in 2002, in order to take into account the possibilities and challenges in coherence with old people in the 21st century.

At the background of this action plan we commit to measures at all levels including national and international levels based on three foundations:

- the elderly and development
- promotion of health and well being at high age
- guarantee of a beneficial and supporting environment'

Thereby the principals of the UN for elderly care are:

- independence
- participation
- care
- self-fulfilment
- dignity

are turned over into practical, and concrete, actionable options.

Targets, measures and demands at national and international levels are named in 117 points.

Especially claimed is point 109, the international network, covering:

- exchange
- consultation, and
- support.

The UN commission for social development will be responsible for the follow-up and the judgement of the turnover measures according to the action plan.

The **International Action Plan 2002**, and national action plans can be retrieved via the internet at the following sites:
http://www.un.org/esa/socdev/ageing/waa/index.html
http://www.un.org/ageing/dpi2230.html


## 1.2. United Nations Principles for Older People

(adopted by the UN General Assembly, December 16, 1991 - Resolution 46/91)

The following excerpt highlights in a more detailed way what aims the United Nations has set for policy-makers and legislative bodies in different societies.

> *'To add life to the years that have been added to life'*

The UN principles aim to ensure that priority attention will be given to the situation of older people. The UN Principles address the independence, participation, care, self-fulfilment and dignity of older people.

The General Assembly appreciates the contribution that older people make to their societies and encourages national governments to incorporate the following principles into their national programmes whenever possible:

### Independence

1. Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
2. Older persons should have the opportunity to work or to have access to other income-generating opportunities.

3. Older people should be able to participate in determining when and at what place withdrawal from the labour force takes place.
4. Older persons should have access to appropriate educational and training programmes.
5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
6. Older persons should be able to reside at home for as long as possible.

## Participation

7. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
8. Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
9. Older persons should be able to form movements or associations for older persons.

## Care

10. Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
11. Older persons should have access to health care to help them maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
12. Older persons should have access to social and legal services to enhance their autonomy, protection and care.
13. Older persons should be able to utilise appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and quality of their lives.

## Self-fulfilment

15. Older persons should be able to pursue opportunities for the development of their potential.
16. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

### Dignity

17. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
18. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

More information is available at:
**http://www.aoa.gov/international/Principles/principle.html**
**www.un.org/esa/socdev/iyop/iyoppop.htm**

## 1.3. European Union and Social Policy

◆ **The European Community Treaty** made in Maastricht 1992 emphasises connections between economic growth, employment and welfare. Social policy and social protection are seen as factors promoting economic growth. The EU-level social policy-decision making is restricted in drawing up general guidelines and principles that can be found in different Council's Recommendations and Charters agreed by Member States.

From an ordinary citizens viewpoint, the question lies more with **national** social policy legislation which is a core responsibility of the Member States. The EU has lain down only **minimum standards** and **minimum rights.**

**The European Social Charter** represents consensus over the basic economic, social and cultural rights. The rights guaranteed by the European Social Charter are as follows. The right to:

- education
- employment
- health
- housing
- non-discrimination, and
- social protection

Under the Charter, states must guarantee the right to the protection of health, social security, social assistance and social services. It lists the **special measures** which must be taken for the elderly. The revised Charter guarantees the right to protection against poverty and social exclusion.

The European Social Charter defines the rights of EU-citizens on general level.

The implementation of these rights is executed by Member States.

## 1.4. Social Protection of Older People - Social Charter

◆ The following additional protocol to European Social Charter specifies elderly people's rights to social protection. As all member States have ratified the Charter, it binds member States and they are expected to adapt their social policy programmes and measures to meet the aims of the Charter. The additional protocol lays the guidelines for the social protection of older people on European Union level in the following way.

### Article 4 - Right of elderly persons to social protection

◆ With a view to ensure the effective exercise of the right of older persons to social protection, the Parties (ie Member States) undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular to:

1. **enable elderly persons to remain full members of society for as long as possible**, by means of:
   a) adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life;
   b) provision of information about services and facilities available for elderly persons and their opportunities to make use of them;
2. **to enable elderly persons to choose their life-style freely and to lead independent lives in their familiar for as long as they wish and are able**, by means of:
   a) provision of housing suited to their needs and their state of health or of adequate support for adapting their housing;
   b) the health care and the services necessitated by their state;
3. **to guarantee elderly persons living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution.**

Source: EUROPEAN SOCIAL CHARTER, Additional Protocol to the European Social Charter ETS no: 128

The Member states are to develop their national social policy legislation according to these EU-level guidelines of the European Social Charter. The national policy on ageing of a Member State should be based on the presented Article 4 - Right of elderly persons to social protection.

# 2. Welfare Policy in Scotland

Welfare policy in Scotland has traditionally been a part of the overall policies as laid down for the whole of the United Kingdom. However, in 1999, Scotland went through the process of devolution and currently all aspects of health, relating to the Scottish people are addressed by the Scottish Parliament and the ministers who work there.

At the present time, 2002, Scotland is in the middle of very important changes in relation to care. Since devolution in 1999, health has achieved the highest possible political status and is taking up between a quarter and a third of all Parliamentary time. Approximately one third of the Scottish Executive's budget is spent on health. Included in this allocation of funds is a significant amount of money for the improvement of elderly care services.

The Scottish Executive is committed to improving care services for the older adult and to try and ensure that all those who require assistance in old age will receive it. The services that they are currently offering and that they wish to offer in the future requires a considerable amount of investment.

The following 2 diagrams will give you an insight into some of the policies that are in place and why they were introduced. There are some policies which have only been introduced this year (2002) and are therefore are in their infancy.

Although part of the United Kingdom, the health care system varies in some aspect from the rest of the country. Scotland is responsible for their own budget and the allocation of resources.

# 2.1. Structure of the National Health Service (NHS)

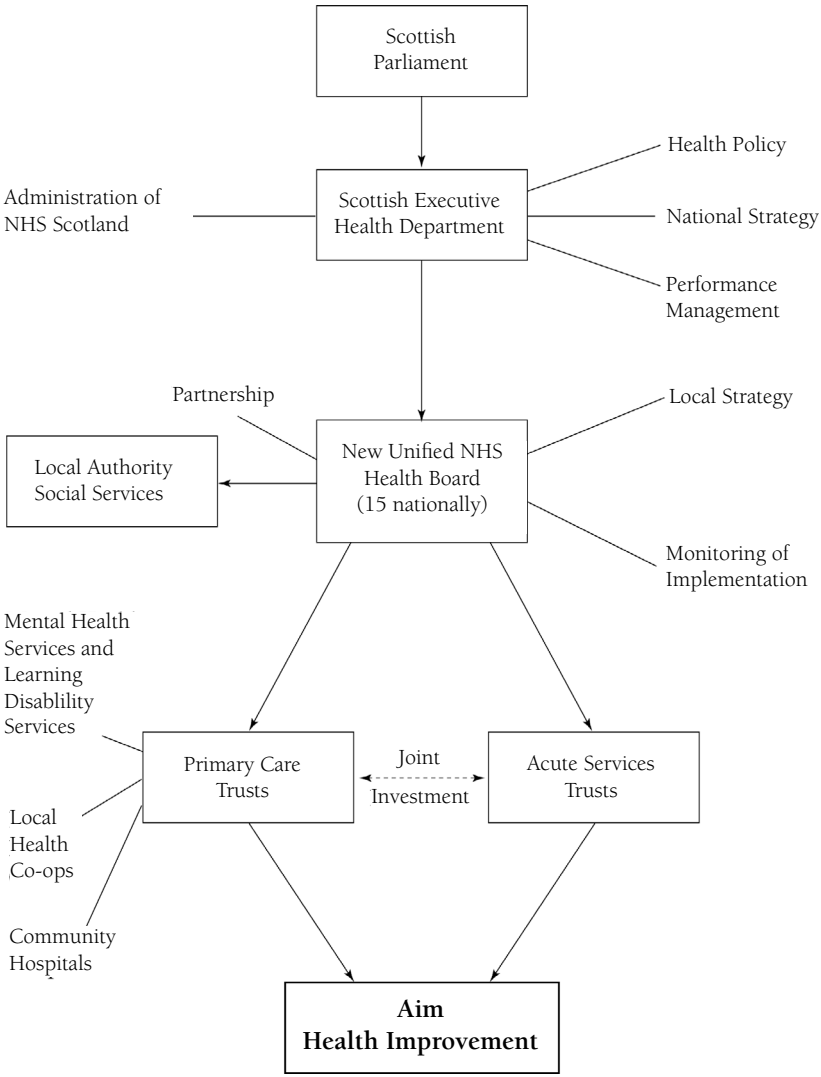



*Figure 1 Current NHS structure in Scotland (April 2000)*

# 2.2. The Structure of Social Services in Scotland

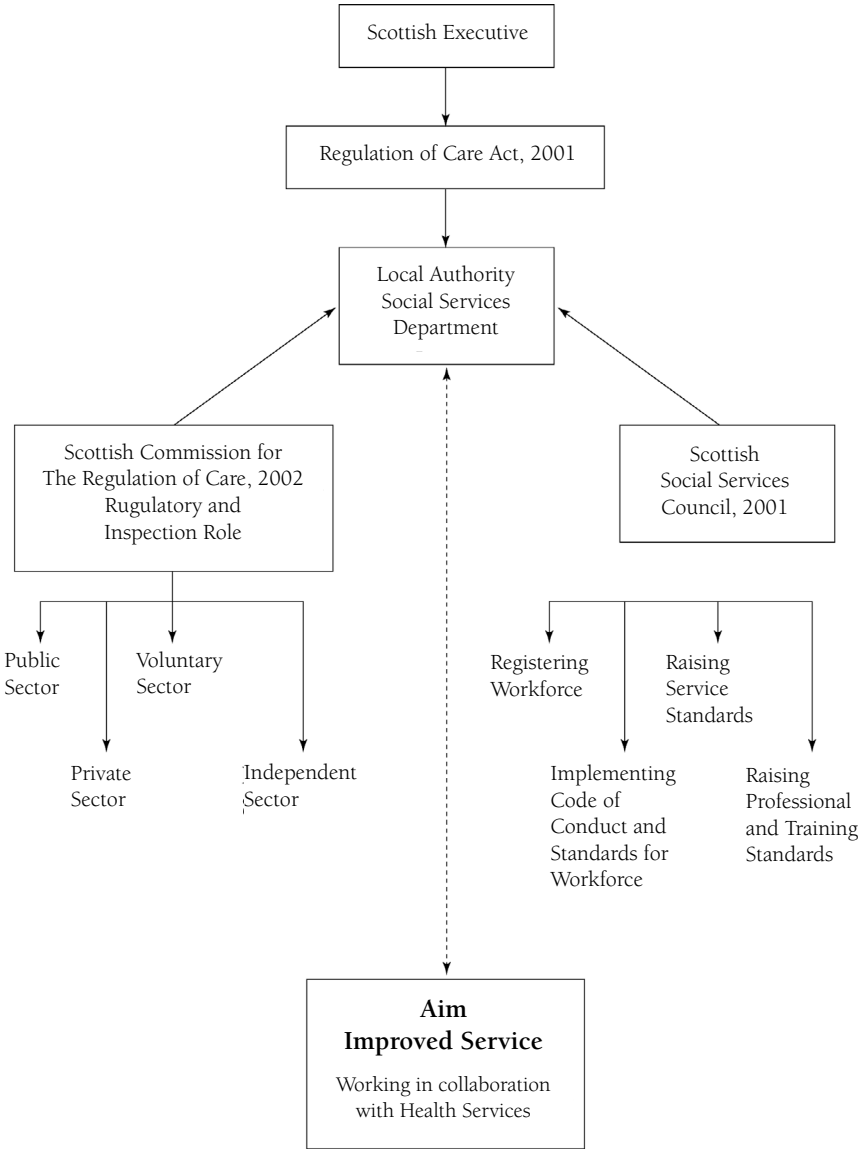
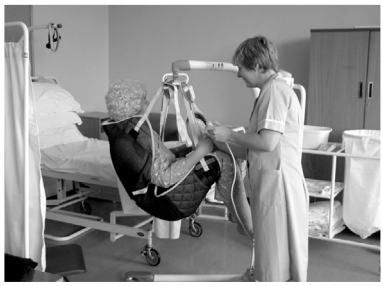



*Figure 2 Changes in Social Services in Scotland*

*Figures 1 and 2* depict the main support structures in Scotland. Both the NHS and Social Services are designed to meet the needs of the whole population, either directly or by being responsible for the monitoring and registration of related services. Many of those who access these services are aged. This may be as a result of hospital admissions, for medical or surgical interventions, or as a result of needing services in their own home to enable them to support a reasonable quality of life.

Primary care is defined as the first contact that people have with health care services. This could be through the General Practitioner, practice nurse, dentist or clinic nurse. The care that is offered is often preventative. Care of the older adult also comes under Primary Care services.

Social Services are responsible for assessing of clients needs. *Figure 2* depicts their areas of responsibility in relation to the care of the older adult, the important aspects in relation to this handbook are explained throughout the pack.



## 2.3. Acts and Policies

### The National Health Service (NHS) and Community Care Act (1990)

This Act resulted in major reforms of both social and health care. The Act was implemented in 1993. Before this Act came into being, people who required care generally received this in large institutions, older adults were generally not treated as individuals and did not have the privacy that they deserved. The ideology behind the *NHS and Community Care Act (1990)* was to offer a 'needs-led' approach to care. In other words, individuals would be assessed and a package of care services would be designed specifically for that individual.

Community Care is providing for the needs of people to allow them to live as independently as possible, for as long as possible, in their own home or in a home-like environment in the community. The assistance required by people to live in their own home or in supported accommodation varies greatly, eg Meals on Wheels provision or residential care.

The main aims of the Act are to provide services and support for people who are affected by problems of ageing, mental illness, mental handicap, or physical or sensory disability to stay in their own home. All of these conditions can and do affect some of the older adults living in Scotland.

The Act is therefore about:

- Helping people to lead, as far as possible, full independent lives
- Helping people reach their full potential
- Improving services that enable people to live in their own homes or in a home-like environment

As the population of Scotland is an ageing one, the government is committed to planning for the future. This involves putting in place systems which will be of benefit in years to come.

## The Regulation of Care (Scotland) Act (2001)

*The Regulation of Care Act (2001)* was introduced to try to ensure that the delivery of care in care homes for older people across Scotland was of the same quality and national standard. In order to achieve this 20 national standards were developed and implemented for care services. These standards must be achieved and are regularly measured and inspected by governing authorities.

Scottish Ministers set up the **National Care Standards Committee (NCSC)** to develop these standards.

The standards have been grouped in such a way as to denote an individuals journey through the service. These are as follows:

- **Before moving in (standards 1 to 6)**

  1. Informing and deciding
  2. Trial visits
  3. Your legal rights
  4. Your environment
  5. Management and staffing arrangements
  6. Support arrangements

- **Settling in (standards 7 to 11)**

  7. Moving in
  8. Making choices
  9. Feeling safe and secure
  10. Exercising your rights
  11. Expressing your views

- **Day-to-day life (standards 12 to 19)**

  12. Lifestyle - social, cultural and religious belief or faith
  13. Eating well
  14. Keeping well healthcare
  15. Keeping well - medication
  16. Private life
  17. Daily life
  18. Keeping in touch
  19. Support and care in dying and death

- **Moving on (standard 20)**

  20. Moving on

The organisation set up to enforce this is called **The Care Commission.** This of course will have a great impact on care in the community as many people who are delivering care to the older adult are

not all delivering the same quality of care. Now, no matter where you live in Scotland, the care service will be assessed against the same standards leading to a more uniformed provision of care, resulting in improved standards throughout the care sector.

An example of the impact this will have on service providers, is that, those who are running private nursing homes must now comply to the new regulations or they will not be able to stay in business. Currently it is acceptable that two people share a room, but that will change to a strict criteria on room-size, en-suite facilities, etc.

## The Community Care (Scotland) Act (2002)

This Act is due to be fully implemented in July 2003 and will also have a direct impact on community care provision. The main points associated with the Act are as follows:

- Fairer charging of services
- Greater choice
- Greater independence
- Increased support for carers
- More effective working between the NHS and Local Authorities

*The Community Care (Scotland) Act (2002)* states that free personal care and nursing care will be provided from July 2002 for older people. Older people were identified as being the largest client group, hence the reason for them being in the first group to be considered for care provision under this Act. The care will be provided in homes as well as in the individuals own home. This will assist in ensuring care is available for all older people. Free personal and nursing care will be based on each person's care needs and should contribute towards fairer charging for care services. The implementation of free personal care will require a concerted response from both those who provide the care and the NHS.

## The Joint Future Group

Susan Deacon, the then Minister for Health and Community Care, established the **Joint Future Group**, in early 2000.

The results of the working group recommended the following:

- All areas of care working together to help resource the care required
- All areas working together in the management of services
- Single shared assessment
- More relevant and intensive home care services

The approach, recommended in **Joint Future**, is about taking forward a new culture in care through different ways of working within existing structures. It also includes the development of a single shared assessment, where one professional can carry out all the basic assessments with the specialist carrying out further assessments as required.

This new outlook is very important for the future of Scotland as with an increasingly ageing population and a dropping birth rate, there are going to be greater demands on the services that are available. By all services working more closely together there should be a greater rationalisation of services and those who require different types of care in later life will hopefully get access to these services.

## The Scottish Social Services Council

**The Scottish Social Services Council (SSSC)** was established in October 2001 as part of the government's drive to raise standards in the field of social services. The SSSC have a duty of promoting high standards of conduct and practice among social service workers and in education and training.

This is an important organisation as social workers provide a wide range of services to many vulnerable and needy people. To be able to offer the best possible care the workforce has to have attained a certain level of training and shown a level of proficiency. Not all will be qualified social workers, some will be nursing assistants who previously had no qualifications, but are now expected to undergo training. Only 20% of the current workforce hold any qualifications. When you consider the client group that they are caring for, you will understand the importance of the introduction of this Council to ensure standards are being raised. The client groups are:

- Older people who need help with some of the activities of daily living or who live in residential or nursing homes
- People with physical or learning disabilities
- People with mental health problems or problems with drug/alcohol abuse

## Working for Patients

In 1989, the White Paper *Working for Patients* was published. The main proposals within this paper included:

- Formation of a new policy board responsible for strategic planning
- Clarification in the responsibilities of the various health authorities
- Changes in the terms and conditions of consultants
- More emphasis of the quality and monitoring of services
- Tax relief for people age 60 and over on private health care insurance
- Encouragement for the use of private health facilities

## The Patients' Charter

**The Patients' Charter** was introduced in 1991. Its official title was *'The Patients Charter, A Charter for Change'*.

In brief, the Charter was concerned with 'rights' and 'standards'. It sought to build upon what was already in existence. The following is a brief summary of these rights and standards.

- **Existing Rights**

Patients already had the right:

1. receive health care on the basis of need, not the ability to pay
2. be registered with a general practitioner
3. receive emergency medical care ant any time
4. be referred to a consultant who is personally acceptable, and to be referred for a second opinion.
5. be given clear explanations of any proposed treatments, including any risks and alternatives, before agreeing to the treatment.
6. have access to your own health records and for the contents to be kept confidential.
7. choose whether or not to take part in medical research of medical student training.

- **New Rights**

In addition, the Charter gave patients the right to:

1. be provided with detailed information on local health services, including quality standards and maximum waiting times.
2. be guaranteed admission for treatment by a specific date, no later than 2 years from when the person was placed on the waiting list.
3. have any complaint about the National Health Service investigated, and to receive a prompt and full written reply to the complaint.

Services have been established so that, where possible, people who need care in the community have the right to the available services, including:

1. domiciliary, day, and respite services to enable people to live in their own homes, where feasible and sensible.
2. a full assessment of need and the delivery of a negotiated package of services to meet those needs.
3. practical support for families who provide care for relatives at home.

- **Standards**

The Charter laid down standards which the Health Service should meet. These were:

1. respect for privacy, dignity and religious and cultural beliefs
2. arrangements to ensure anyone can use the services, including people with special needs
3. provision of information to relatives and friends
4. ambulance service to arrive at an emergency within 14-19 minutes
5. immediate assessment in accident and emergency departments
6. been seen within 30 minutes of appointment time in the outpatients department
7. operations not being cancelled on the day of the operation
8. a named nurse or midwife responsible for each patient
9. arrangement made before discharge from hospital to ensure appropriate care is provided at home.

# 3. Older People in Scotland and Policy on Ageing

## 3.1. Older People in Scotland

As Scotland's population is an ageing one, it has long been recognised that the services being offered required to updated and that education was required regarding society's perception of the elderly.

Life expectancy has increased greatly in the twentieth century and the number of older people is likely to grow in the foreseeable future, with nearly a fifth of the total population being aged 65 and over by 2030. Also by the year 2030, one in 30 people will be aged 80 and over. The pattern of increasing longevity applies to the whole of the UK.

In relation to the ageing population, it should be noted that it is not just that the birth rate has dropped so that there are fewer younger people and that this trend is set to continue, but through improved health care, nutrition, housing and general living standards, people in Scotland are living longer. The services that were in place were under a great deal of strain and could not cope with all of the demands that were made upon it. Fewer families were caring for their ageing parents and hospitals were no longer admitting people just because of their age. There was a considerable increase in the number of residential and nursing homes, which offered varying standards of care. By reorganising both services and by forging closer links with voluntary and independent organisations, the government hope that the breadth of care services will increase and those who require the care will have access to these services.

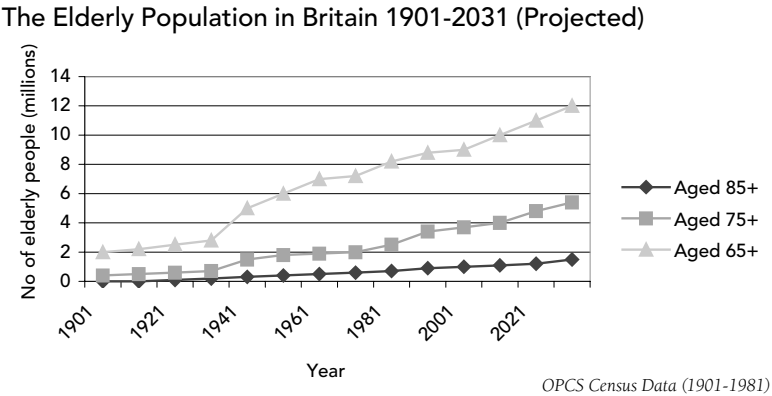



*Figure 3 The Elderly Population in Britain (1901-2031)*

*OPCS Census Data (1901-1981)*
*Population Projections by the Government Actuary (1987-2027)*

## 3.2. General Goals of the Scottish Policy on Ageing

The Scottish government is committed to improving the lives of older people. They acknowledge that, with the population ageing, new challenges face future generations. The following are ways in which the government have introduced initiatives. It should also be noted that there many local initiatives which are effective.

### Ethnic Minorities

Greater emphasis is placed on ethnic minorities as numbers have increased over the years. The Nursing and Midwifery Council Code of Professional Conduct (2002) concurs with The International Council for Nurses (ICN 1974) which emphasises the need for nursing care to be universal. Nursing should reflect the respect for life, dignity and the rights of man, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs.

All people working within health care must take account of the background and culture of those that they are caring for. This is embedded within the care plan, and as this is carried out with the assistance of the client or their family/significant others, then when the plan is implemented it should reflect the wishes of the client.

For further information on the Nursing and Midwifery Council you can look up their website on **www.nmc.com**

### Equality and Diversity

The government published the document *Equality and Diversity: Age Matters* in July 2003. It wished to find views on the proposals for the implementation of new anti-discrimination law under the European Employment Directive. It is the first consultation to focus exclusively on proposals for age legislation.

Implementing the age strand of the Employment Directive will outlaw age discrimination in employment and vocational training. Age Matters wanted views on a number of issues including: retirement age; recruitment; selection and promotion; pay and non-pay benefits; unfair dismissal; employment-related insurance and statutory redundancy payments.

As this is a fairly lengthy document, it is not appropriate to include all aspects of it in this handbook. You can obtain more information on this topic by accessing **www.dti.gov.uk/er/equality/age.htm**

### Social Justice Strategy

The Scottish Executive have set out a strategy for Social Justice in Scotland. For the purposes of this document the focus will be those relating to the Older Adult.

The government state that they are committed to:

- Providing dignity and security
- To encourage increasing numbers of older adult enjoying active and independent lives.

The 5 key milestones are:

1. Reducing the proportion of older people on low incomes.
2. Increasing the proportion of working age people contributing to non-state pension.
3. Increasing the proportion of older people able to live independently by doubling the proportion of older people receiving increasing home care opportunities.
4. Increasing the number of older people taking exercise and reducing the rates of mortality from coronary heart disease as well as reducing the instance of respiratory disease.
5. Reducing the fear of crime among older people.

The document relating to Social Justice is detailed and worth reading as it lays out the governments 'Vision for Scotland' for older people. To read about this in more detail, please access; **www.scotland.gov.uk/about/HD/OPU/00015079/socialjustice.aspx**

## Health Care Developments

In January 2002 a report was produced on the care the country's older people receive from the National Health Service in Scotland. The report was called *'Adding Life to Years'*. This came about as a result of the document 'Our National Health, a plan for action, a plan for change', which indicated that the health of older people would be a new priority for NHS Scotland. The Chief Medical Officer in Scotland chaired an Expert Group on the Healthcare of Older People, which was identified in the plan.

The reason for compiling this information was to implement a forward planning strategy which would help to ensure services meet the future needs of the half a million extra Scots pensioners it will care for within the next 30 years. Involved in the contributing to this report were specialists, patients, representatives of the voluntary sector and other groups.

A specially commissioned survey was also carried out to find out the views of older people on the services NHS Scotland provides; their experiences of these services; and, in particular, whether they felt that they were being discriminated against because of their age in terms of the services they received. The overall result of the survey should that older people are generally satisfied with the services that they receive from NHS Scotland.

Another report published at the same time by the Common Services Agency for NHS Scotland was 'The Health and Well-being of Older People in Scotland - Insights from National Data'.

If you wish to read further on the specifics of this topic, please refer to:
**www.scotland.gov.uk/pages/news/2002/01/SE5265.aspx**
**www.scotland.gov.uk/about/HD/OPU/00015079/healtholder.aspx**

## Healthy Living in Later Life

The Scottish Executive healthy living campaign hopes to encourage people across the country to adopt a healthier diet and lifestyle. NHS Health Scotland is developing a specific programme *'Health in Later Life'* tailor made to the health education needs of older people.

## Physical Activity Strategy

On 13 February 2003 the government launched a National Physical Activity Strategy, *'Let's Make Scotland More Active'*. Although targeted at the whole population, it highlights recommendations specifically for older people such as providing support for older people who are frail but living at home to keep physically active. It also responds to the needs of people in residential homes and has influenced the review of Care Home Standards, so that inspections of care homes will now include an assessment of the opportunities for physical activity.

## Older People's Unit

In March 2001 the Scottish Executive established the Older People's Unit. The main tasks associated with this unit are:

- Developing and consulting and advising Scottish Ministers on involving older people.
- Developing a strategy for older people's issues within the Scottish Executive.
- Raising the profile and awareness of older people's issues within the Scottish Executive.
- Developing a positive external profile for older people's issues.
- Liaison with key interests, including UK Government Departments.

## Older People's Consultative Forum

The first meeting of this forum was in February 2002. The role of the forum is to assist in developing and monitoring an ongoing strategy for older people in Scotland.

Membership includes:

- Scottish Pensioners Forum
- Scottish Pensioners Association
- Black and Minority Ethnic Elders Group
- Confederation of Scotland's Elderly
- Scottish Older People's Advisory Group
- West of Scotland Seniors Forum
- Scottish Trade Union Council
- Age Concern Scotland
- Help the Aged
- Alzheimer Scotland - Action on Dementia

The forum is chaired by the Deputy Minister for Health.

# 4. Services for Older People

## 4.1. How it was

◆ By looking at historical aspects, you can build a picture of how far health care has come in a relatively short space of time.

The following timeline offers a brief overview of key historical aspects leading to the introduction of more formalised care in the United Kingdom:

| | |
|---|---|
| 1760 | Industrial Revolution |
| 1834 | The Poor Law - supervising poor relief |
| 1861 | Workhouses came into being - 81% of hospital beds were provided by workhouse sick wards. |
| 1870 | Liberal government reforms and provided the basis of a welfare state. |
| 1899-1902 | Boer War |
| 1909 | A Royal Commission recommended a unified state health care services run by local authorities. It also wanted to introduce free health care for the poor. |
| 1914-1918 | Little co-ordination of health and social care services for the most vulnerable i.e. children and older people. National Insurance schemes were introduced but they did not meet the needs of the people. |
| 1939-1945 | The government set up emergency medical services and this was thought to have prompted the development of the National Health Service. The Beveridge Report set out the broad framework for the welfare state in Britain. |

(Source: Advanced Health and Social Care, 1997)

## The Beveridge Report (1942)

The report aimed to tackle the 5 major areas of concern: want, disease, ignorance, squalor and idleness - and it covered the whole population.

The plan envisaged a compulsory insurance scheme where a single, weekly contribution would provide a 'cradle to grave' provision of care. This contribution was to cover sickness, medical, unemployment, widows, orphans, old-age, maternity, industrial injury and funeral benefits. Amendments were made to the original idea and eventually in 1948 the National Health Service came into being. (See the figure below).

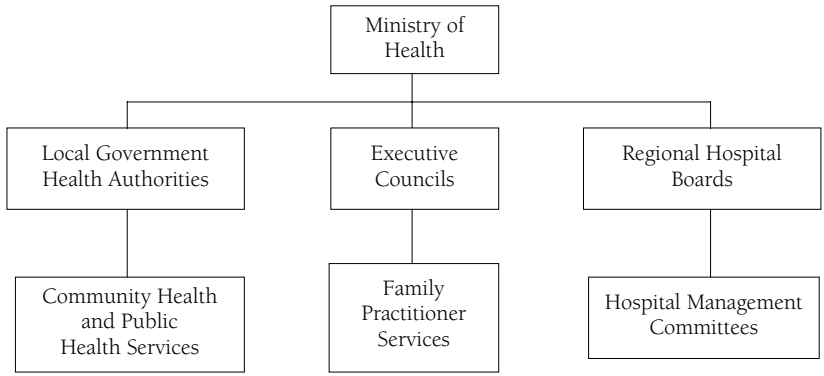



*Figure 4 The structure of the NHS (1948-1979)*

## Health and Social Services (1948-1979)

The National Health Service provided a comprehensive health care system which was open to all and free at the point of delivery. Also, being a national service it had the potential to ensure a high standard of health care throughout the United Kingdom.

In the mid 1940s, the Ministry of Health appointed Welfare Officers, mainly to deal with the problems of evacuation and

later, with housing problems. By 1945, 70 Local Authorities had appointed social workers to help develop the provision of social care. In addition to the Ministry of Health's welfare and social workers, the provisional Council for Mental Health were also providing social care for those with mental health problems.

When the NHS came into existence in 1948, the provision of care by Local Authorities for old and disabled people, homeless families, and child was extended. *The Children Act (1948)* instituted a unified service for all children deprived of a 'normal' home life. Local Authorities created children's departments and employed childcare officers.

During the 1960s, the demand for family service in social care arose and in 1968 the Seebhom Report on personal social care services was published. This resulted in the amalgamation of the children's departments and welfare services, within Local Authorities.

The 1960s showed up problems in the structure of the NHS, with overlaps, duplication and lack of co-ordination of services. This resulted in the re-structure of the NHS in 1974, with 3 tiers of health service management being introduced, at regional, area and district levels. (See *Figure 5*)

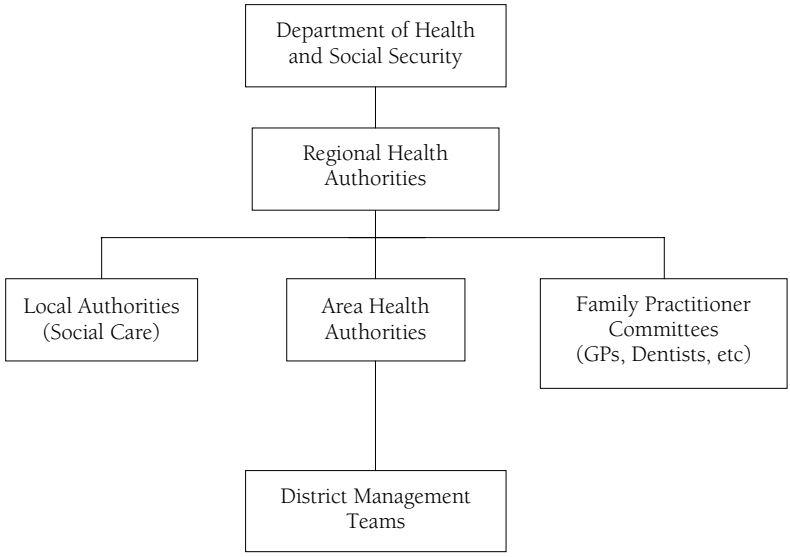



*Figure 5 The structure of the NHS in Scotland (1974)*

The 1970s saw a deterioration in industrial relations throughout the UK including the health care services. Disputes involved nurses, doctors and ancillary staff. The disruption led to long waiting lists and occasional malpractice scandals and affected the general public's support of the NHS. Some people (who could afford it) began to turn to the private sector for their health care.

## 4.2. Present Day Provision for Older People

There are 4 designated sectors that provide services in the sphere of health and social care. These are:

1. Statutory Sector
2. Voluntary Sector
3. Private Sector
4. Informal Care Sector

We will briefly look at each of these in turn and give examples of the organisations that these cover.

### Statutory Sector

Statutory organisations have come about through **Acts of Parliament**. These services must be provided by law. Statute law has increased in significance throughout this century and Acts of Parliament are defined as primary legislation which only becomes law after both Houses of Parliament (House of Commons and House of Lords) have passes them and Royal Assent has been given. Since devolution, the process of how laws are made in the Scottish Parliament has altered. Laws are made in the Scottish Parliament by first introducing Bills into Parliament. Once this process has been completed, it becomes an Act of the Scottish Parliament.

An example of primary legislation directly affecting and contributing to health care provision is the *National Health Service and Community Care Act (1990)*. Every Scottish Local Authority must, by law, provide a range of health and social care services.

Other examples of statutory services are:

- Hospitals - nurses, doctors, physiotherapists, dieticians, occupational therapists, specialists and so on
- General Practitioners
- Dentists
- Opticians
- Social Services

Some of these services may also be provided by the private sector, eg dentists, opticians, dieticians, physiotherapists and social workers.

### Voluntary Sector

Voluntary organisations have traditionally been seen as services which were developed to fill the gaps that the statutory services didn't cover. They were organised by volunteers grouping

together to run their own services. Over the years they have become services providers in their own right.

In 1998, a paper was produced entitled the *'Scottish Compact'*. A working group consisting of representatives from key voluntary bodies and the Scottish Office developed this consultation document. Amongst the groups participating were:

- Age Concern, Scotland,
- Disability Scotland, and
- the Scottish Office Social Work Department.

The aim of the Compact was to officially put in place a system to develop stronger relationships so that the voluntary sector is able to offer greater benefit to society as a whole, but a significant input into the care of the older adult.

The following is a small example of voluntary organisations in relation to care of the older adult.

- Marie Curie - for care of the terminally ill
- Alzheimer's Disease Society
- Age Concern
- Association of Crossroads Care - sitting service, assisting with washing and dressing.
- Samaritans - confidential counselling for those in distress or suicidal
- Cruse - Bereavement

## Financial Issues for Voluntary Organisations

Voluntary organisations are, by definition, bodies that are independent of the state, under the leadership of unpaid volunteers and non-profit making.

Although voluntary organisations are traditionally thought of as having a non-paid workforce, this is not true of all voluntary organisations. Many employees are paid, as they are professionals in their field, eg social workers. This also applies to other organisations, which require expertise in order to fully address issues that arise in relation to their client group, eg the older adult.

The aim of the Scottish Office was to see greater linkage between the public, private and voluntary sectors whereby they could work together to improve the social, economic and environmental conditions in which the people of Scotland live.

Funding for voluntary organisations comes from a variety of sources. Some will be through grants; other funding may come directly from Local Authorities, social services and health boards. Donations also play a significant part, but as the role of voluntary organisations has greatly increased in recent times, then funding allocation has also gone through some changes.

## Private Sector

The private sector is made up of services owned by organisations or individuals. These are run as profit making businesses. Organisations and agencies within this sector may be funded by private health insurances eg BUPA or by private businesses, eg a chain of nursing homes.

Between 1979 and 1984 the number of places in residential homes for older people increased dramatically to almost twice the previous level. This was due to the government agreeing to meet the cost of care of those on low incomes in private and residential nursing homes. This resulted in older people with little money having a choice of being cared for in a private home and having their fees paid for by the government. This proved to be an incentive for the private sector to expand, as it was guaranteed to have the cost of client care paid for by the treasury. At the same time, and in contrast to the growth of the private sector, there was no longer an incentive for the health and social services to provide long term care facilities. This therefore contributed to the decline in the state provision and in the growth of the private sector provision.

In Scotland, the private sector has always been the smallest sector providing care services. Following some of the newer legislation this trend is changing and private sector involvement in care is on the increase.

The services provided by the private sector are subject to the same regulations as Local Authorities and voluntary sector providers. They can however charge what they want for the services they provide. There can be large differences in the amount charged in different nursing homes within the same local area.

The following are examples of services offered by the private sector:

- Private nursing homes
- Private residential homes
- Private hospitals
- Private counselling services
- Complementary therapies
- Psychotherapy services
- Hypnotherapy services

## Financial Issues for the Private Sector

Funding for private sector provision can therefore come from a variety of sources.

- The person using the service
- Local Authority
- Health Board
- General Practitioner

Many General Practitioners are recognising the important contribution that alternative therapies have to play in the holistic care of the service user and will pay for the patients to attend a variety of alternatives to traditional methods.

### Informal Care

Informal care refers to care provided by family members, friends and neighbours. Family carers can include partners, parents, children and siblings, for example. They are generally caring for a loved one and often experience a great deal of stress in providing quality care, as they frequently feel isolated and alone.

The majority of those undertaking the caring are women and it is often a 24-hour day, 7 days a week job, with little support form the professional services.

Some may be entitled to welfare benefits, as has been previously discussed.

Local Authorities rely on the valuable service that informal carers provide. If they didn't provide the service, then Local Authorities would have to find additional resources to meet the needs of individuals for whom the informal carers provide care. The Community Care and Health Care (Scotland) Act (2002) will lead to an improvement in care services ensuring that informal carers will have the right to an assessment of their needs. Local Authorities will have the responsibility to ensure that carers are aware of their right to have this assessment carried out.

*The term Independent Services is often referred to as a provider of care and refers to all services which are not statutory.*

## 4.3. Occupancy Rate Per Type of Provision

The following table depicts the occupancy rate of care home provision and which sector they come under.

| Occupancy Rate Per 1000 Places | Type of Care Home | | | | |
|---|---|---|---|---|---|
| | % Local Authority Residential | % Voluntary Residential | % Private Residential | % Dual Registered | % Nursing |
| 95 or more | 16 | 42 | 36 | 34 | 47 |
| 90-<95 | 20 | 16 | 23 | 18 | 12 |
| 85-<90 | 16 | 15 | 9 | 8 | 10 |
| 80-<85 | 16 | 7 | 8 | 7 | 9 |
| 75-<80 | 9 | 9 | 8 | 12 | 3 |
| 70-<75 | 2 | 1 | 5 | 5 | 10 |
| Less than 70 | 20 | 10 | 10 | 17 | 9 |

*Table 1 Occupancy Rate of Care Home Provision (by Sector) 2002*

Source: Scottish Executive Statistics

## 4.4. Proportion of those in Care by Age

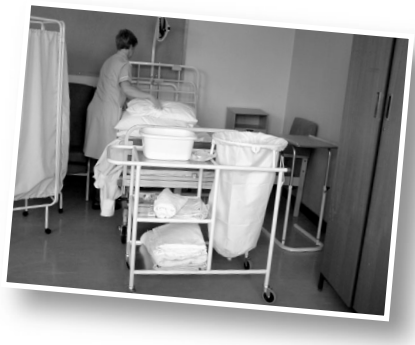
◆ The following table is to illustrate the numbers in receiving care in Scotland.

Aged 65 and over

| Proportion per 1000 population | Age Group | | | | |
|---|---|---|---|---|---|
| | 65-69 years | 70-74 years | 75-79 years | 80-84 years | 85-89 years |
| Men | 3 | 7 | 20 | 4 | 89 |
| Women | 5 | 11 | 31 | 78 | 200 |

*Table 2 Proportion of older people in care homes per 1000 population, by age group within sex (2002)*

Source: Scottish Executive Statistics



## 4.5. Services Promoting and Supporting Independent - Living at Home

◆ In 1979 a Conservative government was elected to Parliament. The new government was keen to introduce care in the community. Several reasons were given for this, including:

- As a means of saving public money in social and health care
- People needed to be transferred from long-term hospital care back into the community

- There needed to be more involvement of the private and voluntary sectors in the provision of care
- Informal care by relatives and neighbours needed to be encouraged
- More effective use of existing resources needed to be made

*The National Health Service and Community Care Act (1990)* resulted in major reforms both in health and social care. This Act was introduced in 1993. Prior to this Act the care people received was generally provided in institutions. Institutional care tended to be service led rather than a needs-led service. The aim of the *NHS and Community Care Act (1990)* was to provide a needs-led service for all those requiring care in the community. As a result of this Act, service users are meant to receive individually tailored services that have been selected from a range of options. Individuals are assessed, a care plan is put together outlining how a persons needs are to be met and an individual care package of services delivered. I was hoped that the model of care advocated in the *NHS and Community Care Act (1990)* would overcome many of the problems that were prevalent in other patterns of care.

**Community Care** is providing for the needs of people to allow them to live as independently as possible for a long as possible in their own home or in a home like environment in the community. The assistance required by people to live in their own home or supported accommodation will vary greatly, eg Meals on Wheels provision or residential care.

As a result of this legislation, the Social Services/Social Work Departments were now concerned with not only providing services but with carrying out assessment of the individuals needs. They then produced a care plan and organised the services to meet the identified needs. They could buy services from a range of suppliers, including voluntary and private sector agencies and from statutory services such as the NHS. The Care Manager will draw up the care plan and co-ordinate the care the individual requires.

The following are the types of services which are available to those being cared for in their own homes:

- Personal care at home
- Help with housework, shopping or preparing meals
- A respite break for carers
- Day centres/lunch clubs
- Training or education for people with learning disabilities
- Help in household budgeting or home making
- Telephone
- Special equipment, or adaptations, in the home to make it more convenient or accessible.
- An alarm system for help
- Holidays
- Residential care or supported accommodation
- Welfare rights advice
- Information on services available in the local area
- Support after leaving hospital
- Guardianship

The main features of the NHS and Community Care Act are:

- Local Authority is responsible for Community Care
- Local Authorities must produce a Community Care Plan each year highlighting priorities
- Local Authorities must consult with a number of other organisations when developing their care plan and setting priorities. Organisations include the local health board, housing departments, voluntary organisations, housing agencies and carers groups
- Local Authorities must display their community care plan for the public to inspect eg in libraries
- Local Authorities must have an effective complaints procedure in relation to complaints and how the authority operates
- Local Authorities must assess individual needs as part of their duty for any person requiring Community Care services
- Local Authorities must monitor standards of care being provided. Inspection procedures apply to all care establishments
- Local Authorities are encouraged to purchase services from alternative providers, not just themselves. More private and voluntary agencies are being used
- Those in receipt of care and their families should be consulted at all stages
- All agencies must work together eg housing, voluntary groups, social services

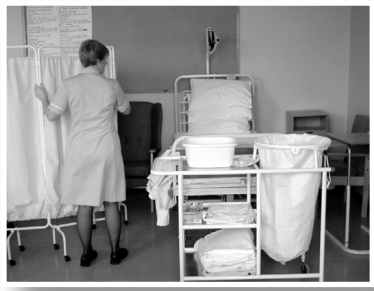
Many of those being cared for in their own homes are independent of family, so are being looked after solely by carers coming into the home to assist the individual with daily living.

## 4.6. Costs Associated with Care at Home

The following will give an idea of what an individual is expected to contribute to their own care needs:

- Personal Care is free, unless the individual feels they require extra. Then they will have to meet these costs themselves through private agency nursing
- Meals on Wheels/Tea on wheels will be paid for by the individual
- Laundry services will be paid for by the individual

- Cleaning services will be paid for by the individual
- Any adaptations to the home will incur a cost to the individual although it is unlikely that the individual will require to meet full costs
- Gadgets/aids required will be part paid by the individual. Some may be taken out on loan at minimal cost
- Assistance with cooking will be part of the care plan and therefore, free
- Shopping services will be a part of the care plan and therefore, free



## 4.7. The Role of the Home Carer

The home carer is employed by Social Services and undertakes training prior to/or during their employment. These employees are not **qualified nurses** but the role that they carry out is vital. There are 2 levels of Home Carers; the first is a basic grade position and the duties that they carry out are basic care activities. The second level is **Advanced Home Carers** and they are trained to carry out more specialised procedures as well as observing and reporting any changes identified.

Some of the duties carried out by the carers are as follows:

### Basic Home Care Worker

- Assisting in the preparation of food
- Assisting with washing and dressing
- Shopping/paying bills
- Accompanying the client to appointments as required
- Following and updating the care plan
- Reporting any changes or concerns to superiors

### Advanced Home Care Worker

The above duties, as well as:

- Changing wound dressings
- Changing catheter bags and monitoring fluid output

Unless a clients condition deteriorates so that they requires medical services every attempt will be made to keep the individual in their own home. However if that is no longer possible then it is likely that there will be no alternative but to admit them into a nursing home.

## 4.8. Balancing Care for Older People

Between 1994 and 1999:

- Long stay geriatric beds decreased by 2,500 (33%)
- Nursing home places increased by 5,000 (34%)
- Residential home places decreased by 1,200 (11%)
- Local Authority care clients reduced by 15,000 (17%), partly on redefining the role of the home help service; but staff increased by 1,300 (13%), meaning more people received intensive packages of care.
- Older people seen at hone by community nurses rose by 8,000 (3%), but the number of home visits fluctuated and eventually reduced at a time when 100,000 more older people were discharged from acute hospitals.
- Local Authorities' expenditure on home care services rose by £7m, but that on residential and nursing home care was increased by £65m.

## 4.9. Day Care Support Services

Support services include all those services which currently come under the heading of **day care**, but exclude care at home and housing support which are covered separately.

Many **day services** are purchased directly within residential packages and are based on an individualised care plan. Others are away from residential services and are provided directly in the community. Day care is seen by carers as an important respite resource.

The statistics show that the number of older people are by far the largest group in need of these services and they are the ones in shortest supply. The statistics do not state if there are older people within the other categories.

The principal goal of these services is to enable the individual to plan and achieve their preferred lifestyle within their assessed range of ability. It is not about

The scales of services across Scotland are significant.

| User Group | Number of Centres | Number of Places | Number Attending |
|---|---|---|---|
| Older People | 364 | 7,737 | 12,362 |
| Learning Disabilities | 157 | 8,742 | 8,587 |
| Mental Health | 17 | 467 | 815 |
| Physically Disabled | 39 | 1,800 | 2,428 |
| **Total** | **577** | **18,746** | **24,192** |

*Table 3 Day Care Support Services*

Source: Scottish Community Care Statistics (1999)

'doing for' someone or about facilitating activities and pursuits which have no meaning, purpose or relevance to the individual. Support services is about working with people as individuals to provide an appropriate level of care when it is wanted; to provide the degree of support necessary to enable self development and the direction desired to pursue personal goals in all aspects of life as is feasible.

Other issues which relate to Day Care are:

- The need for discrete facilities for supported travel
- The need for health and safety requirements and environmental health issues in relation to diet and catering and suitable premises
- Adhering to the importance of relationships in a wider range of religious, leisure, health and voluntary activity in relation to the provision of support services for specific individual need
- People who use support services have the right to:
- make the same choices other people take for granted.
- speak for themselves and not have others speak on their behalf
- be empowered to live lives which are rich in purpose, meaning and be fulfilled.

## 4.10. Sheltered Housing

◆ Local Authorities provided 18,824 'sheltered' housing facilities and 273 'very sheltered' dwellings for the older adult at March 2002, roughly 326 less sheltered and 57 more very sheltered than at the same time the previous year.

Sheltered housing allows individuals to live reasonably independently but to have the security of knowing that someone is on hand should they require it. These housing complexes allow people to have their own flats or bungalows without having to worry about maintenance or repairs. They also benefit from common facilities if they wish - such as a residents lounge, entertainment and activities. Most importantly they have a resident warden to help them with any problems. The warden works in a small office - or often from his or her own flat or house within the complex. At weekends calls for assistance are switched through to central control units where operators contact doctors, repair personnel or send out a 'mobile' warden if necessary.

Some residents will have a **care package** which has been planned by social services, under which homes carers will come to assist with getting them out of bed, washing and dressing. Many services may have an input into sheltered housing complexes, depending in the needs of the residents, ie doctors, social workers, community nurses, voluntary groups or relatives.

Coffee and tea is arranged in the residents' lounge and is a good way of residents being able to socialise so they do not feel alone or isolated. Usually several times a month lunch clubs are arranged within the complex and other older people from the neighbourhood may also come along. Organised activities, such as, bingo, whist or visiting speakers may be arranged for the residents to enjoy.

Cleaning services are available as standard unless the individual would prefer to undertake these duties themselves.

Sheltered housing is based on the standards for general housing with the addition of the following features:

- The housing should be provided at ground or first floor level, or in blocks over 2 stories high served with at least one lift
- Handrails should be provided on both sides of all common access stairs
- Bathroom doors should be either sliding or capable of being opened outwards, and fitted with locks operable from the outside
- Bathroom floor should have a non-slip finish
- Handrails should be fitted beside the WC and bath/shower
- A space heating system must be provided which is capable of maintaining a temperature of 21(C when the outside temperature is -1(C in the following parts of the house: living area, sleeping area, kitchen, bathroom, hallway
- Light switches arranged to line horizontally with door handles
- Socket outlets fixed at a height of at least 500mm above the floor
- An emergency call service should be provided connecting each house to a warden system

## 4.11. Very Sheltered Housing

This type of accommodation postpones or prevents the onset of high dependency. The complexes are made up houses which support 6-10 older people, enabling them to keep control of their lives, to be private and sociable at will.

The residents will take as many of their own possessions and personal memento as is possible. They all benefit from home cooked meals, secure accommodation, en suite facilities and resident house manager. Visiting services can be organised and arranged for the residents who need additional help. These may include home helps, care assistants.

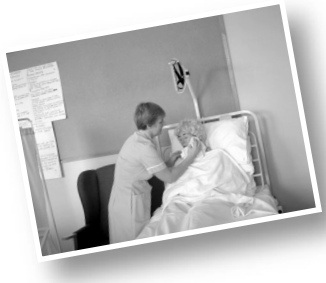
In this type of sheltered housing there is a communal lounge and dining room to allow the residents to meet together. This type of accommodation has a good support network and although the residents are independent. They do not have to cook for themselves as all meals are provided. It allows them to live as independently as possible in their given circumstances.

## 4.12. Registered Residential Care Houses

Registered residential care houses offer additional support to residents who are perhaps too frail to maintain their ideal lifestyle in the less supported 'very sheltered houses'. Social support for older people staying at home is not always an option. Domiciliary care, provided by Local Authorities, averages less than 3 hours a week and this is insufficient for the frail older adult who requires daily assistance and observation.

The registered residential care houses offer:

- 24-hour personal care
- Assistance with bathing, mobility, dressing, washing, feeding and other care/nursing requirements
- Houses designed and staffed to meet the needs of the residents



## 4.13. Residential Care Homes

Residential care homes cater for those who require long-term care and who would be considered frail, but not necessarily in need of nursing care. The care homes are designed to be as 'home-like' as possible. Residents will either have a single room or be in a room which they will share with approximately 2 or 3 others, they are not made up of wards which would be found in hospitals.

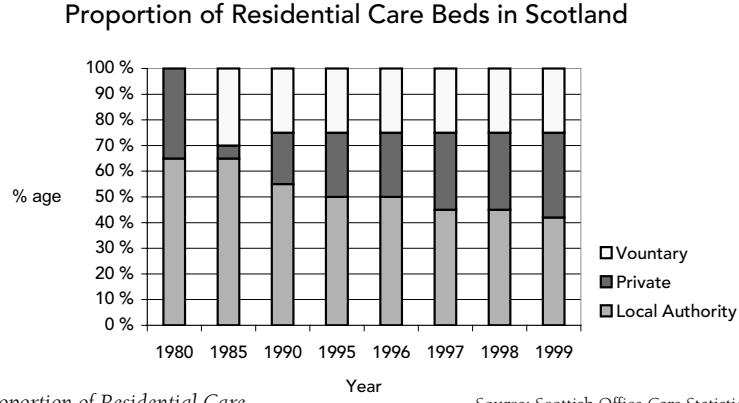



*Figure 6 Proportion of Residential Care Beds in Scotland (1980-1999)*

Source: Scottish Office Care Statistics (1999)

The homes can be run by the Local Authority, be private or voluntary. The following table indicates that the proportion of residential care beds in the local authority sector has been decreasing since 1990, whilst the number of private and voluntary sectors has been on the increase.

These care homes provide a variety of care and social services. They aim to meet the physical, social and spiritual needs of the residents. Should an individual require more specific care, then they may be transferred to a nursing home or to hospital. The aim of this type of care is to allow the individual to lead as full a life as possible. Activities are a part of the daily routine and the residents can access them is they wish. They have the opportunity to go on organised trips, to go out with family and friends.

There is a certain amount of routine, such as meals times, but the residents do not need to get up a certain time in the morning. This type of facility is institutional care but, but it is not necessary long term. Some people will come for respite care to allow their family a break. Others may only stay for rehabilitative reasons and then return home or to another form care.

Care plans are followed so that each individual receives the care for which they have been assessed. These are regularly updated and amended as is necessary. The client's opinion is taken into consideration when these plans are drawn up, as are the view of the family.

The following table offers a clear picture of the average age of the residents in these care homes.

| Age Group | 1980 | 1985 | 1990 | 1995 | 1996 | 1997 | 1998 | 1999 |
|---|---|---|---|---|---|---|---|---|
| 65-74 years | 17% | 13% | 11% | 10% | 11% | 10% | 10% | 11% |
| 75-84 years | 43% | 44% | 41% | 35% | 35% | 34% | 34% | 33% |
| 85 + years | 36% | 41% | 46% | 53% | 54% | 54% | 54% | 54% |

*Table 4 Age of Residents in Care Home for Older People (1980-1999)*

Scottish Office Care Statistics (1999)

## 4.14. Nursing Homes

◆ Nursing homes are designed to offer nursing care out-with a hospital setting but to provide basic nursing services to the clients. Nursing homes tend to provide care to those who require intervention to some degree. This may include illness, specific feeding difficulties, terminal care or drug intervention above what may be associated with old age. The clients may have had stokes or other debilitating illnesses.

Nursing homes also try to provide a home like environment, although this can prove to be more difficult as there tends to be more equipment required. The daily regime is much more of a routine owing to the treatments or procedures which have to be carried out. The staff employed are qualified nurses and nursing assistants.

The nursing homes also provide activities and outings as is able to be experienced by the clients. Their rights and choices are also taken into consideration as is that of their families. Nursing homes are occupied by those who are not able to live with support in their own homes or who are not fit enough to live in residential care.

**(Please see the work that is carried out by nurses in nursing homes included in this pack)**

## 4.15. Hospitals for the Older Adult

◆ The hospitals offer a wide range of services to the older adult. These clients may have specific illnesses such as dementia, motor neurone disease, cancer, stokes or heart disease. This may be associated with diabetes, some may have had amputations. These are just some examples to give you an understanding of the type of client that may be cared for in a hospital for the older adult.

These hospitals are generally wards which have been altered so that the patients are in bays of up to four beds. Some are wards which have beds up either side but have been partitioned from each other. They are not particularly 'home-like', as this is not totally practical for the care that is being delivered.

The hospitals have rehabilitation facilities where the older adult will be assessed on their ability to return home. They will also have daily access to the occupational therapist who will work with the client as a means to preparing them for living independently again. This of course only makes up a certain number of those who are admitted.

## 4.16. Most Commonly used Health Services and Social Care Services by the Older Adult in Scotland

There are a wide range of health and social care services available to all sectors of society in Scotland. The services tend to overlap, especially when considering the older adult, as if one service is accessed then it is likely that others will be required as well. Those who only require one service are in the minority.

The following lists are divided into health and social care services, and are the ones most commonly used.

### Social Care Services

- Home care services
- Night care services
- Meals on wheels
- Tea on wheels
- Laundry services
- Equipment for daily living
- Adaptations to the home
- Day care facilities for older people
- Residential homes for short stays or permanent care for older people
- Nursing home placements

### Health Care Services

- District nurses
- Doctors/specialists
- Occupational therapists
- Speech therapists
- Physiotherapists
- Geriatricians
- Community psychiatric nurse
- Care assistants
- Registered nurses
- Opticians
- Dentist
- Hearing specialist
- Podiatrist
- Health visitors

When on placement in an elderly care establishment, it is likely that you will experience some of these services, especially if you are accompanying a resident on a visit or if the professional comes to visit the patient in the care home or on the ward. It is unlikely that you will see any of these services being carried out in the individual's home, as students at the College do not get that opportunity until they progress onto University to undertake their nurse training.

## 4.17. How it may be

For many older people, their ability to remain independent will be determined by the level of support and practical help provided by relatives, friends and by services such as voluntary, private and state organisations. Difficulties in the future care of the older adult are envisaged to be

a decline in the numbers of care workers. As the population ages so do those that would formally have been carers, and as more women enter the workforce there will be fewer people available to be 'informal' carers.

The growing number of older people is not the real issue. It is the consequences of the increased need for health and social care services. Compared to other age groups, people aged 75 years and over are heavy users of health care services.

It is an accepted fact that the demand for the care for the older adult will increase in the coming years, and that the burden on health care services will be felt both financially and from a staffing perspective. The strategy for the care of the older adult will continue to focus on supportive services in their own home or home care environment wherever possible. Greater emphasis on long term planning will prevail in the field of health promotion for all age groups, to encourage good health and fitness well into old age. Target will still be set to try and reduce the illnesses which can be associated with old age, as a result of earlier life time choices.

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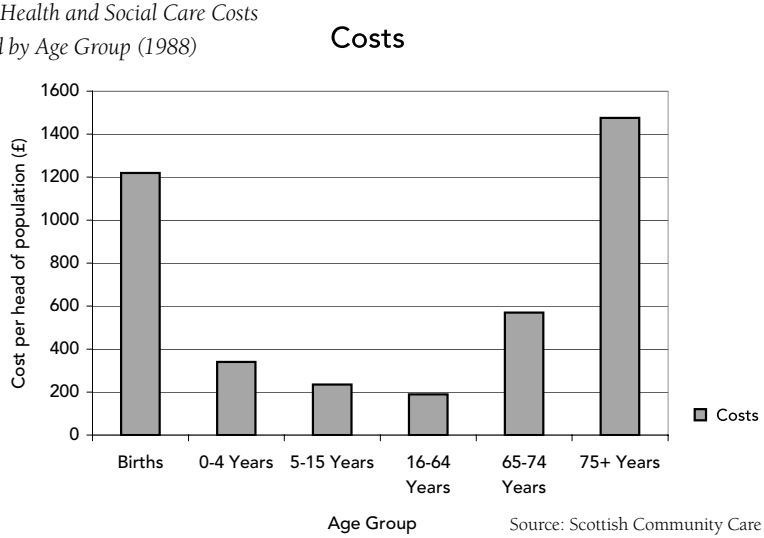
*Figure 7 Health and Social Care Costs per Head by Age Group (1988)*




Source: Scottish Community Care Statistics

and fitness well into old age. Target will still be set to try and reduce the illnesses which can be associated with old age, as a result of earlier life time choices.

Expenditure on pensions and health care for older people will soon become the largest single budget expense. *(International Labour organisation's Report 1995 World Labour Report.)*

The working population faces an increasingly heavy burden in resourcing the labour required for providing the care for older adults. In 1961 there were approximately 6 people of working age for every person over the age of 65. By 2001, there will be fewer than 4 working age people to every person over the age of 65.

In Scotland there is an increasing demand for health care personnel. This applies to both nurses, care assistants and home helps. In some geographical areas there are shortages of dentists, doctors and other associated professions allied to medicine. The government is promoting health care as a priority and has allocated more funding to Universities and Colleges in order to try to increase the number of applicants. The problem with the shortage of staff is not as acute in Scotland as it is in England and Wales, however it is believed that this pattern will affect Scotland in the near future.

# 5. Support Systems for Older People

Support systems in Scotland are fairly comprehensive and are in place to support those who are most in need as well as recognising the rights and entitlements of individuals. For the purposes of this pack the focus will be in relation to the older adult. This chapter will mainly look at financial assistance available to the older person.

Please note that there have been major changes to some of the financial support systems and at the time of writing this information is accurate.

## 5.1 State Pension

The State Pension is for people who have reached State Pension age. It is based on National Insurance (NI) contributions.

Pension ages will change for women from 6 April 2020, where eligibility will be at the age of 65, the same as for men. Women's State Pension age will start to change from 2010.

People are entitled to the pension if they have:
Paid or being credited with NI contributions
Reached State Pension age

The State Pension is made up of the following:

**Basic State Pension** - based on how many NI contributions has been paid or credited with. If contributions are not enough, then the individual may have to pay extra.
**Additional State Pension** - Depending on individual circumstances, there may be entitlement to additional State Pension. This is paid in addition to the state pension.
**Graduated Retirement Benefit** - Based on NI contributions between April 1961 and April 1975.
**Invalidity Addition** - is paid if an individual had invalidity allowance before reaching the state pension age.
**Age Addition** - is paid to anyone over the age of 80 years old.
**Extra Pension for Dependants** - An individual may be able to get extra pension for a husband or wife, any children that they may be responsible for or id someone else looks after children for them.

There are many other additions of payment which an individual may be eligible for. If you wish to find out more, look up the following website: www.thepensionservice.gov.uk/atoz/atozdetailed/retirement.asp

The following amounts are to be used only as a guide as individual circumstances may affect the amount of money the individual gets:

**Basic State Pension (per week)**

| | |
|---|---|
| Based on Individual or late spouses NI contributions | £77.45 |
| Based on spouses NI contributions | £46.35 |
| Non-contributory (based on residence) full rate | £46.35 |
| Non-contributory (based on residence) Married women's rate | £27.50 |
| Over 80 addition | £ 0.25 |
| Over 80 Pension | £46.35 |

## 5.2. Minimum Income Guarantee

◆ This is money that individuals may be entitled to if they meet the following criteria:

Be aged 60 or over
Savings of £12000 or less
If in a care home - savings of £16000 or less
If a single pensioner with a weekly income of less than £102.10
Disabled people, carers and homeowners with mortgages or housing loans

Minimum Income Guarantee will be replaced by Pension Credit from October 2003.

To find out more about this look up the following website: **www.info4pensioners.gov.uk/money_tax/get_more_sc.htm**

## 5.3. Budgeting Loans from the Social Fund

An individual is entitled if they:

- Been receiving Minimum Income Guarantee for at least 26 weeks.
- In need of help with expenses that are hard to pay for, ie furniture and clothing.

The loans are interest free. The amount of money borrowed will depend on personal circumstances, ie how long the person has been on benefits, how many are in the household. The amount of the loan will depend on other loans that they may have. Loans will be re-paid out of benefits received.

## 5.4. Crises Loans from the Social Fund

These loans are designed to assist those who may be in need of money as the result of fire or through being burgled. This money is designed to assist until their next pension payment. The loans are not taxed and re-payment is by agreement.

## 5.5. Community Care Grants

These are awarded if an individual needs help to:

- Remain in their own home
- Return to their own home after being in a place of care
- Ease pressures on the family or the individual

To be eligible the individual needs to be getting the Minimum Income Guarantee. The grant helps with travel costs, clothing or essential items for the home.

## 5.6. Winter Fuel Payments (for year 2003/2004)

To be eligible for this payment an individual needs to be 60 years of age between 15 and 21 September 2003.

If also during the period of the week, as above, and get Minimum Income Guarantee paid, then the individual will get £200.

If an individual meets the age requirements but does not receive the Minimum Income Guarantee, they will be entitled to £200 if the only eligible person in the household or £100 if there are other eligible people in the household.

If an individual is 80 years old or over they will then get an extra payment of £100 per household and get Minimum Income Guarantee.

If not in receipt if Minimum Income Guarantee but is 80 years and over, then an individual will get £100, and if more than one individual in the household who is 80 years old or over, then £50 will be awarded.

£50 will be paid to the individual living in a care home.

## 5.7. Free Personal and Nursing Care

If an individual is living in a care home and is aged 65 years or over, then there is no charge if costs as these are already being met by public funds.

If an individual was paying for their own care in a care home before 31 March 2002, then they will be entitled to £145 per week towards their personal care. They will also receive £65 per week to meet nursing costs. If an individual decides to receive these funds then they will no longer receive Attendance Allowance or the care part of the Disability Allowance.

Personal care can include:

- Personal hygiene, ie bathing, showering, hair washing and oral hygiene.
- Continence management, ie toilet and skin care
- Food and diet, ie assisting with eating and special diets.
- Assistance with mobility
- Counselling and support services
- Assistance with medication, application of creams and dressings
- Help with dressing and getting up and going to bed.

## 5.8. Attendance Allowance

### Who is entitled?

- An individual who requires help to look after themselves
- An individual who becomes ill or disabled on or after their 65th birthday
- An individual who requires help for at least 6 months

### What is the Payment?

Attendance allowance is paid at different rates depending on the level of disability.

The following figures are a guide to the weekly amounts paid:

- Higher rate - £56.25
- Lower rate - £37.65

# 6. The Concepts of Working in the Care of Older People

Caring for the older adult has changed significantly over the last number of years. New legislation has been introduced to assist with ensuring the care that is being delivered is of a high standard and suitable to meet the varying needs of the individual. The government has set an objective, which is, to have a specialist stroke unit in every hospital in the country by 2004. This may be a somewhat unrealistic target, however the wheels have been set in motion for the achievement of this goal.

All care workers, whether they are qualified nurses, care assistants or home carers must abide by a set of guidelines which are set by both social and health care bodies. In Scotland, the approach to care is multi-disciplinary, needs-led and holistic. This means that all individuals will be assessed by a clinician and other specialists will be involved should they be required. The clients and families' opinions and wishes will be taken into consideration and adhered wherever possible. If the individual does not have family, then they can have an appointed advocate who will expresses the clients' wishes on their behalf. The individual is considered as a 'whole' person, not just someone who has an illness, infirmity or disease. This can be best described as their, physical, intellectual, emotional, social and spiritual needs. No person should be compared to another or likened to another, but should be classed as a unique individual who should be respected.

All care workers are expected to understand and follow the principles of the 'value base'. This is essential in ensuring that a holistic approach to care is undertaken. From this value base care practice for the individual is designed and amended as necessary. The value base may be different depending on the client group but the basic principles are the same.

The **value base** is the term used which helps to define the value that a carer must consider when attending to the needs of a client/patient.

Below is an example of a value base for an older adult in a nursing home.

## 6.1. Value base

- continuity and consistency
- choice
- dignity
- confidentiality

**Respect - empowerment**

- communication
- access to relationships
- open access to records
- independence
- fulfilment

### Potential development

- hope/encouragement
- working together
- partnership

### Membership sharing and caring

- responsibility
- the environment
- privacy

### Rights - empowerment

- involvement in decisions (participation by client/family/advocate)
- health and safety (protection, welfare, care)
- access to all health care services/ treatment/rehabilitation)

What you may notice from the value base is that attempts are made to give the individual (where possible and appropriate) control over their lives and the decisions that may be made on their behalf. The examples are then broken down into daily, weekly, termly and annual activities or responsibilities. This helps to remind staff that this is an ongoing process and one which must be consistent.

The value base is a set of guidelines on which the care practice is built around.

Below are a few examples of how this is achieved.

### Value base - examples of care practice

Daily:

- individual interactions between the older adult and staff
- food, mealtimes
- waking up/dressing
- going to bed
- washing/toileting
- personal space, use of bedrooms, bathrooms etc
- activities
- consultation on treatments/ procedures
- access through complaints procedures
- sharing, participation

Weekly:

- care plan reviews
- financial management/pension (if able and appropriate)
- contact with a range of health care services
- involvement in weekly meetings (older adult representative)

Termly:

- participation in planning:
- activities
- celebrations/special events
- leisure
- cultural events
- home visits
- places of worship
- medical issues/care issues

Annually:

- annual reviews
- annual reports

What you have read, helps to understand that no matter how old, it is very important that an individual has choices and is able to vocalise them. The care designed for the individual is to suit them and not the staff who are caring for them. This style of management is much more time-consuming and requires a greater staff compliment to make this work efficiently.

## 6.2. Defining Care Work with Older People

From what you have read so far, you should now have a fairly clear picture of how care of the older adult is organised in Scotland and the importance of including the individual and their families in their care.

Nursing of this client group covers many facets. It includes the medical care and treatment of the individual, as reaching old age is usually accompanied by medical problems, so traditional intervention is necessary. It may also cover frailty, some loss of memory, loss of confidence and inability to cope. The nurse must therefore treat the person as a whole and that is the basis of caring for the older adult.

Emphasis in Scotland, has in recent times, been on care in the individual's own home. Community services have increased and new types of posts have been created to accommodate the types of services required. Even those who have to been admitted into institutional care owing to an illness or crises in their lives will be assessed and if appropriate rehabilitation will be the focus of their care with a means to sending them home with support.

The care worker requires to be observant, encouraging, motivating and have the best interests of their client at heart. Their role is essential as they are the staff who are likely to spend more time with the client in basic care duties. They are also more likely to build and develop positive relationships with the client, as the nurse will have a greater remit across a number of clients. The care worker is often the one who reports changes in a client's condition or other observations relating to the individual. Their role is key in the care of the older adult.

The care worker's duties are those of attending to the basic care of the individual. Their remit will vary depending on where and with which client group they are working.

The following list encapsulates all duties that a care worker may be required to carry out:

- personal hygiene ie bathing, showering, body washing
- toileting and supporting the incontinent client
- feeding
- bed making
- respecting the client's own possessions including the care of their clothes.
- preparing light snacks
- changing wound dressings (if trained)
- lifting with the aid of appropriate equipment
- assisting with mobility
- recording pulse, blood pressure and temperature (if trained)
- recording intake and out put on fluid charts
- offering support to relatives
- communicating and offering psychological support to the client

All care workers must undertake training in certain key areas. It is the employers' responsibility to ensure that all staff have training in Health and Safety, Risk Assessment, Manual Handling and Food Hygiene. It is the employees' responsibility to adhere to the principles that they have been taught.

The following poems you may be familiar with, but they do emphasise the perspectives of both the client and the nurse.

## Look Closer

*What do you see nurses, what do you see?*
*What are you thinking when looking at me?*
*A crabbit old woman, not very wise,*
*Uncertain of habit, with far away eyes,*
*Who dribbles her food and makes no reply,*
*When you say in a loud voice, 'I do wish you'd try',*
*Who seems not to notice the things that you do,*
*And forever is losing a stocking or shoe,*
*Who quite unresisting, lets you do as you will,*
*With bathing and feeding, the long day to fill,*
*Is that what you're thinking, is that what you see?*
*Then open your eyes, you're not looking at me.*

*I'll tell you I am as I sit here so still,*
*As I move at your bidding, as I eat at your will,*
*I'm a small child of ten with a father and mother,*
*Brothers and sisters, who love one another,*
*A young girl of sixteen with wings on her feet,*
*Dreaming that soon a true lover she'll meet;*
*A bride now at twenty - my heart gives a leap,*
*Remembering the vows that I promised to keep:*
*At twenty-five now I have young of my own,*
*Who need me to build a secure happy home;*
*A woman of thirty my young now grow fast,*
*Bound to each other with ties that should last;*
*At forty my young sons will soon all be gone,*
*But my man stays beside me to see I don't mourn;*
*At fifty once more babies play round my knee,*
*Again we know children, my loved one and me.*

*Dark days are upon me, my husband is dead,*
*I look to the future, I shudder with dread;*
*For my young ones are all busy with young of their own,*
*And I think of the years and the love that I've known.*
*I am an old woman now and nature is cruel,*
*'T'is her jest to make old age look like a fool,*
*The body it crumbles, grace and vigour depart,*
*There is now a stone where it once had a heart.*
*But inside this old carcass a young girl still dwells,*
*And now and again my battered heart swells,*
*I remember the joys, I remember the pain,*
*And I'm loving and living life over again.*

*I think of the years all to few - gone to fast,*
*And accept the stark fact that nothing can last,*
*So open your eyes nurses, open and see,*
*Not a crabbit old woman, look closer - see ME.*

*(Phyllis McCormack)*

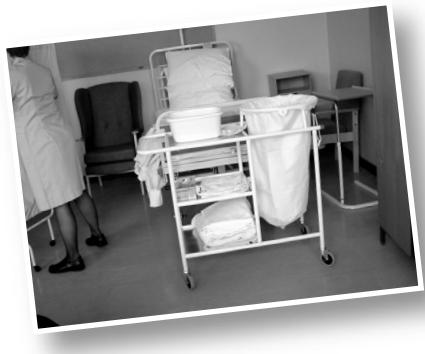
## A Nurse's Reply

*What do we see you ask, what do we see?*
*Yes we are thinking when looking at thee!*
*We may seem to be hard when we hurry and fuss,*
*But there's many of you and too few of us.*
*We would like far more time to sit by you and talk,*
*To bath you and feed you and help you to walk,*
*To hear of your lives and the things you have done;*
*You childhood, your husband, your daughter, your son.*
*But time is against us, there's too much to do -*
*Patients too many, and nurses too few.*
*We grieve when we see you so sad and alone.*
*We feel all you pain, we know of your fear,*
*That nobody cares now your end is so near.*

*But nurses are people with feelings as well,*
*And when we're together you'll often hear tell*
*Of the dearest old gran in the very end bed,*
*And the lovely old dad and the things that he said.*
*We speak with compassion and love, and feel sad*
*When we think of the lives and the joy that you've had.*
*When the time has arrived for you to depart,*
*You leave us behind with an ache in our heart.*

*When you sleep the long sleep, no more worry or care,*
*There are other old people, and we must be there.*
*So please understand if we hurry or fuss -*
*There are many of you and too few of us.*

*(Liz Hogben)*



# 7. Responding to the Needs of the Client

## 7.1. Becoming a Client

◆ The client generally comes to the attention of the health care services, through referral from their general practitioner or through concerns raised by family and/or friends.

The individual may already be receiving some form of care, but these services may require to be increased or amended as the individual's condition has changed. Generally care is provided due to a change in life circumstances, decreasing health or as the result of an injury. A client may need to change from one type of care facility to another ie from residential care to nursing home care, if the original facility does not offer both.

The general process that follows is that the individual will be assessed. This includes physical, social and psychological assessment. The purpose of the assessment is to gauge the overall well-being of the individual and to ensure that the package of care that they receive is the most suitable in meeting their needs.

Working together in partnership with other organisations and professions is an essential part of the process.

## 7.2. Assessing the Needs of the Client

◆ As has been previously mentioned, assessment is **needs-led**. This means that it is the need that the client has that is addressed on an individual basis. It refers to identifying what services are required to improve the quality of care offered.

Under the NHS and Community Care Act, all assessments must be based on the **actual** needs of the clients and their carers, irrespective of what resources are available. A needs-led assessment fits resources to people - not people into services.

Needs Assessment can be divided into 2 categories:

1. macro - this refers to the needs of a community, region or nation
2. micro - this refers to the needs of the individual

Both of these categories are inter-related, as they impact on each other. Local Authorities have the responsibility of producing and publishing community care plans, which are directly relevant to the needs of their particular community. Social services also have the responsibility to allocate not only the resources, but also the funding.

Community care plans should be easily accessible to the local public, and many regional departments actively seek out the publics' and service users' opinion. These care plans should give details of the types of services they intend to provide, to help support clients and carers. These plans are reviewed annually, and at this point, opinion is sought from the service user, carers and support organisations. These views are important as they assist in updating or modifying the services provided to that particular region. They also help in identifying where there are gaps in provision. It is acknowledged that a community's needs will change over time and that there may be variations in the allocation of the type of services within a given area.

Ensuring individual needs are met requires an understanding of wider health issues. This affords an overall picture of health in a community, region or country.

Two documents were published in 2001 which have assisted in identifying trends in Scotland's health. They are:

*'Our National Health' - A Plan for Action, A Plan for Change.*

*'Our National Health' - Delivering Change - Working Together for a Healthy, Caring Scotland.*

Included in these reports are details of those illness and diseases which are most prevalent in Scotland, and ones which should be targeted at community level for preventative campaigns.

These reports are essential, as with the population ageing the government wishes to understand which illness are associated with lifestyle and are therefore preventable. This will impact greatly in the future as if resources can be saved with a reduction in preventative diseases then greater funds may be allocated to a hopefully healthier older population.

The following diagram depicts the assessment process. (All categories are included.)

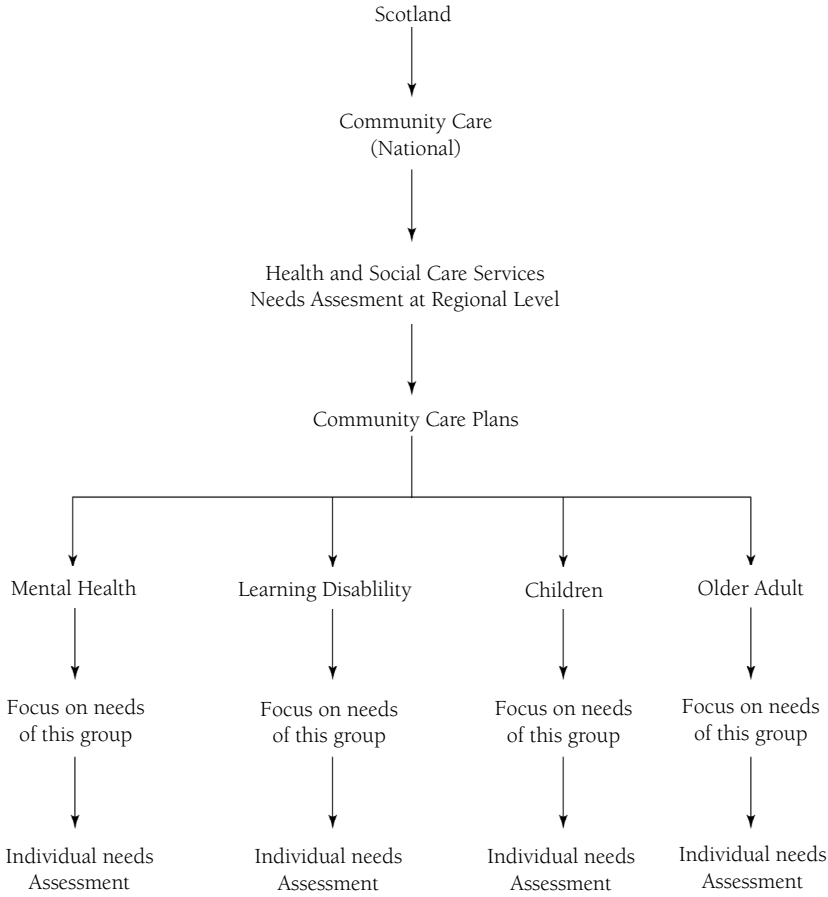



*Figure 8 Macro-Micro Needs Assessment Process*

# 7.3. Client Need

The term "need" is used to describe the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life.

Individuals may consider their needs to be different from that of the assessor. It is therefore vital that the assessor understands their viewpoints and what is important to them. This will determine the scope of the assessment and the degree of detail required in order to complete the assessment. Needs may be categorised in different ways:

- Personal and social care
- Physical health
- Cultural and religious needs
- Accommodation
- Transport/access
- Finance
- Education/employment/leisure
- Needs of carers

The following diagram indicates how 'needs' are determined:

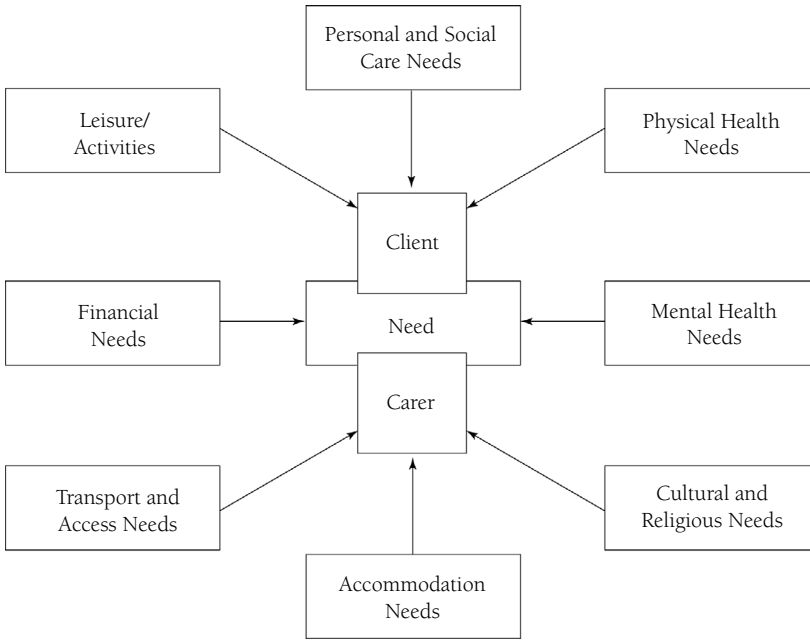



*Figure 9 How "needs" are determined*

To gain a better insight into how the needs are assessed, please refer to Appendix I, which is an example of a form used in residential or nursing home.

# 7.4. Care Planning

Care planning can only be agreed once assessment has been carried out. Care planning is the tool which provides direction for all of those who are working with the individual.

Care Planning is one of the most important aspects in ensuring that an individual receives the care that they require. It is an inclusive process where the client and or relatives/significant others have an input into this process. Care planning determines the care that the individual will receive and that is why it is so important that the plan covers all of the assessment needs identified. It:

- ensures continuity/responsibility/commitment
- should be realistic/practical/workable
- recognises client's choice/carer's needs
- gives consistency - linking all appropriate services
- has flexibility

As assessment and care planning are a continuous process and one which is reviewed and amended, see the examples in Appendices II and III a completed assessment form and the care plan that was devised from it.

# 7.5. Teamwork and Multi-Disciplinary Work

◆ The following diagram illustrates how the collaborative process should work:

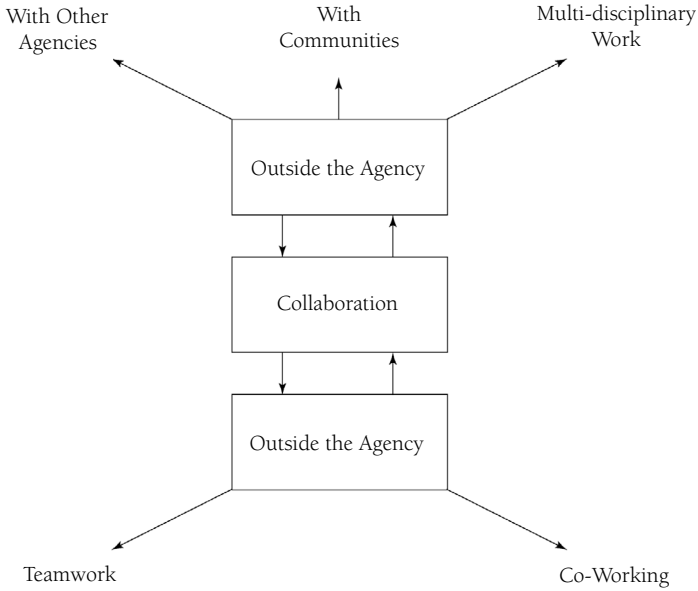



*Figure 10 Teamwork and Multi-Disciplinary Work (Collaborative Process)*

In Scotland, there are several key concepts which relate to the principles of networking and the foundation stones of an holistic approach to care.

These include:

- teamwork
- co-working
- agency work
- community work
- multi-disciplinary work.

Each of the headings will be explained briefly.

## Teamwork

Successful teamwork relies on those involved working together to achieve the goals of the organisation. These goals can relate to the procedures of the organisation, its mission statement, the responsibilities of the individuals or the benefits of those using the service. Teamwork requires the team to collaborate effectively. This involves good leadership, each member's views being valued and respected and individuals being given the opportunity to express their views and opinions.

## Co-working

Co-working describes the process of 2 or more people collaborating with an organisation or service-user in order to achieve a common goal. The co-workers work directly with the individual. The notion of co-working has come about through existing key workers who are already in place within social services. The co-worker then works directly with the older adult and/or their family. Their role is significant in the care of the older adult and can be summarised as:

- assisting with the co-ordination of care
- assisting in co-ordinating the care plan
- advocating and empowering the service user
- being reliable, approachable and dependable
- liasing with own and other organisations
- maintaining clear and accurate records which are updated on an on-going basis.
- reviewing and evaluating the care being given, so that it represents the best practice possible.

These workers are essential when it comes to community work as they are now the lynch pin for the older adult being cared for in their own home.

## Agency Work

Working with other agencies has become an integral part of the care process in Scotland. For example, an individual who is terminally ill, suffering form cancer, may benefit greatly from the service and expertise of Marie Curie nursing care. Patients can receive a closely monitored regime for pain relief, spend some time in respite care and have the advantage of receiving counselling and emotional support. Agency work relies on a great deal of planning and co-ordination. Success depends largely on having good knowledge of the organisations and what they have to offer the older adult.

## Community Work

In Scotland the emphasis is now on community care, and this relies on there being services available in the community for the older adult to access, such as lunch clubs, day centres etc. The community where the individual lives

may not have all of the services that they require, so it is important that they can access the nearest facilities. This relies heavily on community nurses, social workers, district nurses, home care workers, community dieticians and general practitioners.

## Multi-Disciplinary Work

◆ Multi-Disciplinary Work incorporates much of what has already been discussed. It involves the collaborative process, including effective teamwork. This is viewed as being important in its own right as it is used as a model to show how all of the services fit together to the benefit of the individual.

A patient in a hospice may require the services of nurses, doctors, social workers, complementary therapists, district nurses and counsellors. Some or all will be necessary at some stage of the patient's illness. The nature of the team will vary depending on the circumstance of the individuals involved.

The following diagram illustrates how the package of care relates to the individual.

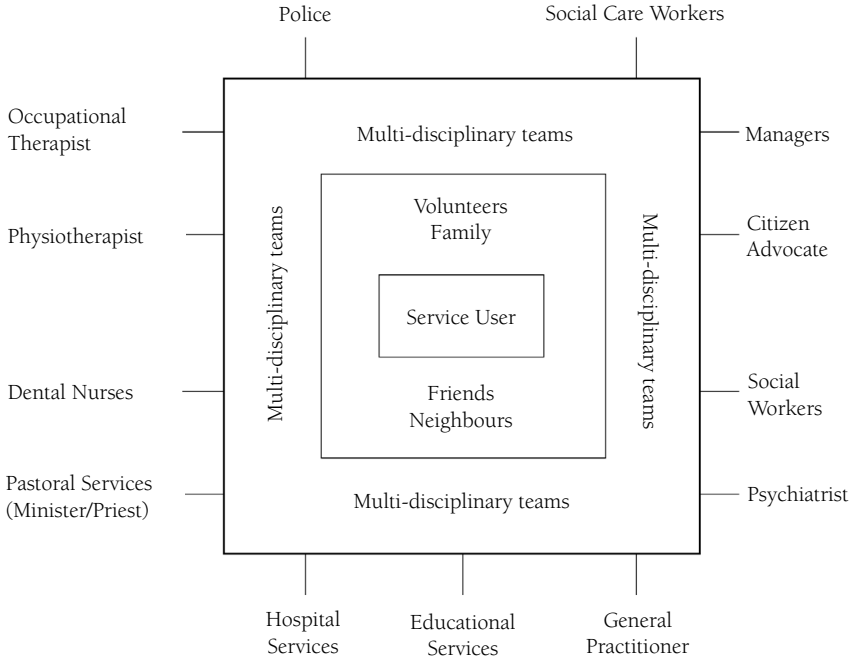



*Figure 11 Package of Care for the Individual*

# 7.6. Primary Nursing Care

Primary Nursing Care is the term is used to describe all first line care available to each and every individual. The primary health care team are made up of those professions which offer the care ie doctors, nurses, dentists etc.

The principles of good primary care in Scotland can be understood from the following illustration:

| | |
|---|---|
| Knowledgeable Professionals<br><br>Skill in Care and Treatment | Knowledgeable Professionals<br><br>The Community and People using Services |
| Professionals aware of each others contribution including Interprofessional Working | Premises should be well maintained<br><br>Equipment should be safe |

*Figure 12 Principles of Good Primary Care*
(Source: Adapted from Department of Health - 1996)

The diagram depicts all the aspects required to be able to offer a holistic approach to care for the individual.

## The Nursing Process

As part of the Primary Health Care team the care worker caring for their patient, they will be a part of the 'nursing process'.

The nursing process is a problem-solving framework that enables the nurse to plan care for a client on an individual basis. The nursing process in not undertaken once only, because the client's needs frequently change and the nurse must respond appropriately. It is a cyclical process consisting of 5 stages. See the illustration below to understand this more fully.

The diagram shows that all of the parts which make up the nursing process are equal in importance, from diagnosis through to planning. As the needs of the individual often change, then so the 5 parts of the nursing process are re-evaluated.

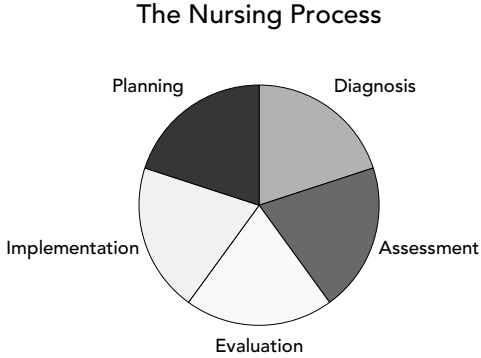



*Figure 13 The Nursing Process*

Each individual has their own care plan which assists the workers in ensuring the appropriate care is being given. Practically all areas of care provision follow the same approach to care. Each individual has a named carer/nurse allocated to them. This offers continuity of care for the client as well as having a named contact for the family. This nurse will attend any meeting regarding changes to their care and will also be responsible for ensuring that all records are accurate and updated. In the nurses' team he/she will have health care workers and they too will be allocated to certain clients.

## 7.7. 'A Day in the Life of a Health Care Worker'

To give you an idea of the type of work undertaken by health care workers, there will follow 4 case studies offering descriptions of the duties carried out by the worker and the circumstances of the clients.

The 4 areas to be looked at, will be:

1. the home care worker
2. the care assistant in a residential home
3. the care worker in a nursing home
4. the care worker in a hospital for the older adult.

### The Role of the Home Care Worker

The following is a description of the remit of the basic grade home care assistant.

I work for Social Services as a home care assistant. I have been in this post for 2 years.

I am currently studying the Scottish Vocational Qualification (SVQ) in Care Level 3. This is a work based qualification and I am assessed in the workplace. I have previously undertaken in-service courses on manual handling, health and safety, food hygiene and care practice. When I first started this job I worked with a senior Home Care Worker who not only helped me understand what my job involved, but also explained the holistic approach to care.

All of the clients that I care for are very different people and have different needs. It is important that I respect them as individuals and that I follow the care plan that has been made for them. Part of my

role is to be observant and to pass on to my Care Supervisor any changes in the person's condition.

I believe that it is very important to allow the client to remain as independent as possible so I always make sure that I encourage the client to carry out tasks that they feel able to do. I also ask the client how he/she would normally like things done and I try my best to follow their wishes.

Although I only work days there are services which cater for assisting the client to go to bed and for getting clients up in the morning. For the clients I care for there are no night services apart from an emergency telephone number as all of the clients are able to live on their own. There are night services available, but these tend to be private services and the client may have to pay.

I visit a number of clients, mainly older adults. I will focus on a 72 year-old lady who lives on her own.

Mrs Jamieson lives in a ground floor flat near the city centre. She was up until 6 months ago, a very active lady. She loved to "window-shop", visit her friends and played bingo every Thursday evening. Whilst out visiting friends, she slipped on the doorstep and fell, fracturing her hip. This resulted in her being hospitalised and spending time in a rehabilitation unit. She now walks with the aid of a stick and has a pronounced limp.

On returning home, she found if difficult to settle in. She lost her confidence and initially spent 2 nights in her own home before going to stay with her sister. Realising that her sister found it difficult having her stay owing to her own medical problems, she returned home after a fortnight.

Her husband and only child died in a car accident 40 years ago and she never re-married.

On returning home she was quite withdrawn. She did not participate in her usual activities. The consultant at the hospital referred her for a "dexa-scan" and it was found that she had wide-spread osteoporosis. Her greatest fear is she will fall again and fracture another bone. Over the last 2 months, she has become quite frail, her weight has dropped and she feels unable to go out on her own.

Mrs Jamieson was assessed and her immediate and longer term needs were identified, this included her receiving support to be able to remain in her own home.

Initially, Mrs Jamieson found it difficult to accept people coming into her house, but after a short period of time she expressed her gratitude and stated that she enjoyed the company.

My remit is to assist and facilitate Mrs Jamieson to live as independently as possible.

I arrive at her home at approximately 8.30 am, usually Mrs Jamieson is up. I assist with her washing and dressing and with making her breakfast. An important part of my job is to build a positive relationship with Mrs Jamieson, to encourage her to be independent and to do as much for herself , as possible. We have recently gone out for short walks, weather permitting and last week we took a taxi into town, as she wanted to buy new night attire and some underwear. This she enjoyed very much and gave her confidence a boost.

I generally shop for groceries twice per week, and assist her in preparing simple meals on those days. Mrs Jamieson had discussed the possibility of receiving Meals on Wheels or Tea on Wheels a couple of days per week.

I assist Mrs Jamieson with some light cleaning. She cannot manage to use the vacuum cleaner, but carries out some dusting. Her clothes are washed and ironed by laundry services.

Mrs Jamieson does not have a shower but does enjoy a bath. After her fracture of her hip, she had a "bathing aid" fitted to her bath which allows her to be lowered and raised from the bath easily. She does however, require to be supervised and occasionally assisted with this process.

She now attends a lunch club on Tuesdays, and although reluctant to attend at first, is now enjoying these outings. Her friends visit a couple of times per week although have not yet persuaded her to return to her Bingo evenings.

Other services that visit are; the community nurse, who checks on Mrs Jamieson's medication. She also had the occupational therapist visit her at home prior to leaving hospital to check if she required any alterations to her home or aids to assist with independent living. The chiropodist visits every 8 weeks.

Mrs Jamieson is coping much better. Her outlook is bright and she looks forward to her outings and activities. Although physically, she is much weaker, she is able to live independently, with support.

**Please note that it would not be possible to undertake placement in this setting.**

## The Role of the Care Assistant in a Residential Home for the Older Adult

If working on an early shift, my day begins at 7.30 am. All the clients are older people, the youngest being 69 years old. The home accommodates 20 residents. All have their own rooms with en-suite facilities. The residents' rooms are finished with their own belongings including furniture, pictures, ornaments and photographs of loved ones.

I have worked in the home for 5 years and I know all of the residents very well. Some have been there for as long as I have

been employed. I am usually assigned to 10 residents on a rotational basis, this is on an approximately 4-week rotation.

Most of the residents are fairly independent. They are in residential care for a variety of reasons. Some due to having had minor strokes, some who find it hard to cope at home and who wish to live in a more secure and protected environment. Others, who are frail, but do not require significant medical intervention. Some are in the early stages of dementia.

On arriving at work, we receive a brief report from the night staff, who update us with the clients' conditions.

At approximately 8.00 am, I go round all of my residents to say "good morning". Those that require assistance with washing and dressing are assisted. Breakfast is served between 8.30 am and 9.30 am. This allows residents to have time to get ready at a more leisurely pace. Most will be at breakfast by 9.00 am. Medication will be dispensed by the nurse prior to breakfast or at breakfast depending on the type of medication they receive. I assist in serving the breakfast, and in clearing away the dishes.

Whilst the residents are having their breakfast, a colleague and myself, change and make up beds. Dirty clothing is removed from laundry baskets and taken to the laundry (all clothing is labelled with the client's name). Some items are sent for dry cleaning - the client pays for this service themselves.

Most of the residents return to their rooms after breakfast. Any dressings that require changing are carried out by the nurse, but I assist her and chat to the client to put them at their ease.

If the doctor visits, I will chaperone, if required. Every day is different. Many of the residents will go out during the day. Some lunch out with family or friends. Others are members of clubs. Visitors can visit at any time, there are no restrictions, although most will visit in the late morning or mid afternoon.

I am very involved in organising activities for the residents. Some of the activities that I have assisted to organise include:

- Musical evenings held in the residents' lounge
- Evenings to the local theatre
- Trips to local areas of interest
- Coach trips with lunch out
- Bridge evenings
- Shopping trips
- Gentle exercise classes

In the course of the morning I may accompany a resident to the doctor, chiropodist or to a clinic appointment at the hospital. Although these services will come to the home, many of the residents prefer to go themselves. This also applies to the hairdresser. Generally only residents who are not able to go out will prefer outside services to come to them.

At lunchtime, I help in setting the table. I check the book to see who will be

having lunch out. The tables are set with tablecloths and linen napkins, iced water jugs and glasses, condiment sets as well as the usual cutlery. It is very unusual for a resident to eat in their room. This generally occurs if a resident feels unwell.

After assisting with cleaning away the dishes, I spend some time checking and up-dating any care plans that are part of my remit.

In the afternoon, I may organise and encourage residents to participate in some activities.

Talking to residents is an important part of my job and allows them the opportunity to talk about their lives and their families. Some of the clients have no family and this can make them feel isolated, so we try to make their lives as fulfilling as possible without being "pushy" or intrusive.

The "early shift" finishes at 3.30 pm. If on a "back shift" I would start work at 2.00 pm and work along side the early shift staff. I would assist in organising the evening meal, again checking who is out for dinner.

In the early evening I would assist with bathing and showering residents, and help them prepare for bed, if they wish. Many will prefer to watch television in their rooms in their night clothes after their bath/shower.

I will often be asked to help choose and set out clothes that they wish for the next day.

During the day and in the evening tea, coffee and cocoa and so on is available when they wish. In the evening however, I go round each room and offer an evening drink.

I finish my shift at 10.00 pm. Half and hour after the night shift (one person) come to work.

The most satisfying part of my job is inter-relating with the clients, encouraging motivation and maintaining independence.

I have been accepted at University to start my nurse training in January - I can't wait!

## The Role of the Care Assistant in a Nursing Home for the Older Adult

My name is Kay Jones and I am studying on the HNC Health Care course at College. Currently I am on placement at a nursing home for the older adult. I attend placement 2 days per week and this will continue over the duration of my course. I will give a breakdown of a working day. I have chosen one which was very busy and very interesting.

There are 30 beds in the nursing home and they are split into 2 areas. Although we have both men and women the 2 wings are integrated. I have been working in the same area for the last 6 weeks. The team working comprises of: the sister in charge, one qualified staff nurse, 4 care assistants and myself. I work alongside a care assistant for the duration of the shift, but if there is anything interesting to observe the staff nurse will inform me.

I arrived at work at 7.15 am, changed into my uniform and was on my ward area for starting work at 7.30 am. I went round and said good morning to the clients (those that were awake). I was given the report with the rest of the early shift from the night nurse. She informed us that one of the patients that I look after had deteriorated overnight and that her condition was very poor. Her family had been informed, and were coming in to see her. One of my other patients had become very confused overnight and would not settle. Jane, the care assistant and myself started our work at approximately 7.50 am, by helping those patients who were able to sit by their beds while we changed the beds. Breakfast is served both, in the dining room or in the patient's room. Breakfast is available form 8.00 am until 10.00 am, but this is flexible. This nursing home encourages the patients to be able to choose when they wish to get up or have breakfast. This works quite well for those who are more able, but for those that require assistance then the staff do tend to pick the time for getting the patient up or assisting them with feeding.

When we arrived at Mrs Kane's room, an 82-year old lady, she was quite distressed as she had just experienced faecal incontinence. We reassured her that this happens sometimes and that she was not to worry. We stripped the bed and took Mrs Kane for a shower, which she really enjoyed. We chatted to her about her family, and she told us some funny stories and before long she was bright and happy again.

After her shower she wished to return to bed for a rest, so we brought her breakfast which she had in her room. We made up her bed with clean linen and then assisted her back into bed. We later learned that her medication had been changed and that it was the probable cause of this particular bout of incontinence. Mrs Kane was very relieved to hear this. By 10.00 am she was dressed and sitting in the day room reading.

During the rest of the morning Jane and I assisted with bathing and showering and serving the morning teas and coffees. We changed the beds and tidied the bathrooms and shower rooms. We had our break at about 10.30 am.
At 11.30 am I was asked to accompany Mr MacLeod on a hospital visit. This gentleman has become increasingly breathless and was due for a chest X-ray. He is an 89-year old gentleman who has lived most of his life in the Far East working for an export company. He lived there many years after he retired, but after his wife's illness he decided to return to Scotland. Soon after their return, his wife

died and Mr MacLeod managed to live independently for a few years, but latterly he was diagnosed with dementia and was unable to cope at home. His condition has been deteriorating over the last few months and he has undergone a number of tests. I returned in time for lunch at 1.00 pm without Mr MacLeod as the hospital decided to admit him.

Whilst I was away Mrs Johnstone, whose condition had deteriorated overnight, died. I was asked if I wanted to observe the nurses prepare her body. Although I found this a daunting prospect, I felt that it was important to go through this experience. I did not know what to expect as I had never seen a dead person before. What surprised me was how peaceful she looked, and almost younger looking than when she was alive. The nurses were very calm and unhurried as they washed her. They spoke to her all the time in quite voices and explained what they were doing. They changed the bed linen, put on a white gown and brushed her hair. I found the experience very moving. They drew the blinds down so that the room was dimmed but not dark. The staff explained that other family members were coming to see their mother and grandmother and wanted her to look as presentable as possible. The most difficult part I found was speaking to the relatives and coping with their most obvious grief. The family were so grateful for the care that she received.

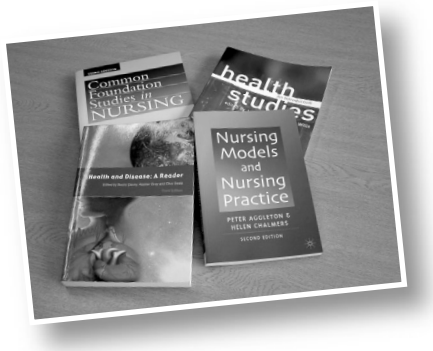
In the afternoon I assisted with toileting and later with serving afternoon tea and coffee. My shift finished at 3.30 pm. I found that particular day very fulfilling as I felt I experienced a very sad part of this profession and it dispelled some of the anxieties that I felt in dealing with the death of a patient.

If I was on a back shift, I would start work at 2.00 pm and finish at 9.30 pm. The duties involved would be assisting with toileting, activities, accompanying patients on trips or to appointments. Observing wound dressings, serving the evening meal and assisting with feeding, evening bathing or showering, preparing patients for bed and helping them into bed. I would also assist in the writing up or updating care plans.

I very much enjoy working in the care of the older adult. I find it very rewarding in assisting to give the best care possible to those who are no longer able to cope on their own or who have no families to look after them. Before starting working and studying care I never fully understood what was meant by respecting dignity and individuality because it was something I had control over in my own life. I have learnt that empowering and individual, no matter what their physical or medical condition, is vitally important. For an individual to respond positively to the situation that they now find themselves in, the care staff have to be respectful of their wishes and of their physical problems.

Another aspect of care, which I have taken on board is to ensure that all

hygiene precautions are carried out. Whilst on placement I have been able to attend 2 in-service training sessions. One was on (Methicillin Resistant Staphylococcus Aureus) MRSA and the other on Risk Assessment. Both of these I have found very beneficial, and a member of staff has been appointed to look at current systems operating in the home and to update these so that good practice can be carried out throughout the home.




## The Role of the Care Assistant in a Hospital for the Older Adult

My name is Sarah Young, I am 18 years old and I am studying on the Preparatory Course to Nurse/Midwifery Education. I have just completed a 2-week placement at a hospital for the older adult. Before going on placement I have undertaken an awareness course in Manual Handing and have completed a programme of study called, 'Investigating Skills for Caring'.

To try to give a reasonably full picture of what a working day consists of I have broken it down into approximate time scales.

The morning shift starts at 7.30 am.

7.30 am We all receive the report from the night nurse who updates us on any changes that have occurred overnight.

7.50 am I am allocated to a staff nurse who acts as my mentor during my time on placement. We go to the patients that we have been allocated to and begin to those up who are able. The patients generally sit by their beds to have their breakfast, which we serve after getting them up. Some of the patients are not able to get up or to eat breakfast unassisted, so we help with feeding. The nurse in charge comes round with the drug trolley and administers medication.

8.30 am We help to clear the breakfast dishes onto the trolley and begin bathing and dressing the patients. Some are unable to be bathed and require to be given bed baths. Many are capable of washing themselves but need assistance to get into and out of the bath and for this we use hoists and mechanical lifts. There is a clear "no

manual lifting" policy, but the ward has a large selection of lifting equipment. The patients will then either sit in the day room or in the sun lounge. The majority can walk with the aid of a stick or 'zimmer' frame, others have wheelchairs as they are no longer able to walk.

11.00 am By this time the beds have also been changed and their rooms tidied up. The nurse will take time to write up the care plans and to pass on any observations to the senior nurse. The doctors will tend to start their rounds before 11.00 am, but this will continue throughout the day depending on the needs of the client. Some patients may spend some of the morning in the rehabilitation unit accompanied by the occupational therapist and a care assistant. I have been on a home visit with one of my patients. This was very interesting and I am pleased to report that the patient did very well and a week later was able to return home to live independently with support. The patients will also be served tea/coffee in the morning, although this is available on request.

12 noon Lunch is served to the patients, and again I assist with feeding patients. Some patients are being 'peg-fed' and I have been able to observe this on a few occasions. The senior nurse again administers the medication.

The late shift begins at 1.00 pm, with the senior nurse on the early shift giving report.

1.00 pm Lunch dishes are cleared away and some patients are assisted to return to their beds for a rest. Others choose to remain in the day room and either watch television or participate in activities that have been arranged. In the afternoon, some of the patients may have a visit from the hairdresser, the chiropodist or the dentist. Others may have appointments in another hospital or in the rehabilitation unit. During the afternoon we will assist with toileting, preparing the patient for any medical intervention carried out by the nurse or doctor, such as a wound dressing or catheterisation. Any patients that require to be weighed is carried out.

3.00 pm Afternoon tea and coffee is served and visitors generally come at this time. Nursing duties continue as before.

5.00 pm The evening meal is served, and medication administered. Assisting with feeding and toileting continues. Fluid and weight charts are marked up. Evening meal dishes are collected.

6.00 pm Many of the patients return to the day room to watch the news and favourite 'soap operas'. Other patients choose to start preparing for bed. Some have televisions in their room and like to go to bed to watch it for a short while before going to sleep. We assist the patients who need assistance and wish to go to bed. We also tidy up the room in preparation for the next day.

During the course of the evening we make sure that the ward to tidy, this also includes the sluice room. We check that there are enough latex gloves out for the next day, and that all of the trolleys ie the bed bath trolley is full stocked for the night staff. We will go round regularly and check on our patients. We spend some time chatting with the patients, but if it has been a very busy shift, it is not always possible to spend as much time with the patients as you would like.

The night staff start at 8.30 pm, and receive the report from the Senior Nurse on the late shift.

9.00 pm The staff from the late shift go home, after serving a hot drink to the patients if desired.

9.00 pm The senior nurse goes round all of the patients and has a brief chat with those that are still awake and administers the medication. The medication times are devised so that those who are likely to sleep early are prescribed their medication at more appropriate times. It is very rare that a patient has to be woken up to be given tablets.

9.00 pm The rest of the staff will begin to go round the patients and assist with toileting or turning the patients position in bed.

11.00 pm The round will continue again and will continue throughout the night. Generally it will be every 2 hours so not as to disturb the patients sleep more often.

On night shift, the ward may be extremely busy depending on the status of the patients and no 2 nights are the same. Time is spent updating patient files as well as ensuring that the ward and other rooms are in a presentable condition for the staff coming in the morning.

Midnight Night staff breaks begin.

6.00 am Some patients have drugs which are prescribed at this time, but that only applies to a very few patients. None of the patients are woken up, except those who require to go to the toilet as 2-hourly care has taken place throughout the night. The blinds are drawn in the day room and sun lounge. Updating reports and all patients charts are checked.

7.00 am The table is set for those who do not have breakfast in their rooms. Any patients who wish to get up will be assisted, and early morning tea given out.

7.30 am The early shift arrive and receive report. The night staff continue with their duties until they leave at 8.00 am.

# 8. Vocational Training

## 8.1 General Goals of Practical Nursing Curriculum

Vocational training in Scotland is organised somewhat differently that you experience in your own country.

Training in care takes many forms and is continuing to be updated. If considering 'vocational training' then we have a training programme which is called the 'Scottish Vocational Qualification (SVQ) in Care at Level 2, Level 3 and Level 4. All of these qualifications are designed for people who are already in employment. The qualification takes between 12 and 18 months for Level 2 and between 18 and 24 months for Levels 3 to complete. Other vocational qualifications included in this section are the SVQ Registered Manager in Health and Social Care (Level 4). The 'Scottish Progression Award' (SPA) in Home Care practice and the SPA in Advanced Home Care Practice.

The candidate works through a variety of units and is assessed on their practice as well as on knowledge and understanding.


## 8.2. Qualifications in Care

The following is a breakdown of the subjects that the students will undertake in each of the qualifications:

### SVQ in Care (Level 2)

**Mandatory Units**

- Foster People's Equality, Diversity and Rights
- Promote Effective Communication and Relationships
- Promote, Monitor and Maintain Health, Safety and Security in the Workplace.
- Contribute to the Protection of Individuals from Abuse

**Optional Units -** *candidate must select 5 of the following units*

- Promote Communication with Individuals where there are Communication Differences.
- Receive, Transmit, Store and Retrieve Information

- Enable Clients to Eat and Drink
- Contribute to the Ongoing Support of Clients and Others Significant to them
- Support Individuals Experiencing a Change in their Care Requirements and Provision
- Enable Clients to maintain and Improve their Mobility through Exercise and the Use of Mobility Appliances.
- Contribute to the Movement and Handling of Individuals to Maximise their Physical Comfort.
- Enable Clients to Maintain their Personal Hygiene and Appearance
- Enable Clients to Access and Use Toilet Facilities
- Enable Clients to Achieve Physical Comfort
- Promote Communication with those who do not use a Recognised Language Format
- Monitor and Maintain the Cleanliness of Environments
- Support and Control Visitors to Services and Facilities
- Assist in Supplying and Maintaining Materials and Equipment
- Contribute to the Effectiveness of Work Teams
- Prepare Food and Drink for Clients
- Enable Individuals to maintain Contacts with Potentially Isolating Situations
- Contribute to the Support of Clients During Development Programmes and Activities
- Enable Individuals to Manage their Domestic and Personal Resources
- Enable Clients to Maintain their Mobility and Make Journeys and Visits
- Support Individuals when they are Distressed
- Enable Clients to Participate in Recreation and Leisure Activities
- Contribute to the Care of a Deceased Person

## SVQ in Care (Level 3)

**Mandatory Units**

- Promote people's Equality, Diversity and Rights
- Promote Effective Communication and Relationships
- Promote, Monitor and Maintain Health, Safety and Security in the Workplace
- Develop One's Own Knowledge and Practice
- Contribute to the Protection of Individuals from Abuse

**Optional Units** - *the candidate must select 7 from the following units*

- Promote Communication with Individuals where there are Communication Differences
- Prepare and Maintain Environments for Clinical Procedures
- Contribute to the Development and Effectiveness of Work Teams
- Contribute to the Development, Provision and Review of care Programmes

- Support Clients During Clinical Activities
- Undertake agrees Clinical Activities with Clients Whose Health is Stable in Non-Acute Care Settings
- Prepare and Undertake Agreed Clinical Activities with Clients in Acute Care Settings
- Enable Individuals to Find Out About the Use of Services and Facilities
- Enable Individuals to Administer their Financial Affairs
- Support Individuals in Undertaking Health Care
- Contribute to the Moving and Handling of Individuals to Maximise their Physical Comfort
- Support Individuals when they are Distressed
- Contribute to the Management of Clients Continence
- Obtain venous Blood Samples Using Invasive Techniques
- Obtain and Test Capillary Blood Samples
- Receive, Transmit, Store and Retrieve Information
- Enable Individuals, their Family and friends to adjust to and Manage their Loss
- Enable Individuals, their Family and Friends to Explore and Manage Change
- Support Individuals and Others through the Process of Dying
- Support Inter-disciplinary Teams in Delivering Individualised Programmes of Care to Clients
- Contribute to raising Awareness of Health Issues
- Represent Individuals' and Families' Interests when they are not able to do so themselves
- Contribute to developing and maintaining cultures and strategies in which people are respected and valued as individuals
- Contribute to the planning, implementation and evaluation of therapeutic programmes to enable individuals to manage their behaviour
- Record and report the respiratory function of patients
- Contribute to the Assessment of individuals needs and the planning of packages of care
- Record and evaluate an ECG at rest
- Support clients during speech and language therapy
- Prepare and restore the client and the environment prior to, and following, physiotherapy programmes
- Assist with and carry out agreed physiotherapy mobility and movement programmes
- Prepare equipment for, and support clients during occupational therapy
- Assist clients to develop self and environmental management skills
- Prepare, implement and evaluate agreed therapeutic group activities
- Assist individuals to move from a supportive to a more independent living environment
- Contribute to the care of a deceased person

- Support the efficient use of resources
- Contribute to the selection of personnel for activities
- Contribute to the development of teams and individuals

## SPA - Home Care Practice

**Mandatory Units**

- Foster people's equality, diversity and rights
- Promote effective communication and relationships
- Promote, monitor and maintain health, safety and security in the workplace
- Recognising and reporting abuse and challenging behaviour in a home care setting
- Food Hygiene Practices

**Optional Units** - *candidates must complete 1 optional unit*

- Enable clients to maintain their personal hygiene and appearance
- Prepare food and drink for clients
- Support individuals when they are distressed
- Enable clients to eat and drink
- Contribute to the management of client continence

## SPA - Enhanced Home Care Practice

**Mandatory Units**

- Promote peoples equality, diversity and rights
- Promote effective communication and relationships
- Promote clients to maintain their personal hygiene and appearance
- Carry out enhanced care activities

**Optional Units**

- Contribute to the development and effectiveness of work teams
- Contribute to the movement and handling of individuals to maximise their physical environment
- Support individuals and others through the process of dying
- Promoting good nutrition in a care setting
- Prepare equipment for, and support clients during, occupational therapy
- Support others in the implementation of physiotherapy programmes and treatments
- Recognise, respond and report challenging behaviour in a care setting.

# 9. Employment in The Care of Older People

There are a wide variety of jobs within the care sector, this is due to there being many different roles within a multi-disciplinary team. The labour market is healthy in Scotland for care posts, these range from nursing care assistants, social care workers, home carers, social workers and nurses. Please note that these posts do not include all positions within the wider health care profession, but for the purposes of this pack these are the most relevant.

As explained previously there are skills shortages in parts of the UK, this is not too prominent in Scotland although it is estimated that with an increasing elderly population there will be skills shortages in the future.

The government is committed to training in care services and has over the last number of years increased the number of nurses going through training. In the areas of adult nursing and mental health nursing the employment market is healthy.

All care workers, no matter their status, must have a criminal record check carried out by Disclosure Scotland. Care workers are not covered by the Rehabilitation of Offenders Act and any criminal convictions, no matter when they occurred will be disclosed. Not all convictions will prevent an individual working within the care field and any convictions which may be considered as not being of such a nature as to prevent an individual working with vulnerable people will go before a panel for a decision to be made as to the suitability of the individual. It is also important to note that all students who undertake a placement within the care field also have go through the Disclosure Scotland procedures.

All qualified nurses are registered with the Nursing and Midwifery Council and must adhere to their Code of Conduct. To read the Code of Conduct in full, look up **www.nmc.gov.uk**

The following are examples of some job advertisements.

# 9.1. Examples of Employment Advertisements

**Home Carer (Advertised 25 October 2002)**

**Home Carers**

**£5.70 per hour**

Do you enjoy caring for people? Are you hardworking and able to use your own initiative? If so you could apply to become one of a dedicated team of Home Carers who assist people to live in their own homes by providing assistance with personal and domestic care.

There are a number of permanent vacancies in for Home Carers, who are required to work either day shift, back shift, split shift or weekends only.

If you have experience of working with people or are prepared to be trained to work as a Home Carer you can apply for a post by completing a simple application form. The use of a car is desirable.

**Ref:** SWM/69/DC
**Contact Tel:** 01383 313333
**Closing Date:** 11 November 2002

*For Social Work posts you will be required to obtain a criminal conviction Enhanced Disclosure Certificate, which will be checked before appointment can be confirmed.*

## Social Care Officer
## (Advertised 25 October 2002)

**Social Care Officer**

**£7,555-£9,012 (Bar at £8,099)**

Based within one of the residential homes for older people, working 20 hours per week, you will provide a service for older adults with varying needs including physical disabilities and dementia. Your duties will include ongoing assessment and review of service users' needs, assisting with daily living tasks, participating in social and recreational activities, and responding to emergency situations.

You will have excellent communication skills and the ability to assess a situation and take appropriate action. You must be dependable and flexible in terms of working a 24-hour shift based system including nights and weekends. Ideally, you will hold an SVQ Level 2 in Care, or be willing to undertake training to attain this.

**Ref 575** is temporary to cover for maternity leave.
**Ref 578** is temporary initially for a period of no more than 6 months.

*For an application form and further information, please telephone our 24-hour recruitment lines on (01307) 473336.*

**Closing Date: 8 November 2002**

## Social Care Worker (Advertised 27 October 2002)

**Social Care Worker (35 hours per week)**

**£13,976-£16,673 pro rate**
(Placing on pay scale depends on qualifications)

**Vacancy 33259/SCO (Lifelong Care)**

You will provide support to residents with their physical, social and emotional needs.

An SVQ Level 2 in Care is essential along with experience of working in a social or health care setting, experience of working in a social care setting for older people would be an advantage.

**Closing date: 11 November 2002**

# 10. Useful Web-site References

## 10.1. Health and Social Care Web Sites

**www.hebs.NHS.uk** - Health Education Board for Scotland
**www.sosig.ac.uk** - Social Science Information Gateway
**www.bma.org.uk** - British Medical Association web site (articles)

## 10.2. General Web Sites

**www.bbc.co.uk/health**
**www.biome.ac.uk**

## 10.3. Government/Legislation Web Sites

**www.audit-scotland.giv.uk/search/ndx/01hl3ag.htm**
**www.scotland.gov.uk**
**www.ukonline.gov.uk**
**www.legislation.hmso.uk**
**www.open.gov.uk**
**www.scottish.parliament.uk**
**www.doh.gov.uk**

## 10.4. Statistics

www.statistics.gov.uk/themes/health-care
www.scotland.gov.uk/stats
www.scot.nhs.uk/isd/health-topics.htm
www.gov.uk/stats/sss/sss.00.asp

# 11. References

## 11.1. Books

Alcock, P, 2003. Social Policy in Britain. Palgrave
Hann, C, 1999. Health Policy in Britain. Palgrave
Moonie, N 1997. Health and Social Care. Heinemann
Scottish Executive. 2001. National Care Standards. Astron

## 11.2. Internet

Scottish Executive. 2002. *Free Personal Care only days away* (Online)
**http://www.scotland.gov.uk/pages/news/2002/06/Shed119.aspx**
(Accessed 03 October 2003)

Scottish Executive. 2002. *Care regulation body begins its work* (Online)
**http://www.scotland.gov.uk/pages/news/2002/04/SE5630.aspx**
(Accessed 03 October 2003)

Department for Work and Pensions. *Extra money for over 80s.* (Online)
**http://www.thepensionservice.gov.uk/winterfuel/extramoney.asp**
(Accessed 03 October 2003)

Department for Work and Pensions, *Winter Fuel Payments* (Online)
**http://www.thepensionservice.gov.uk/winterfuel** (Accessed 03 October 2003)

Department for Work and Pensions, *Pensioners Guide* (Online)
**http://www.info4pensioners.gov.uk/money_tax/index_sc.htm**
(Accessed 03 October 2003)

Scottish Executive. 2002. *Residential care home figures published* (Online)
**http://www.scotland.gov.uk/pages/news/2002/12/Shed273.aspx**
(Accessed 03 October 2003)

Scottish Executive. 2002 *Statistics Release, Residential Care Homes, Scotland 2002* (Online)
**http://www.scotland.gov.uk/library5/health/rchs02-00.asp** (Accessed 03 October 2003)

Scottish Executive. 2001. *National Care Standards - care homes for older adults* (Online)
**http://www.scotland.gov.uk**

# 12. Acknowledgements

Marie McArthur, the writer of the materials, would like to offer grateful thanks to the following for their guidance, support, donation of appropriate materials and proof-reading for accuracy of this package of information.

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Mr John Russell, Fife Publishers

# 13. Glossary

**Community Care**

Assessing the needs of individuals and devising a package of care to meet those needs, allowing them to remain in their home or in a home-like environment in the community.

**Key Worker**

A person who is assigned to an individual and is their main contact.
This person may be able to advocate on behalf of the client.

**Nursing Care**

where the individual requires clinical nursing and medical intervention.

**Residential Care**

Where the individual may be more independent and not requiring significant nursing services.

## 13.1. List of Abbreviations

| | |
|---|---|
| NHS | National Health Service |
| SSSC | The Scottish Social Services Council |
| BUPA | British United Provident Association |
| GP | General Practitioner |
| WC | Water Closet |
| HNC | Higher National Certificate |
| MRSA | Methicillin Resistant Staphylococcus Aureus |
| SVQ | Scottish Vocational Qualification |
| SPA | Scottish Progression Award |

# 14. Appendices

## 14.1. Appendix 1:

Example of Nursing/ADL Assessment Form



**NURSING/ADL ASSESSMENT** | *Name:* | *Unit:*

| **BREATHING** | **CP** |
|---|---|
| **SMOKES** Yes: ☐ No: ☐ *No. Per Day:* **COUGH** Yes: ☐ No: ☐ **Productive:** ☐ *Sputum Colour* | |
| **SHORTNESS OF BREATH** Yes: ☐ No: ☐ *With Exercise:* ☐ *Without Exercise:* ☐ | |
| *Alleviated By:* | |
| **OTHER PROBLEMS** | |
| | |
| **SPECIAL AIDS NEEDED** | |
| **EATING & DRINKING** | |
| **DENTURES** Top: ☐ Bottom: ☐ None: ☐ **HAS OWN TEETH** Top: ☐ Bottom: ☐ None: ☐ | |
| **LAST SAW DENTIST:** **PROBLEMS WITH MOUTH** Chewing: ☐ Swallowing ☐ | |
| **PROBLEMS WITH FEEDING** Ulcers: ☐ Pain: ☐ **APPETITE** Good: ☐ Poor: ☐ | |
| **FLUID INTAKE/DAY** =*Litres/Day* **ALCOHOL INTAKE** Yes: ☐ No: ☐ *Quantity:* | |
| **WEIGHT** Gain: ☐ Loss: ☐ Stable: ☐ *How Much:* *Over What Period:* | |
| **FOOD LIKES** | |
| **FOOD DISLIKES** | |
| **AIDS/ASSISTANCE REQUIRED** | |
| **SPECIAL DIET** | |
| **COMMUNICATING** | |
| **VERBAL** No Problem: ☐ Recent Memory Changes: ☐ Problem Learning: ☐ Problem Understanding: ☐ | |
| **VISION** Normal: ☐ Impaired: ☐ Near Sighted: ☐ Far Sighted: ☐ *How many Pairs of Glasses?* | |
| **HEARING** Normal: ☐ Impaired: ☐ Aid: ☐ **ORIENTATION** Time: ☐ Place: ☐ Person: ☐ | |
| **MEMORY** *Short Term* Good: ☐ Poor: ☐ *Long Term* Good: ☐ Poor: ☐ | |
| **CONVERSATION** Rational: ☐ Irrational: ☐ **CONSCIOUS LEVEL** Responds to External Stimuli: ☐ Aware of External Environment: ☐ | |
| **SLEEP & REST** | |
| **USUAL BEDTIME** am/pm Has Problems Falling Asleep: ☐ Early Morning Wakening: ☐ Wakens at Night: ☐ Restless in Bed: ☐ | |
| Is anything taken to aid sleep? | |
| On Awakening, Remedy to get back to Sleep? | |
| **NORMAL SLEEP PERIOD** From: To: **SPECIAL AIDS** | |
| **NUMBER OF PILLOWS** [ ] **DAYTIME NAP** Yes: ☐ No: ☐ What Time of Day? | |
| Safety in Bed & Getting out of Bed | |
| **DRESSING ABILITY** | |
| **TOTALLY INDEPENDENT** Yes: ☐ No: ☐ **CAN SELECT CLOTHES** Yes: ☐ No: ☐ | |
| **CAN PUT ON GARMENTS** Yes: ☐ No: ☐ **CAN DO UP BUTTONS etc.** Yes: ☐ No: ☐ | |
| **CAN UNDRESS** Yes: ☐ No: ☐ **SPECIAL AIDS NEEDED** | |
| **ASSISTANCE REQUIRED** Yes: ☐ No: ☐ *If Yes, Specify the Amount:* | |
| | |

*All Sections of the Assessment should be completed by entering a Detailed Note, and/or Ticking the Appropriate Answer Box.*

Enter "X" in CP column for problems or needs that require Care Planning

| | CP |
|---|---|
| **SAFETY & AVOIDANCE OF DANGER** | |
| **TENDENCY TO FALL or LOSE BALANCE** Yes: ☐ No: ☐ *Detail:* | |
| | |
| **GETS LOST EASILY** Yes: ☐ No: ☐ **HAS WANDERED FROM HOME ENVIRONMENT** Yes: ☐ No: ☐ | |
| **SPECIAL AIDS NEEDED** **OTHER RISKS** | |
| **ELIMINATION & CONTINENCE** | |
| **NOCTURIA** Yes: ☐ No: ☐ **DYSURIA** Yes: ☐ No: ☐ **HAEMATURIA** Yes: ☐ No: ☐ | |
| **URGENCY** Yes: ☐ No: ☐ **HESITANCY** Yes: ☐ No: ☐ **INCONTINENCE** Yes: ☐ No: ☐ | |
| *If Incontinent, Describe Frequency & Pattern:* | |
| **NORMAL DAYTIME FREQUENCY** [ ] times/day. **NORMAL NIGHT FREQUENCY** [ ] times/night. | |
| **BOWEL FUNCTION** **Regular:** Yes: ☐ No: ☐ *How Many Times:* **Per DAY / WEEK** | |
| **NORMAL/FORMED** Yes: ☐ No: ☐ **DIARRHOEA** Yes: ☐ No: ☐ **CONSTIPATED** Yes: ☐ No: ☐ | |
| **INCONTINENT** Yes: ☐ No: ☐ **Ways of Indicating Continence Needs?** | |
| **Ability to Locate Toilet Facilities** **Independence in Using Facilities** | |
| **CONTINENCE AIDS** **USUAL APERIENT** | |
| **HISTORY OF** *Nausea* Yes: ☐ No: ☐ *Vomiting* Yes: ☐ No: ☐ *Dysphagia* Yes: ☐ No: ☐ | |
| **MAINTENANCE OF BODY TEMPERATURE** | |
| **DO YOU USUALLY FEEL HOT** Yes: ☐ No: ☐ **COLD** Yes: ☐ No: ☐ **AVERAGE** Yes: ☐ No: ☐ | |
| **SPECIAL AIDS NEEDED** | |
| **MAINTENANCE OF PERSONAL HYGIENE** | |
| **CONDITION OF NAILS** *Last Chiropody Appointment:* | |
| **CONDITION OF HAIR** | |
| **PREFERS** **Bath:** ☐ **Shower:** ☐ **Bed Bath:** ☐ **Preferred Frequency:** | |
| **SELF CARE** *Can Wash Hands* Yes: ☐ No: ☐ *Can Wash Face* Yes: ☐ No: ☐ | |
| *Can Wash Body* Yes: ☐ No: ☐ *Can Wash Hair* Yes: ☐ No: ☐ *Can Brush Hair* Yes: ☐ No: ☐ | |
| **PROBLEMS/ASSISTANCE REQUIRED** | |
| | |
| | |
| **CONDITION OF SKIN** | |
| **OBSERVATIONS** **Rashes** Yes: ☐ No: ☐ **Injuries** Yes: ☐ No: ☐ **Oedema** Yes: ☐ No: ☐ | |
| **Healing Problems** Yes: ☐ No: ☐ **Pressure Sores** Yes: ☐ No: ☐ | |
| *If the answer is YES to any of these Observations, Describe in Detail:* | |
| | |
| | |
| | |
| **OTHER SKIN PROBLEMS** | |

| MOBILITY | CP |
|---|---|
| **USUAL EXERCISE TAKEN** | |
| **PROBLEMS GETTING ABOUT AT HOME** Yes: ☐ No: ☐ | |
| **ENERGY LEVEL** AVERAGE ☐ TIRES EASILY ☐ HIGH ENERGY ☐ | |
| **ARE YOU ABLE TO** CLIMB STAIRS Yes: ☐ No: ☐ DO HOUSEHOLD CHORES Yes: ☐ No: ☐ | |
| **AIDS USED** WHEELCHAIR ☐ WALKER ☐ STICK ☐ PROSTHESIS ☐ | |
| **NEEDS HELP WITH** WALKING ☐ STANDING ☐ SITTING ☐ TOILETING ☐ | |
| GETTING OUT OF CHAIR ☐ GETTING OUT OF BED ☐ TURNING IN BED ☐ | |
| **BALANCE AND GAIT** STEADY ☐ UNSTEADY ☐ UNSTEADY AT NIGHT ☐ | |
| **IS THERE ANY EVIDENCE OF WEAKNESS/PARALYSIS** Yes: ☐ No: ☐ Left side: ☐ Right side: ☐ | |
| **OTHER PROBLEMS** | |
| | |

| EMOTIONAL NEEDS | |
|---|---|
| **WORRIES ABOUT** Illness Yes: ☐ No: ☐ Admission Yes: ☐ No: ☐ Treatment Yes: ☐ No: ☐ | |
| **MOOD** Anxious: ☐ Withdrawn: ☐ Distressed: ☐ Angry: ☐ Cheerful: ☐ Depressed: ☐ | |
| **OTHER OBSERVATIONS** | |

| EXPRESSING SEXUALITY | |
|---|---|
| **CLOTHING PREFERENCES** | |
| **HAIRSTYLE** | |
| **FOOTWEAR** *Preference for Personal Care (Male or Female)* NONE - MALE - FEMALE | |
| *Uses Perfume/Aftershave* Yes: ☐ No: ☐ *Uses Deoderant* Yes: ☐ No: ☐ *Uses Make-up* Yes: ☐ No: ☐ | |
| **OTHER** | |

## ROOM PRIVACY

Ascertain whether the resident wishes to have his/her bedroom door locked Yes: ☐ No: ☐

| | | CP |
|---|---|---|
| TEMPERATURE | °C | |
| PULSE | | |
| RESPIRATIONS | | |
| BLOOD PRESSURE | *mm/Hg* | |
| WEIGHT | *Kg* | |

**URINALYSIS**
If "No Abnormalities Detected" enter NAD in BOX.

**Observations:**

*Signature of Person Responsible for Admissions & Assessments:*

_____ *Date:* _____

*NAMED PERSON Responsible for Resident's Care Planning:*

_____ *Date:* _____

## ADL ASSESSMENT SCALE

*Resident's Name::* .....

### BREATHING

0 No respiratory problems
1 Prone to chest infections
2 Requires regular medication and/or oxygen
3 Demonstrably breathless on exertion
4 Breathless at rest

### EATING AND DRINKING

0 Eats/drinks unaided
1 Eats appropriately with aid
2 Needs help and encouragement to eat
3 Requires feeding by others
4 Has to be fed, liable to choke

### COMMUNICATION

0 Has no problem communicating
1 Can indicate needs and hold a simple conversation
2 Understands simple instructions
3 Cannot indicate need and has short retention
4 No effective contact
5 Obstructive in conversation

### HEARING

0 Good hearing with/without aid
1 Poor hearing without aid
2 Poor hearing with aid
3 Deaf - Registered: YES/NO

### SIGHT

0 Without spectacles/lenses
1 Good long distance sight with/without aid
2 Good short distance with/without aid
3 Blind - Registered: YES/NO

### SLEEP

0 Sleeps without medication
1 Needs occasional medication
2 Wakeful periods with/without medication
3 Restless most/part of the night

### DRESSING

0 No assistance required to dress/undress including difficult fasteners
1 Dresses imperfectly but adequately
2 Can manage to dress with minimal supervision and verbal prompts
3 Requires one helper to dress
4 Requires more than one helper

### CONTINENCE

0 Always incontinent
1 Occassionally incontinent - full control with some assistance and encouragement
2 Incontinent at least once a day
3 Prone to UTI
4 Very irregular/frequently incontinent - catheter/orostomy/ileostomy/other

### PERSONAL HYGIENE

0 Can wash and bathe
1 Can wash unaided but needs assistance bathing
2 Needs help washing and bathing
3 Needs one person to do washing and bathing
4 Needs assistance from more than one person

### PRESSURE AREAS

0 Fully mobile, no risk
1 Low Risk
2 At Risk/Medium Risk
3 High Risk

*refer to Waterlow or Medley*

### MOBILITY

0 Moves around independently including stairs
1 Moves around independently not including stairs
2 Walks with a stick, frame or assistance
3 Poor mobility, even with aid
4 Immobile

### CLEANING

0 Regularly and adequately does household chores
1 Occasionally does housework
2 Does not do housework chores
3 Makes no attempt/is incapable of doing housework

### PUBLIC TRANSPORT

0 Independently uses buses, taxis, etc.
1 Independently uses taxis only
2 Uses public transport when accompanied
3 Unable to use public transport

### SUPPORT

0 Informal support or carer capable of sustained care
1 Informal support carer coping but possibly of breakdown
2 Main carer absent
3 Unable to manage alone - at Risk

### Guidelines

**1 - 12** = Low Dependency
Can do without support or requires assistance with a range of daily activities.

**13 - 24** = Medium Dependency
Moderate impairment, considerable support required for a range of daily activities

**25 - 36** = High Dependency
Marked impairment - full support required

**37+** = Marked Dependency
Severe impairment - eg Dementia, full care

**Re-Assessment should be undertaken every six months, or more frequently if required**

| CRITERIA *Date =* | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BREATHING | | | | | | | | | | | | |
| EATING AND DRINKING | | | | | | | | | | | | |
| COMMUNICATION | | | | | | | | | | | | |
| HEARING | | | | | | | | | | | | |
| SIGHT | | | | | | | | | | | | |
| SLEEP | | | | | | | | | | | | |
| DRESSING | | | | | | | | | | | | |
| CONTINENCE | | | | | | | | | | | | |
| PERSONAL HYGIENE | | | | | | | | | | | | |
| PRESSURE AREAS | | | | | | | | | | | | |
| MOBILITY | | | | | | | | | | | | |
| CLEANING | | | | | | | | | | | | |
| PUBLIC TRANSPORT | | | | | | | | | | | | |
| SUPPORT | | | | | | | | | | | | |
| TOTAL SCORE = | | | | | | | | | | | | |
| *Initials of Person Completing Assessment* | | | | | | | | | | | | |

## 14.2. Appendix 2: Example of Needs Assessment

**Needs Assessment for Miss Smith**

| | | | |
|---|---|---|---|
| Customer: | Miss Smith | | |
| Care Manager: | | | |
| Key Worker: | To be agreed after placement | | |
| Review Date: | 6 weeks after placement | | |
| | **Needs** | **How needs are to be met** | **Action** |
| A | *Accommodation*<br>Supportive environment in which to develop independent daily living skills | Social Worker to discuss proposed placement with Social Services | Social Worker to discuss proposed Support Services |
| B | *Tasks of daily living*<br>(i) Assistance/guidance with undertaking co-ordinated household routine<br>(ii) Assistance/guidance with budgeting/finance<br>(iii) Assistance to build independent shopping skills<br>(iv) Assistance to build confidence when travelling alone | Social Worker to discuss the needs with staff and agree to daily plan to meet all identified needs | Social Worker to discuss the needs with staff and agree a daily plan to meet all the identified needs |
| C | *Personal Care*<br>Maintain a regular personal care routine | Assistance where necessary | Revise home bathroom situation |
| D | *Emotional Support*<br>(i) Reassurance<br>(ii) Encouragement when demotivated by mental state | Building of relationships with Care staff<br>All agencies involved with Care Plan | Continuity of Care through Day Centres, Lunch Clubs and Social Activities<br>Named person contact |
| E | *Social contact/occupation*<br>(i) Social contact/leisure activity in a community setting<br>(ii) Structured occupation | Day Social Project | Social Worker to liaise with Day Social Project Manager<br>Social Worker to liaise with Centre Manager |
| F | *Medication*<br>Monitoring and reviewing | Local Health Clinic | Community Psychiatric Nurse |

| **Client's Name**: Miss Smith | | **Doctor**: ..... **Telephone No**: ..... | | | **Key Holder**: | |
|---|---|---|---|---|---|---|
| **Address**: ..... ..... | | | | | | |
| **Special Instructions**: 5 weeks' trial<br>**Next Review**: | | **Other agencies involved**:<br>Day Centre<br>Day Social Project | | | **Location**: | |
| *Monday am* | *Tuesday am* | *Wednesday am* | *Thursday am* | *Friday am* | *Saturday am* | *Sunday am* |
| Assist with personal hygiene | Day Centre 0930-1530 hours | Rehabilitation Unit (1000-1200 hours) | Day Centre 0930 hours | Day Social Project 1000-1200 hours | Visit family all day | Church Service |
| *Lunch* | *Lunch* | *Lunch* | *Lunch* | *Lunch* | *Lunch* | *Lunch* |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Client's Name**: Miss Smith<br>**Address**: ……<br>…… | | **Doctor**: …… **Telephone No**: …… | | | **Key Holder**: | |
| **Special Instructions**: 5 weeks' trial<br>**Next Review**: | | **Other agencies involved**:<br>Day Centre<br>Day Social Project | | | **Location**: | |
| *Monday pm* | *Tuesday pm* | *Wednesday pm* | *Thursday pm* | *Friday pm* | *Saturday pm* | *Sunday am* |
| Accompanied Shopping Trip | Day Centre<br>1530 hours | Visit to Occupational Therapist<br>1400 hours | Day Centre<br>1330 hours | Day Social Project<br>1400-1600 hours | Visit family all day | Quiet day |
| *Evening Meal* | *Evening Meal* | *Evening Meal* | *Evening Meal* | *Evening Meal* | *Evening Meal* | *Evening Meal* |
| Personal Time | Personal Time | Personal Time | Personal Time | Personal Time | Personal Time | Personal Time |

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| John Russell | DTP – Fife Publishers |


All materials of the project are downloadable for free from partners websites:

www.caritas-mg.net/frame9.htm
www.haus-berg.com
www.davinci.nl
www.whitehallcollege.com
www.hesote.edu.hel.fi/english
www.linkoping.se/birgitta
www.linkoping.se/ljungstedtska
www.dundeecoll.ac.uk/work_placements_abroad