CHCAGE001
Facilitate the empowerment of older people

Student Name:

Learner Guide
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How to study this unit

You will find review learning activities at the end of each section. The learning activities in this resource are designed to assist you to learn and successfully complete assessment tasks. If you are unsure of any of the information or activities, ask your trainer or workplace supervisor for help.

The participant will be required to demonstrate competence through the following means:

**Methods of assessment**

- Observation in the work place
- Written assignments/projects
- Case study and scenario analysis
- Questioning
- Role play simulation
- Learning activities
- Class discussion and group role-plays
- Assessment tasks

**Asking for help**

If you have any difficulties with any part of this unit, contact your facilitator. It is important to ask for help if you need it. Discussing your work with your facilitator is considered an important part of the training process.

**Name of facilitator:** __________________________ **Phone number:** _______________
Welcome to the unit CHCAGE001 Facilitate the empowerment of older people, which forms part of the 2015 Community services training package.

Application: This unit describes the skills and knowledge required to respond to the goals and aspirations of older people and provide support services in a manner that focuses on improving health outcomes and quality of life, using a person-centred approach. This unit applies to support workers in residential or community contexts.

The skills in this unit must be applied in accordance with Commonwealth and State/Territory legislation, Australian/New Zealand standards and industry codes of practice.

WHAT YOU WILL LEARN

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| Element 3: Support the rights of older people | 3.1 Assist the older person to understand their rights and the complaints mechanisms of the organisation  
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4.3 Identify strategies and opportunities that maximise engagement and promote healthy lifestyle practices  
4.4 Identify and utilise aids and modifications that promote individual strengths and capacities to assist with independent living in the older person’s environment  
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Element 1: Develop relationships with older people

Introduction

Structure and profile of the aged care sector:

Australians are an increasingly diverse group in terms of their backgrounds, care needs, preferences and incomes and wealth. Aged care services are provided both in the community and in residential facilities. Community care is primarily provided by informal carers. The need for some form of assistance with personal and everyday activities increases with age. In 2003, 32 per cent of those aged 65–74 years needed some form of assistance, compared with around 86 per cent of those aged 85 or older.

Publicly subsidised aged care services are extensively regulated and predominantly funded by the Australian Government, although all levels of government are involved to some extent. Government is involved in: allocating places to approved providers; assessing client eligibility for services; funding services; setting prices; and regulating quality. The regulated aged care sector has changed significantly over the past decade or so.

Structure of Aged Care - Governing Bodies

- **Commonwealth Department of Health and Ageing: Information**: access to services, general information and advisory to government and lobbyists.

- **Medicare Australia**: Funding of Aged Care Funding Instrument Vic Department of Health: legal and procedural control and standards complaints process.

- **Aged Care Standards and Accreditation Agency**: Every 3 years full application against 44 standards and support visits when scheduled.

- **Council food inspectors**: Quarterly review of environment.

- **Work cover**: Monitor the safe work environment of all staff.
Demographics

Let’s look at the impact of ageing demographics, in particular the ‘baby boomer’ demographics, i.e.: people born between 1946 and 1965. To begin, what do we mean by ‘demographics’ and why does it matter? What is policy? And how does an understanding of demographics affect the process of making policy?

Demographics is the science of statistics in relation to people, to births, deaths, marriages, fertility rates, numbers of children, age of population, mortality rates, health, etc. It focuses on what has been, what is (current situation), projections and comparisons, trends and patterns. It allows us to view the current situation in relation to what has been and to forecast likely future scenarios, allowing us to anticipate requirements and to work towards meeting those requirements.

Policy can be defined as a social or political goal chosen by a government (or organisation) and the framework to put the policy into practice. Good policy is a mix between research and government intention or direction, i.e.: how the elected government of the day will address these issues in the policy context, for example policy in relation to employment, environment, health care, education and aged care. Both development of policy and the science of demographics, are specialisations in their own right. Within the context of this publication, it is important to understand the connection between the demographics of ageing and the way in which aged care policy is developed and implemented in Australia.

The demographic of the baby boomer: those people born between 1946 and 1965

This was the post-war period and featured an increase in affluence and high levels of immigration. Because of this, the baby boomer generation is disproportionate in size to previous and subsequent generations. The demographic hump of the baby boomer generation means that the number of people over 65 is estimated to increase from three million to five million.

The proportion of people aged over 65 is expected to double between 2001 and 2051, to around 24 per cent of the population. At the other end of the spectrum, the following generations are smaller in number; hence the numbers employed and supporting an ageing population will decrease. In other words, as the ageing population increases we can expect an increase in the cost of income support, e.g.: pensions, health care services and more. Given the smaller numbers in the workforce, it will be increasingly difficult to support an increased ageing population.

Until comparatively recent times, the only option for care available for ageing people existed within the family. It was not uncommon for parents to either move in with one of their married children, or to at least live nearby for daily contact and practical support as needed. Care for the ageing within the family is still an expectation in some cultures, although less so in westernised societies.

Advancing years and declining health of older members of the family raise all sorts of issues for family members such as:

- Feeling guilty if they are either unable or unwilling to care for an ageing family member.
- Feeling the need to make up for past ‘misdeeds’ by taking care of an ageing relative unwillingly.
- Feeling fear at the prospect of losing the parent/s they have always regarded as being totally reliable, capable and accessible.
- Fearing the death of parents.

When an older person needs additional support, it is perfectly natural for a family member to wonder if perhaps they could have done more to help in the past. However, this is not a good motive for accepting responsibility for the care of an older relative, no matter how much they may be loved. Becoming a care giver for an older member of the family out of a sense of guilt is likely to be unproductive in the long term. The person who has become the carer may become resentful, approaching the situation from a sense of duty, rather than out of genuine love, caring and ability.

People who look on the changes of old age as the start of a new stage in a life rather than the end of an old stage, may cope with the situation far better, even if their loved one has dementia.
This demographic dynamic has fuelled much government policy related to ageing, e.g.:

- Compulsory employer superannuation contributions
- Increasing levels of contribution
- An increased focus on self-funded retirement (rather than relying solely on aged pension)
- Abolition of compulsory retirement in all states and territories excepting Tasmania
- The current changes to superannuation policy, encouraging older people to gradually move out of the workforce (rather than the sudden exit of retirement).

**Who are Older People in Australia?**

- Considered to be people over 65 years
- From a diverse range of experiences
- Have a diverse range of values
- Have a diverse range of needs, goals and personal preferences.

**Health of Older People Statistics**

- Increasing age is related to long-term health conditions, higher rates of disability and poorer reported health status.

- Population ageing, and the health of older people, is likely to impact on the overall health status of the Australian community.
  (ABS:2006)

- Projected population by age 2004 to 2101.
Life Expectancy:
- Females born in 2002-04 are expected to live to 83.0 years and males to 78.1 years
- Between 2004 and 2101, the proportion of males in the 85 years or more age group is projected to increase, from 32% of all people aged 85 years or more in 2004 to between 44%-47% in 2101
- This is due to the expected narrowing of the gap between male and female life expectancy (ABS 2005), (OECD 2005).

Living Arrangements:
- The differences in marital status for older males and females impact on living arrangements and other forms of support
- Over time, older people experience loss, not only of a partner, but often incremental loss of independence through disability and other factors associated with ageing
- The longer life span of females is reflected in the marital status data for older people
- Across the older age groups, the proportion of both males and females in the widowed category increases with age, with more females widowed than males in each age group (ABS 2006a).

Health Status:
- Self-assessed health status is considered to be a strong predictor of morbidity and mortality (Gerdtham et el 1999; McCallum et al 1994)
- Long-term health conditions are more common with increasing age
- In 2005, nearly 100% of people aged 65 years or more reported at least one long-term health condition.

Most common reported conditions (ABS 2006):
- The eye (90%),
- Musculoskeletal conditions (66%)
- Osteoarthritis (28%)
- Circulatory system (57%)
- Respiratory conditions (15%).

Leading causes of death:
- The leading causes of death- 65 years + diseases of the circulatory system
- Malignant neoplasms (particularly lung, prostate, and colorectal cancers).
- Accidental falls.

Significant issue with ageing:
- With 4% of those aged 75 years and over having reported an injury event from low falls in the four weeks prior to interview
- Common Health Problems for Indigenous Australians
Role of carers

Who are carers?

Section 5 of the Carer Recognition Act 2010 (Cwlth) defines carers as follows:

For the purpose of this Act, a carer is an individual who provides personal care, support and assistance to another individual who needs it because that other individual:

- Has a disability, or,
- Has a medical condition (including a terminal or chronic illness), or
- Has a mental illness, or,
- Is frail and aged.

The Australian Bureau of Statistic (ABS) (2008, A Profile of Carers in Australia, 4448.0, pp 102-107) provides the following definitions:

- ‘A carer’ – a person of any age who provides informal assistance, in terms of help or supervision, to a person with disability, or long-term medical condition, or an older person aged 60 years or over. The assistance must be ongoing or likely to be ongoing for at least six months.

- ‘Primary carer’ – a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more core activities (communication, mobility and self-care).

According to the ABS report, there were 2.5 million carers in Australia aged 15 years and over in 2003 – 16% of the population of Australia. Approximately 91% of primary carers were related to the people they are caring for, with approximately 42% of carers caring for partners, 26% of carers caring for a parent and 23% of carers caring for a child.

Issues faced by carers

Those families and carers who try to achieve the best possible outcomes for the elderly are faced with numerous problems, some of which include:

- Isolation
- Lack of income
- Lack of support from other family members or the community.

In attempting to provide continuous care, in the name of love these people may be unwilling to give up their role of carers, and as a result of long term caring, become withdrawn, might experience relationship problems and generally they feel ‘burnt out’. These people often refuse to accept offers of assistance from appropriately resourced organisations including government.
What is consumerism?

Consumerism is an approach to service delivery and can refer to the way we approach aged care services. It comes out of a context of client rights, autonomy and participation, in the decision-making process. Consumerism is about older people having the power to make choices regarding how their needs are met. The concept of consumerism has both positive and negative aspects.

Some of the positives in a consumerist approach to service provision include:

- Independence
- Individual rights
- Client choice

As people grow older and experience changes related to age, their relationships with others may also change. The number of older people is increasing and this may cause society and its expectations of, and attitude to older people to change. It is obvious that there is enormous difference between the 'older people' of yesteryear and people of the same age today.

Many older people are now more active, enjoy better health, and have a radically different attitude to age. Whereas, there was a sense of inevitability, of the effects of ageing, now people are more inclined to stave off its effects, whether with nip and tuck, or exercise and organic diets. Earlier generations conformed to expectation, adopting the retirement uniform of pipe and slippers or twin-set and pearls, but their descendants are as likely to buy a Harley, take a gap year, or take an overseas trip.

Now, as in the past, the most important aspirations of older people are summed up by the phrase "I don't want to be poor and I don't want to be sick". But as the baby boomers enter retirement they tend to view these as issues more of personal responsibility, and seek individual empowerment to achieve them. The challenge is to meet their demands as consumers, not dependents, thereby enabling them to realise these aspirations. The alternative will be to lose an opportunity, and to store up future cost.

The negative aspects of consumerism include:

- Sufficient supports are presumed/required
- An ability to articulate requirements is required
- Sufficient financial resources are required to form choices based on a broad pool of potential services/service providers
- Most successful when within the domain of the educated middle classes
- Consumer demand influencing public policy
- Promoting a trend towards 'homogenizing and differentiating' – there is more
The impacts/effects of stereotypical attitudes and myths on the older person

What is ageism?

The term “ageism” was coined by Robert Butler, M.D., in 1968. Dr. Butler is a geriatrician who saw that society had developed myths, stereotypes and misunderstandings about people as they age. Like “racism” and “sexism,” people who express ageism make general statements that are not true. Terms such as these imply that one group is inherently superior to another. We quickly see that denying a man a job because of his colour is “racist” and saying women should never work outside of the home is “sexist.”

Ageism makes judgments about the actions, character and desires of people based on their age. There is also a sense that old age is inferior to youth. Ageism has developed over many years as our society as a whole has put a greater value on youth than on aging. Television, movies and the printed media tend to strengthen the idea that young is “good” and old is “bad.”

Myths and stereotypical attitudes towards the aged

People who have little or no contact with elderly people are more likely to accept the myths and stereotypes of aging. People may visit their grandparents or see other older people while shopping, but many people never spend any time getting to know an elderly person as an individual. Young people who believe the stereotypes see no reason to become close to an old person as they are seen as having little to offer.

People may also believe the myths of aging because information about normal aging is scarce. As the size of the elderly population has grown, interest in research on aging has increased. Early research was found to be invalid due to the subjects chosen so, until very recently, reliable information about the aging process has not been available. It is important for each of us to evaluate our own ideas about aging. To be able to increase our knowledge of aging we must be open to new ideas and to eliminating our own judgments regarding growing older.

Let’s consider some of the more common myths.

Myth one: More alike:

The idea that we all become more alike as we age is common, but false. We quickly see the uniqueness of a child but tend to group people together into “sameness” as we age. Just the opposite is true. As we age, we become less like our peers than younger people. This uniqueness happens because, as years pass, people learn different things, face different things and respond differently to life’s occurrences. Also, the actual number of years lived affects people differently. Some people are “old” at 65 and others are “young” at 90. Everyone ages physically, emotionally and spiritually at different rates, so the longer we live, the more chance there is to be different.

Myth two: senile:

The word “senile” actually means to age or grow old. It has come to mean “dementia.” Dementia is not a normal part of aging. It is a disease that affects the brain and nervous system. “Alzheimer’s disease” is a type of dementia. Only 5 percent of those over 65 will develop dementia. 2011 Alzheimer’s Disease Facts and Figures data reports that one in eight adults has Alzheimer’s disease.
Myth three: Serene: Many of us are familiar with the term “golden years” when referring to retirement. Not all older people view those years as “golden.” Many older people face poverty, isolation, grief, physical decline, loss of social stature and decreased control over their lives.

These stresses may be reduced by help from family, friends, churches, public agencies or community networks, but no matter how much help is given, some stresses cannot be avoided. Some people are not able to cope with their situation. Suicide rates are higher for people over 65 than for younger people.

Myth four: Sexless: There is a strong belief in our society that sex is for the young and that older people should not and/or cannot engage in sexual activity. Old and young people believe this myth. Many older people stop sexual relations because they have learned it is “bad” for them to continue. Elderly people who continue to have sex often feel guilty. Either way, it has a devastating emotional effect on them.

Research has found that sexual activity and enjoyment do not decrease with age. People with physical health, a sense of well-being and a willing partner are more likely to continue sexual relations. People who are bored with their partner, mentally or physically tired, afraid of failure or overindulge in food or drink are unlikely to engage in sexual activity. These reasons do not differ a great deal when considering whether or not a person will engage in sex at any age.

Myth five: Inflexible: Inflexibility means to be resistant to change and to be unable to adapt to new situations. People of any age can be inflexible. Increased age does not make a person inflexible. The opposite is true. Older people must adjust to changes such as retirement, disease, illness, death of family and/or friends and lifestyle. Without the ability to accept change, adjustment to these changes would be impossible. Research shows older people may change their opinion slower than younger people, but most remain open to change throughout their lives.

Myth six: Unproductive and uncreative: This idea probably comes from the fact that society equates productivity and creativeness with employment and earning money. In reality, many older people have the freedom after retirement to really develop their creative side. People now have the time to be active as volunteers in all areas. Many elderly people remain active and productive throughout their lives. We would all be missing a great deal without their creativity.

Myth seven: Difficulty learning new skills: There are differences in learning rates and styles between age groups, but it would be incorrect to say older people have difficulty learning. Preschoolers learn differently from children in primary school and they learn differently from Secondary school students. We do not assume these differences are wrong. How older adults learn is different from younger learners, but that does not mean they cannot understand new information.

Myth eight: “Cranky”: Young and middle-aged people who are able to get along with others will be able to do so when they are older. People who are difficult to get along with when they are young will be difficult when they are old. How people adjust to change, accept and respect others when they are young will most likely be their style when they are old.

Myth nine: Lonely: Sixty percent of the population at large sees the elderly as lonely. Many people believe the elderly are usually abandoned by their family. Despite these beliefs, most elderly people are not abandoned by family and usually have close contact with one another. When asked about loneliness, only 12 percent of the elderly felt loneliness was a problem. Family and friends largely determine whether or not an elderly person is lonely and rarely is an elderly person totally abandoned in our society.

Myth ten: More religious: Members of the present older generation did not become more religious as they aged, but grew up in a time when there was more formal religious training given to children. Their lives were often started on a more religious path that continued throughout their lives. It seems the difference is generational rather than age-related.
Ensuring quality care

Can we eliminate ageism?

Butler felt ageism is a form of bigotry and that it is a very serious national problem. He felt that the myths and stereotypes of aging are so deeply ingrained in our society it will be very hard to change. Over the years a number of things may help reduce the prejudices of aging. The elderly population is growing rapidly in our nation. As the numbers increase, so will their power and influence over politics, society and economics. More youth will have contact with older members of society. The elderly themselves will then have the opportunity to help eliminate ageism. Research may further aid in reducing ageism by providing scientific information to dispel the myths of aging. Circumstances in life cause everyone to age differently. Future research can look at how individual experience affects aging.


Activity

One

The impacts/effects of stereotypical attitudes and myths on the older person

1. Tick which of the following are based on stereotypes?

☐ All old people are incontinent of urine.

☐ All people over 70 have dementia.

☐ All old men are grumpy.

☐ All old women are fussy.

☐ All young people have no common sense.

☐ All people who are homosexual have AIDS.

☐ All migrants cannot speak English.

☐ All males are smarter than females.

Which of the following comments are ageist?

☐ Old people cannot learn anything new.

☐ She must be incontinent, she’s over 90.

☐ He cannot have sex, he is 78.

☐ Mrs. Daring cannot skydive because she is too old.

Which of the following are myths?

☐ Most people over 70 live in nursing homes.

☐ He is blind so is probably deaf as well.

☐ She cannot do anything — she is demented.

☐ Old people do not have sex.

2. Briefly explain your understanding of the term ‘positive ageing’.
The impact of social devaluation on an individual’s quality of life

Social devaluation is the systemic belief that a group or person has less social value than others. Such devaluation can have a negative consequence for the individual or group affected by it. Socially devalued parties have fewer opportunities and are recognized less for their accomplishments.

The concept of societal devaluation is a part of a larger social theory called Social Role Valorization, (SRV) which was coined by Wolf Wolfensberger in 1983. This theory helps us understand the methods of devaluation and how they affect society. Social role valorization is a tool meant to address the psychological consequences of devaluation and they can be counteracted.

It looks at attitudes, beliefs and the impact these things have on:

- The individual who is being devalued
- Others within the community
- The services we, as a society, provide to those who are devalued.

The core actions involved in SRV are:

- Providing new, valued roles to devalued people or groups, e.g.: holding Masters Games and other such events which enable older people to take on the valued role of athlete
- Enhancing the perceived values of roles held by devalued people (or groups), e.g.: promoting the role of older people in passing down knowledge
- Attributing roles associated with devalued groups and/or people to those who are more highly valued, e.g.: knitting, traditionally considered a hobby of older people gaining popularity with teenagers and young adults.

Two major strategies in SRV are image enhancement and competency enhancement. Image enhancement involves the creation of a positive image by enhancing a person (or group’s) social image. Competency enhancement involves ensuring the devalued person is given the skills they need to fulfill socially valued roles within society.

Normalisation

Normalisation is not concerned with trying to make people ‘normal’ (whatever that means), but with the concept that all people are entitled to ‘normal’ life experiences, and that this right should be supported and defended for those of us who are at risk of social devaluation for any reason, eg: age, ethnicity, disability. These life experiences may be as basic as being able to participate in the normal routines of everyday life such as, cooking, going to work and shopping. Normalisation grew out of the regimented institutional system and attempted to remedy the effects of ‘institutionalisation’ by duplicating the everyday round of daily activities in that setting. With the flow of people from institutions to the community, ‘normalisation’ evolved into social role valorisation.
**Conducting interpersonal exchanges in a manner that promotes empowerment and develops and maintains trust and goodwill**

Being able to communicate effectively is probably one of, if not the most important skill an aged care worker can possess in the health and community service sectors. Your ability to communicate openly, compassionately and objectively will have a huge impact on your ability to achieve outcomes with the people you work with. It is not only the ability to connect with a patient/client, but also your ability to connect with your colleagues, funding bodies, external organisations and the wider community.

Your work will also involve empowering individuals to self-manage in other words to live independent lives. Central to the establishment of the care worker/client relationship is the worker’s ability to use a wide range of communication strategies and effective interpersonal skills. Effective communication is an essential factor in creating and maintaining a successful relationship. Regardless of the setting and the length of interaction, the health care worker acts in a therapeutic way to manage the boundaries of the relationship.

It is important to recognise people’s individual differences and individual needs and acknowledge that those with complex needs may face challenges in both encoding and decoding communications. The health care provider will need to develop a high level of interpersonal skills to establish, understand and maintain positive relationships with clients and others. The health care provider should be aware that each personality will react to different styles and approaches in communication. If particular needs and requirements are taken into consideration individuals respond in a positive manner and a relationship of trust and respect is created.

**Building rapport**

Rapport building is a skill that requires practice. We all have relationships with individuals with whom we have a natural affinity. However, it is quite likely that we will find ourselves working with clients and colleagues with whom we do not have this natural or spontaneous affinity. In these situations we can still develop a positive relationship by practicing the skill of rapport building. Rapport building refers to the flow of information between two parties. Building rapport with clients and colleagues involves creating an environment of mutual respect. As you get to know your client this rapport will develop even further.

**We develop rapport with clients to:**

- Help the client feel relaxed and comfortable
- Keep the interview or conversation going
- Assist the person with a disability to open-up or commit to a plan of action.
Expressing empathy

Empathy is sensing another’s feelings and attitudes as if we are experiencing them ourselves. It is our willingness to enter into another’s world and be able to communicate to that person our sensitivity to them.

Simply asking if a client found parking easily shows some empathy for their situation.

Create empathy by:

- Taking seriously others’ needs and concerns
- Valuing feelings and attitude
- Respecting others’ privacy, experience and values
- Listening actively
- Encouraging further elaboration and clarification
- Reserving judgment and blame
- Withholding unsought advice.

Remember that it is easy to feel empathy for someone with a similar world view. The challenge is to feel empathy when someone thinks in a very different way. Empathy is essential for building rapport and developing effective communication and positive relationships. It makes people feel that you are on their side, and that you understand them, even when at times you don’t agree with them at all; sometimes empathy is confused with sharing common experiences. If you have experienced similar life situations as your client, then you are able to more fully understand what that person is communicating, and going through. However, even if you don’t have common experiences being able to show empathy can still take place.

Support workers can use empathy to:

- Build a relationships with your client and colleagues
- Stimulate self-exploration
- Check understanding
- Assist communication
- Focus your attention on the client
- Make future strategies.

The communication process

There are two key factors that underpin the relationship you establish with a client:

1. The relationship is a two-way process — it does require some responsibility on the client’s part as well.
2. The client’s best interests should be the focal point in all interaction and action. In order to assist the client to identify their problems, you must establish a relationship in which clients feel comfortable to reveal themselves. Identify what their issues are, and what they would like to do to change their situation.

The key factors in this process are:

- Attention
- Active listening
- Empathy and respect.

Your genuine interest will encourage the client to be open, reflect on their own situation, think about their issues, and explore possibilities for change. Your behaviour demonstrates your respect. Be aware of how you respond, both in terms of gestures, and verbal/non-verbal indicators.
Do your responses demonstrate?
- Understanding
- Suspension of personal judgement
- Warmth
- Acceptance
- Support
- An appropriate degree of challenge – encouraging the person to view their situation realistically
- Confidence in their ability to cultivate their own inner resources in order to change their situation
- A desire to help them to identify issues and goals.

‘Active’ listening

‘Active’ listening is one of the most important skills you develop while working with clients. It means you are paying all your attention to what the other person is saying. Active listening does not mean that you claim you are listening to someone while you are carrying out other tasks. Active listening is a task in itself requiring full concentration. It is essential you develop your skills of active listening in order to understand the true needs of the client. It is important in developing trust and rapport because it demonstrates your willingness to hear and to understand clients’ issues.

You demonstrate active listening by:
- Being aware of the client’s non-verbal behaviour
- Listening to verbal messages with a view to understanding them
- Keeping your own values and judgements at bay – not allowing them to influence how you will respond
- Shutting out distractions – remaining fully focused
- Being aware of the client’s underlying emotions and the context of what they are communicating
- Giving the client space to express himself or herself without interruption or interpretation.

There are a number of skills inherent in active listening.

Attending: There is a real difference between hearing someone talk, and really listening to what they are saying. Attending is our starting point for active listening. By ‘attending’ we mean ‘being with’ the other person. How do we demonstrate this? Not only through words, but also by looking, acting and being attentive. People know when we are attending to them and when we are not. You need to make sure that your actions (your words, your tone of voice, your posture and your non-verbal gestures) all reflect your concern and attention to the person.
You can demonstrate that you are attending to your client in the following ways:

- Make sure you face the client, and that your body is turned towards them. This indicates they have your attention.
- Make sure your posture is open, i.e.: no crossed arms and legs. An open posture demonstrates your willingness to hear what the client is saying and that you have not closed yourself off from them.
- Lean towards the client, if safety permits, while still allowing the appropriate amount of personal space – this will indicate that you are engaged by what they are saying.
- Maintain eye contact if culturally appropriate, in order to indicate that your attention is focused, and that your thoughts are not wandering off elsewhere.
- Demonstrate that you are relaxed. Sit comfortably, try not to fidget and be aware of what expressions you might be making with your face. Your composure will help the client to feel at ease.
- Be aware of your own emotions and acknowledge them. If you have just been through a very tense or difficult time with a previous situation, acknowledge your mood with the client. This will help the client to avoid any misinterpretations of your interaction with them.

**Following:** This requires you to listen to the person without interrupting and distracting the speaker. It’s important you use what are called, ‘minimal encouragers’, i.e.: simple responses that encourage the speaker to tell their story, including nods, verbals such as ‘mmm…’, ‘ok’, ‘uh-huh’. Alternatively, you may need to ask relevant questions that demand more of an answer than ‘yes’ or ‘no’. In other circumstances, it may be more appropriate to simply maintain an attentive silence. In addition, there are supporting skills to assist both you and the speaker to get to the ‘heart’ of the issue.

**Reflecting/summarising:** Reflecting involves feeding back what you perceive both verbally and emotionally from the client. Reflecting lets the client know you are focused and that you are working to clarify and understand what they are saying and feeling. We use this language every day in our interactions with others. We affirm the other person by paraphrasing or summarising what we have heard them saying.

The point of the reflection is to let the client know that you are listening. If you can feed back to them what they are saying, it affirms their trust in you. Be cautious – reflection is not interpretation. It is important not to hijack the conversation with your own summations about what the client is experiencing. It is also not the time for giving advice. What you are seeking through reflection is an opportunity to support the client to delve more deeply into what they are experiencing in order to define and clarify their issues.

**Paraphrasing for clarification:** Reflecting involves rephrasing the essence of the message to the person, confirming that you have understood them correctly and encouraging them to continue (e.g.: ‘It sounds like this has been really frustrating for you…’). Paraphrasing relates more to the actual content of what has been said, e.g.: ‘So you’re saying that Centrelink has told you that you owe them over a thousand dollars?’ Paraphrasing helps us to check that our understanding of what is said is the same as what the speaker is trying to communicate.

**Focusing:** This is a process that helps the client prioritise and focus their concerns. When people are upset, angry or distressed, they often complicate their issues by bringing in old hurts, incidents from time gone by and unrelated issues. To help both of you to deal with the matter at hand, by focusing, you ask the person (gently and politely) to focus on their main concern, e.g.: ‘Of those things you have mentioned, what concerns you most?’ or, ‘It seems to me that the main issue we need to focus on is…’

**Summarising**

When you become involved in a long conversation with someone, you can summarise the most significant parts and relay this back to them. This assures both of you that you genuinely understand what is said, e.g.: ‘So, it sounds like you’re particularly worried about….'
Using questions

Another way of letting someone know we are listening to them is to ask them questions. By asking questions we can clarify what they are saying and find out more about their story.

Tips for asking questions

- Only ask questions that will help move the client forward
- Avoid asking questions because you feel at a loss and asking a question gives you a way out
- Avoid questions that satisfy curiosity but have little or no relevance to the issues at hand
- Too much questioning can make the client feel they are being interrogated
- Too little questioning can imply a lack of interest or concern
- Avoid questions that ask for trivial information which does not relate to the client’s immediate concerns.

Types of questions

There are two broad types of questions: open and closed.

Open questions: Open questions encourage the exploration of thoughts and feelings as they ask the talker to describe something in their own words. Open questions are great to use when you want the other person to expand on the topic or issue they are talking about. Open questions are useful to find out about a problem, for example, ‘What seems to be the problem?’

Closed questions: Closed questions usually lead to a specific answer and often narrow down communications. They usually begin with:

- Is …?
- Are …?
- Have …?
- Has …?
- Do …?
- Did …?
- Does …?
- Can …?

They require either a yes or no answer or a short factual comment. Closed questions don’t encourage clients to talk further. They are useful, however, if you want a specific answer, eg, ‘Do you need these by Wednesday?’ The use of closed questions in a directive way to ‘sell’ a product or a course of action (eg, ‘Would you like to pay by cheque or credit card?’) is a forced choice question designed to close a sale and is not appropriate in a clinical environment.
Two

Initiating interpersonal exchanges with clients as appropriate

Role play: read the scenario below and complete the task.

Action required:

Complete a role-play with your assessor playing the role of Mr Zappala and you as the health care worker. Role play this and demonstrate/list how you would:

a. Build a relationship with Mr Zappala
b. Demonstrate the interpersonal skills you would use.

Scenario

Today you have been given a client who has been receiving care and support from your organisation for 5 years, from the same carer, but the carer has just finished working with your organisation. You have read over your new client’s care plan. Mr Zappala, has been living independently for many years, informed the previous carer last week that his sister, who he sees every week, had suddenly passed away.

Today he seems distant, and not able to communicate clearly, often speaking in his first language, Italian, which he apparently does not do during his visits. There is a very bad smell in his home and you notice that there are some heavy boxes in the hallway that make it difficult to get to the bathroom easily.

He seems to not be so clear in his responses and communication, and he does not get up and make a cup of tea for you both as he usually likes to do. You are concerned about his health and safety. You make a cup of tea for you both and sit and talk with him. While you are in the kitchen, you notice that the element on the stove is on but nothing on it. You also have a mild slip in the kitchen from a puddle of water.
Recognising and respect older people’s social, cultural and spiritual differences

The needs of culturally diverse clients

Community and health services need to consider the diversity of their clients’ values, beliefs and cultural expectations. To work effectively with culturally diverse clients, you will need knowledge and skills.

You will need to:

• Be aware of your own cultural background/experiences, attitudes, values, and biases that might influence your ability to assist clients from diverse cultural populations. It is essential that you correct any prejudices and biases you may have regarding different cultural groups.

• Educate yourself wherever possible to enhance your understanding and to address the needs of culturally diverse clients. This may involve learning about cultural, social, psychological, political, economic, and historical material specific to the particular ethnic group being served.

• Recognise that ethnicity and culture may have an impact on a client’s behaviour.

• Assist clients to become aware of their own cultural values and norms, and facilitate discovery of ways clients can apply this awareness to their own lives and to society at large, as well as within the organisation.

• Respect the client’s religious and/or spiritual beliefs and values.

• Work to eliminate biases, prejudices, and discriminatory practices.

• Provide information in a language that the client can understand.

• Provide information in writing, along with oral explanations.

(Adapted from Pine et al 1990)

Migration: Cultural awareness involves an understanding of the migration process itself. Migration is a key influence on a person’s life, with differing effects due to the different experiences of pre-migration, migration and resettlement. While some migrants undergo a relatively easy transition, most migrants will undergo some - if not many - challenges in adjusting to life in a new country.

Some of the many post-migration stressors include: the stress of separation from homeland, family members, friends and support networks; racial discrimination; changes in lifestyle and socio-economic status; culture shock; language barriers; and the ongoing trauma of pre-migration experiences, which may have included war and political instability, physical and psychological abuse, and travelling as a refugee or living in a refugee camp.
Aboriginal Australians: The colonisation of Australia by white settlers resulted in drastic changes in the traditional lifestyles of Aboriginal people. With the loss of tribal lands came a large-scale breakdown in traditional cultures and values. The new settlers brought diseases which ravaged Aboriginal communities. Foreign laws and policies denied Aboriginal people the basic rights to practise their culture, beliefs and languages.

The issues and problems which Aboriginal people face today are complex, particularly when planning and administering care. There are still many Aboriginal people, and in particular elderly Aboriginals, for whom traditional cultures and beliefs form an integral part of their thinking and daily life. As a care worker, it is vital to address the cultural needs and practices of Aboriginal people in order to offer them quality care. Many of us probably know little about elderly Aboriginal people, their traditions and cultures, their urban existence or their historical experiences. There are many aspects of Aboriginal culture and beliefs which, if understood, will assist care workers in performing their job.

These include:

- The concept of sharing and togetherness which is most important to Aboriginal people. Law, customs and traditions bind the people together, however a single authority does not exist. Decisions are made by a council of elders.

- Body language is an important component of communication.

- Family, traditional ties with the land and the need for a mobile lifestyle, can make it difficult for Aboriginal people to stay in one place for extended periods and without the support of their family group.

- For Aboriginal people who have lived traditional or semi-traditional life-styles, the absence of outdoor life, open fires, dogs and family interaction can lead to difficulties for elderly Aboriginal people when they are confined to residential basic care facilities.

Aboriginal people have strong beliefs about illness and death and these can vary between different groups and between different areas, therefore it is important not to generalise. Funerals are an important ritual which all family members are expected to attend for many people of Aboriginal descent, lowering the eyes is a sign of respect, as direct eye contact is considered improper.

Torres Strait Islanders: Torres Strait Islanders are also suffering from cultural breakdown and the loss of traditional lifestyle, particularly with regards to caring for their elderly. In Torres Strait Island tradition, old people are regarded as the wise heads of their families and prefer to remain in a shared living arrangement with the extended family group. Therefore if elderly Torres Strait Island people are sent into formal care facilities, it may be regarded as a form of abandonment or ultimately a death sentence. Traditional tensions may exist between different types of Islander groups which can also lead to difficulties in a residential care based environment.

Torres Strait Islander people have a strong sense of tradition and particular beliefs and rites concerning birth, marriage, care of the dying, death and burial customs. According to traditional beliefs, family and community members must be involved in the care of the dying, and in the death and burial of their loved ones. Torres Strait Islander people have little tolerance for those who negate or ignore their traditional beliefs and customs.

Cultural resources: There are many ethnic agencies and groups who can advise and assist care workers to obtain relevant information about customs, beliefs, religious rites and ceremonies, socio-cultural recreation and activity, language and communication needs.

Many ethnic community groups have libraries containing books, newspapers, cassettes and other written information. Some ethnic community groups or agencies arrange a visiting service or interpreters. The Directory of Ethnic Community Organisations in Australia, published by the Department of Immigration, Local Government and Ethnic Affairs, can be purchased through the Australian Government Bookshop. Remember that as a carer, the more you develop your understanding and cross-cultural awareness of the specific needs of aged people from different cultural backgrounds, the greater your ability to communicate and provide quality care will be.
Religious, cultural spiritual and ceremonial needs

Every individual has the right to practise their own spiritual and/or religious beliefs. Part of the cultural heritage of your clients will be their various spiritual and religious practices. Spirituality is a very important issue in the lives of many, especially as we grow older.

As a person nears the end of their life they begin to question the afterlife and form a stronger bond with a sense of spirituality or religion. It is often during times of loneliness, sickness, stress or loss that the individual calls upon spiritual or religious assistance. For many people their spiritual needs are met through religion, for others spirituality is about spending time on their own and reflecting, or forming a closer bond with their family, or even going for quiet walks in the park. For you to support your clients in achieving maximum well-being, it is important that you attempt to understand what some of their spiritual needs may be.

These include:

- Practising their beliefs such as praying at specific times or in specific ways adherence to dietary restrictions
- Involvement with a church community
- Attending the church, synagogue, mosque, temple or other place of worship of their choice
- Being provided with literature that complements their spiritual or religious beliefs
- Having access to others of similar beliefs for social communication
- Being given respect and privacy whilst practising religious beliefs.

Important information related to a client’s religious or spiritual beliefs should be included on the care plan.

You can show your support for a client’s personal beliefs in religion or spirituality by:

- Talking about their religion to get a better understanding
- Discussing important celebrations or special religious events which are approaching, e.g.: Easter, Jewish Passover, Muslim Ramadam
- Assisting clients to attend religious events
- Adapting routines to acknowledge religious events, e.g.: not disturbing clients during prayer
- Remaining non-judgmental at all times.

Many religions observe particular dietary preferences, e.g.: Muslims do not eat pork, Jewish people only eat kosher food and also do not eat pork, and many strict Hindus do not eat any meat. It is important that carers know about a client’s religious dietary preferences and document the information on the care plan. There may be times when as a carer, you need to assist your aged clients to organise the preparation or modification of meals, their room or their environment in order to meet religious, cultural or ceremonial requirements. For many people including older people, spirituality refers to the desire for meaning and purpose in life, the need for love and a sense of belonging, hope, forgiveness, and a relationship with God and the transcendence of the human spirit.
Cross-cultural communication and your client

Quite often, we assume that because someone speaks English, we will understand them and that they are similar to us. This can be far from the truth. The English language is spoken in many countries and each of these has their own unique cultural heritage. There may be unfamiliar words, expressions and style of talking. Humour may be expressed quite differently. Accents may be difficult to understand and the way we seek to clarify all of the above may not be understood by the person we are trying to communicate with.

The way cultural groups are referred to between countries can differ significantly so it is always good to check how someone prefers to be referred to. Calling someone a Yugoslav and not Croatian can have dire consequences. African Americans prefer to be referred to as blacks, whereas this would not be considered an appropriate way to refer to, Indigenous Australians. It is important to apply the usual communication skills of observation (picking up on body language, to make sure you are not offending), asking questions and demonstrating a genuine willingness, to understand.

Using interpreters

Often we find ourselves communicating with people who don’t speak the same language as we do. In order to provide a professional, confidential and effective service to everyone it is essential to use trained interpreters to help communicate effectively with people from backgrounds that are culturally and linguistically different from our own.

Interpreters are people who translate spoken language and they convert information from one language in to another. In Australia the National Accreditation Authority for Translators and Interpreters (NAATI) is the organisation responsible for accrediting and training interpreters and translators. Interpreters accredited by NAATI are bound by a Code of Ethics and have been tested as being qualified to interpret at a particular level.

There are five levels of NAATI accreditation ranging from a Language Aide level to senior professional level. In the community services industry we usually recommend that you use the services of a Level 3 interpreter (Professional Interpreter level). The agency you work for will usually have policies, procedures and guidelines for accessing interpreters and may use a particular interpreting service.

Interpreters can however be provided by the following services:

- The Department of Immigration and Multicultural Affairs Translating and Interpreting service (TIS). This is a 24-hours-a-day, seven-days-a-week service which provides both telephone and face-to-face interpreters. They can be contacted on 131 450 or 1300 655 081 (for those who live outside metropolitan Sydney)
- The Community Relations Commission for Multicultural NSW—Language Services Division. This is the NSW Government’s interpreter service and also operates 24-hours-a-day, seven-days-a-week. It can be contacted on (02) 9716 2248 or 1300 651 500
- The Department of Health and Centrelink both have their own interpreter services for their own clients or service users
- There are also private interpreting agencies and people who work as freelance interpreters. When using these services or people you should check their qualifications (you want them to be NAATI accredited to at least at Level 3) and there may be a higher fee for these services.

Avoid using jargon: Using plain English is crucial when talking and interacting with clients. Using jargon (words not commonly used or used by workers in a particular industry) tends to disempower people and cause them to feel confused, stupid or frustrated. When we use our own words when paraphrasing, reflecting or summarising, it’s essential that we use words that clients will understand and which will help them either to gain an insight into what is happening for them or to confirm that we are on the right track. The goal of interpersonal communication is to enhance the relationships we have with people and to understand what is happening for them. This will not happen if we try to impress them with our use of the English language or try to show them how knowledgeable we are.
Three

Recognise and respect older people’s social, cultural and spiritual differences

How might an aged care worker demonstrate respect for diversity of race or cultural, spiritual, or sexual preferences in an aged care organisation?
Maintaining confidentiality and privacy of the person within organisation policy and protocols

Aged care, disability and other Community service workers regularly work with sensitive information that is communicated in confidence. Confidentiality is a fundamental component of service provision. It safeguards client privacy and promotes trust between clients and service providers. Confidentiality as a principle suggests that you keep information about clients private in order to safeguard their dignity and their right to the basic privacy afforded to every other individual. Most organisations working in the human service industry have policies and procedures in place regarding privacy and confidentiality of information, based on legislative requirements.

**How to maintain confidentiality**

The following simple guidelines can help you maintain client confidentiality:

- Client information should never be discussed with friends or relatives in a social setting
- Material kept in files about clients should generally relate only to the service delivery being offered to that client and factors that may affect service delivery
- Confidential documents must be out of sight and reach in public areas. This includes vehicles. Keep any identifying documents in a locked bag or case?
- Client information should never be disclosed to neighbours or family, who may be contacting the service to find out whether the person is a client of the service
- Client information should never be disclosed to other agencies that are not involved with the client. For example, the Department of Housing may want to report their concerns about a tenant who may or may not be a client of the service. In this situation, it is possible to receive information about the person, but not confirm whether the person is known to the service, without the client signing consent to release of information
- Names and other personal details of clients should not be revealed in public forums such as meetings, conferences, workshops or seminars.
Breaches of confidentiality

All community service organisations have a responsibility to keep client or service-user information private and confidential. In some circumstances, clients can take legal action against a worker or an organisation under the law of negligence. We owe a duty of care to our clients to prevent any risk of harm. Most agencies have policies and procedures relating to privacy and confidentiality which identify the rights of clients and responsibilities of workers. Often workers are asked to sign a confidentiality agreement when they begin working for an organisation.

By signing this agreement workers are stating that they will respect and uphold the organisation’s policies and procedures and ensure that client information is not disclosed without the client’s informed consent. This is a legally binding document that clearly states a worker’s obligation to treat all client information confidentiality. If a worker breaks client confidentiality they are seen to have breached (If something is breached it has been violated or broken) the policies of the organisation and, as a result, he or she may be dismissed from their position—that is, sacked! This may also open the worker to legal action from a client.

If you, as a worker, notice that another worker seems to be breaching client confidentiality you should:

- See if they have the client’s permission to share the information (you can either ask the worker or check in the client’s file)
- Check to see what the agency’s policy is regarding breaches of confidentiality and follow the procedures outlined
- If there isn’t a policy, and if you feel comfortable enough, approach the worker and express your concern
- Talk with your supervisor and tell them what you have observed or overheard and express your concerns
- Ask that all staff receive training in confidentiality, why it is important and how to maintain it.

Maintaining privacy

Under various laws such as the Privacy Act 1988), (Cwlth), people have a right to privacy. Your organisation will also have policies and procedures about privacy, even if you are not a government organisation. In addition there are standards in certain areas such as aged care and disability service provision that will require you to uphold privacy. The person making the inquiry needs to be informed of exactly how information collected about them will be used.

Privacy and dignity is built into the care delivered to patients/clients as well as the environment it is delivered in. Responsibility for protecting this does not lie with one individual or group, but with all staff at every level. Staff should deal sensitively with the various circumstances in which the patient’s privacy and dignity may be infringed.

Privacy, dignity and modesty

- Patients’ care actively promotes their privacy and dignity and protects their modesty
- Patients are protected from unwanted public view (including that of the health care worker and other patients) including using curtains, screens, blankets, screens etc
- Patients should have access to their own clothes whenever possible.
- Arrangements are made so that patients can have private telephone conversations
- Health care staff should be easily identified by patients by the use of name badges, uniforms etc
- Patients are routinely asked if they require a chaperone for any intimate procedures with the patient permission a family member or friend may act as a chaperone for any procedures.
Four

Maintaining confidentiality and privacy of the person within organisation policy and protocols

1. Consider yourself in the role of aged care worker in an age care home you work for or are attached to for work experience. What are some of the ways you would respect client privacy? List and describe three ways.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Confidentiality

2. Define confidentiality, using your own understanding of the concept, and then check this definition with a dictionary definition of the term.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
Working with the person to identify physical and social enablers and disablers impacting on health outcomes and quality of life

Barriers and enablers

Literature gives us an insight into what prevents or enables the promotion of social, psychological and physical well-being for older people with high support needs. Information, money and support are the most frequently mentioned barriers in the literature, but other people’s time, access to transport, equipment and technology are also significant.

Good information: can enhance people’s lives by opening up social and leisure opportunities; improving access to services, financial entitlements, rights and health information; and relieving anxiety (MacDonald, 1999). In an age where information is transmitted in new and different ways, some older people will find it particularly difficult to access. In addition, those with high support needs and/or those who do not speak or read English well may require information to be presented in accessible formats (Bowes, et al., 2009; Godfrey and Johnson, 2009).

Older people in general often express anxiety about having sufficient financial resources to remain independent and enjoy quality of life now and in the future (Cattan and Giuntoli, 2010). The link between poverty and health in old age is well established and those with high support needs are likely to be doubly disadvantaged, both by having fewer financial resources in retirement and by needing more financial resources in order to pay for support, adaptations, transport and so on (Blood and Bamford, 2010). Where finances are limited (and this is particularly true for those who have low incomes but do not qualify for publicly funded social care), older people with high support needs may not be able to meet even their most basic aspirations – for a hair-cut, an occasional trip out or to buy a birthday present (Coalition on Charging, 2008).

The amount, quality and type of support: received from both formal and informal carers and supporters can act as an enabler or a barrier to the well-being of older people with high support needs. Having the time to communicate effectively with supporters is, in itself, socially and psychologically beneficial. It is also essential if care is to be provided respectfully (Bowers, et al., 2009; Blood and Bamford, 2010) and other aspirations are to be identified and supported. This can be particularly important to people with a dementia diagnosis, who may need additional time, skills and creativity from carers to communicate effectively (Williamson, 2010).

Access to transport, equipment and money to pay for taxis: are key enablers to being able to get out and about (Holland, et al., 2005).

Technology can improve well-being by reducing anxiety about falls or crime, or making homes more accessible. There are advances here, for example, in design and technology for people with a diagnosis of dementia (Dementia Services Development Centre, 2010). However, budget restrictions combined with a lack of knowledge and vision of those working with older (as opposed to younger) people sometimes means that access to appropriate assistive technology or even basic mobility equipment for this group can be poor (Blood, 2010).
Ageing process

Our concept of what makes a person old is based on many different issues including:

- **Life expectancy**: A person is considered to be old when they are near the end of their life expectancy
- **State of health**: An older person is often thought of as younger than they really are if they continue to be active in later life
- **Physical appearance**: Older people have grey hair, wrinkles, sometimes a stooped posture and or limited or restricted mobility
- **Social roles**: Often when people have retired they are considered to be old, since their role has undergone a significant change, and may be devalued by other members of society

Being aware of normal changes will also assist in planning home and lifestyle adaptations, which will enable senior clients to attain and maintain their optimum functioning levels.

**What is normal aging?**

When studying the effects of aging it is important to understand that aging is a natural process and is quite separate from diseases, caused by infection or by abnormal degeneration of body tissues. If the effects of disease in an aged person are put down to “just old age” treatable conditions get ignored or overlooked. The result being that the elderly person does not receive the treatment or assistance they may need. Some of the changes associated with getting older, such as greying hair and the appearance of wrinkles, are hard to avoid.

With normal aging, there is a decrease in bone mass, muscle strength and lean body mass and an increase in fat body mass. Physiological and anatomical changes related to aging include increased susceptibility to heat and cold exposure, decreased immune responses to infections, increased falls, and toxicity to medications. These factors place older adults at risk of worsening health and premature death.
The rate of ageing

The ageing process begins when we are conceived and continues through to our death. The rate of the ageing process will differ between people and is related to both environmental and genetic factors. There are older people who have impaired health or reduced abilities, but many do not. Even so, there are many physiological changes that, while not experienced by all older people, tend to be associated with old age.

These include:

- Reduced activity and vigour
- Grey hair and wrinkled skin
- Reduction in hearing and sight
- Changes in skeletal and muscular systems
- Less tolerance to diseases
- Reduced recovery rate from accidents or illness
- Changes in metabolism that may lead to increased weight
- Changes in blood pressure
- A slowing of reflexes
- A reduced tolerance to alcohol
- A possible decline in memory.

There are many changes in lifestyle and social status that are also directly related to old age. Many older people live independently and maintain a very active lifestyle well into their 80s. However, a person generally retires from full-time paid work in their early to mid-60s. Accompanying this retirement are many changes in their lifestyle and social status.

These include:

- **Occupation**: they may become part-time employed or retire from work altogether
- **Increased leisure time**: allowing them freedom to participate in activities of their choice
- **Independence**: this will certainly increase at first, particularly for self-funded retirees, however, a reversal may occur if a person’s physical abilities decline significantly
- **Earning capacity**: without earned income older people may find themselves on a fixed income or limited to what can be earned on their investments
- **Status**: they are no longer looked upon as the ‘boss’ by peers, they no longer have the status that comes with being ‘gainfully employed’, they may develop new roles such as grand-parenting

In order to understand the concept of ageing it is important that you look at the whole person from both a social and psychological point of view. An active and positive older person will appear a lot younger than chronological age would suggest, and may, through being active and positive, gain a long life expectancy. Although many changes take place in the human body during the process of ageing, many older people are in generally good physical health. Individuals who reach 80 years of age or more, can expect to have some type of impairment, however, this is just as likely to be minor as major.
There are many different physical changes that are associated with the process of ageing.

- Bones become progressively thinner and more brittle which can result in easy fracture. The disease of osteoporosis, which affects mainly women, is a condition of reduced bone density that can produce this effect.
- The range of movement in joints reduces which can make it difficult for a person to grasp objects and can result in stiffness, reduced mobility and slower reflexes.
- Reduced strength and loss of muscle cells results in reduced mobility. This limited mobility makes it difficult for an older person to prevent themselves from falling and can limit their ability to participate in daily activities, such as personal grooming and hygiene.
- Older people may have reduced vision in a number of areas, including: depth perception, responses to light, distortion of colours, reduced sharpness of vision and reduced vertical or peripheral visual fields.
- Older people often suffer some degree of hearing loss. This can range from having difficulty distinguishing sounds, through to complete deafness. Loss of hearing can increase the risk to the person’s health and safety, and cause them to become isolated through their inability to communicate fully.
- The nerve sensors for smell are reduced in the ageing process which makes it difficult to distinguish specific odours. This limited sense of smell can increase the risk of a person’s health and safety if, for example, they are unable to identify the smell of smoke.
- The sense of touch can be affected and reduced by the ageing process. This is especially important when the older person finds it difficult to perceive and adjust to heat, cold or pain.
- Accompanying the ageing process is increased difficulty in distinguishing between certain tastes.
- Metabolism tends to slow down with older age which can lead to an increase in weight if an individual does not adjust the level of food intake. Overweight and obesity can create many compounded problems for the older person, e.g.: diabetes.
- The heart is basically a muscle, and like other muscles tends to lose its efficiency as time goes on. The cardiovascular system as a whole is also slowed down with the process of ageing. The combined effect of these is a reduction in oxygen levels in the blood and may result in an increase and/or sudden falls in blood pressure.
- The ageing process is associated with reduced efficiency of the central nervous system. This can lead to problems such as a stroke or reduced flow of blood. A significant number of older people suffer from states of confusion due to a range of possible disorders, which may include various forms of dementia, Alzheimer’s disease, multi-infarct dementia or other diseases of the brain.
- Memory tends to diminish with the ageing process, with an increased loss of short-term memory accompanied by a real clarity of the long term memory.
- There tends to be a lower tolerance in older people for alcohol, largely as a result of a reduced metabolic rate. This increases the risk of over consumption. There tends to be a reduced tolerance to exercise in older people, related to both mobility problems and a decreased capacity of the pulmonary system.
- Loss of muscle tone in the digestive tract leads to difficulty in absorbing nutrients in foods. Older people can suffer from constipation as a result. Progressive loss of the tissues in the kidney can lead to effects on the excretory functions.
- Changes in the skin are associated with the ageing process. The skin becomes thinner, frailer, dryer and prone to injury.
When working with older people it is important that you remain positive and continually look at their abilities not disabilities, even if they require aids or assistance. You may be surprised at just how many abilities older people have, particularly if you have a preconception that old people are necessarily frail and ill.

**The Physiological process of ageing**

It is important to remember that there is a distinct difference between ageing processes which are inevitable, and sickness or ill health which is not inevitable. There are many diseases or health problems that are commonly associated with older people, however they are not part of the ageing process, and can and do, affect younger members of our society.

Physiologically every individual will age in a different way. Ageing is a natural process that generally begins in early adult life, around the mid-20s, and commences with changes in cells. Some of these changes can be visually obvious such as wrinkles or greying hair. Others are internal changes that occur over a long period of time.

**The rate of physical ageing of the individual is considered to be based on or determined by:**

- The genetic makeup of the individual
- The wear and tear that the individual has suffered throughout their life
- The strength of their immune systems
- Spontaneous mistakes or errors made by the cells themselves.

There are many theories about the ‘hows and whys’ of the ageing process that try to explain why an individual will deteriorate or lose function in comparison to another individual. As a care worker it is important that you learn about the main conditions and diseases that can eventually lead to death in older members of our society.

**The Pathological processes of ageing**

It is difficult to determine when a person is old or what makes a person old. What is important to remember is that the cells within our body are continually dividing throughout the course of our life in order to replace cells that die. As we grow older, this rate of cell division declines and therefore the rate of cell replacement does not keep pace with the breakdown of cells within the body. Although our body does hold a large reserve of cells in many of its parts, the process of ageing does lead to a slow deterioration. Although many cells continue to divide throughout the course of our life, the nerve and muscle cells cannot do this forever. As a result their function gradually decreases, resulting in a decline in various body functions.

**Health conditions which commonly affect the older person**

These include:

- Cancer
- Heart disease
- CVA (Cerebro-vascular Accident – stroke)
- Osteoarthritis
- Osteoporosis
- Dementia
- Diabetes.
- Depression
- Arthritis.
These will be the most common causes of illness and death that you will encounter in dealing with your older clients.

**Cardiovascular disease**

The ageing process results in changes to cardiac function and loss of elasticity in the blood vessel walls.

**As a consequence of these changes, older people are more prone to:**

- Hypertension - high blood pressure
- Postural (orthostatic) hypotension - abnormally low blood pressure occurring when a person assumes a sitting or standing position
- Angina pectoris - chest pain which results from a diminished supply of oxygen to the heart
- Cerebrovascular accident (CVA) (stroke) - caused by deprivation of oxygen supply to the brain. CVA is one of the leading causes of death in the Western world and the principal cause of disability in older people
- Myocardial infarction (heart attack) - blood flow to the heart is completely interrupted, causing death of cardiac muscle (necrosis)
- Congestive cardiac failure (CCF) - affects up to 10% of people over 70 years of age
- Atherosclerosis - hardening of the arteries.

**Hypertension:** When the heart has to pump blood under too much pressure the result is hypertension or high blood pressure. When the heart pumps blood around the body, it causes pressure to be put on the blood vessels. If this pressure is too high, the inner lining of the vessels can be damaged. Fatty deposits are then likely to build up in the damaged area leading to coronary heart disease or a stroke. A person suffering hypertension will often not have any symptoms; therefore blood pressure should be checked regularly by your doctor.

**High blood pressure can be caused by:**

- Smoking
- A high salt diet
- Overweight
- Stress
- Alcohol intake.

**Stroke**

A stroke is the sudden disturbance of the normal blood supply to the brain. This may involve:

- Thrombosis, where a blood clot blocks the artery
- Embolism, where there is a blockage of a small artery
- Haemorrhage, which is bleeding from a ruptured blood vessel in the brain.

This disturbance leads to damage of the affected areas of the brain. The effects of the stroke will depend on which areas of the brain were damaged and how severe the stroke was.
Possible effects of strokes may be:

- Paralysis of the limbs, most commonly the arms, on one side of the body
- Paralysis of one side of the face which leads to a lopsided look and difficulty with eating and speaking
- Incontinence
- Dysphasia, which is an impaired ability to understand or use language, most common in people who are paralysed on the right side of the body
- Dysarthria, which is an impairment of the physical ability to speak, which may result in slurring or distortion. Swallowing and chewing may also be impaired, while the ability to understand speech is not affected confused emotions including uncontrolled weeping or bursts of laughter.

Cancer: Cancer can occur at any age; however there are some that are more common to older people. Cancer is caused by an abnormal multiplication of cells in the body that then spread uncontrollably. It is believed that inherited characteristics, the physical environment and individual lifestyle and diet can all contribute to the risk of cancer. A growth can be benign or malignant. A benign growth is non-cancerous, while a malignant growth is cancerous. A cancer begins as a new growth in which the cells divide in an uncontrolled manner. When these cells begin to invade the surrounding organs and tissues of the body, it has become a cancer. Different cancers will affect the body in different ways; however there are some general effects and signs that should be looked for.

These include:

- Sudden or unexplained loss of weight
- Persistent infection
- Anxiety or depression
- Persistent pain in a specific area
- Anaemia and fatigue
- Loss of appetite.

Any of these symptoms should be followed up immediately as some of the indirect effects can lead to problems with the nervous system, cardiovascular system and digestive system.

Some of the early warning signals of cancer that individuals may report include:

- A sore that does not heal
- Unusual bleeding or discharge
- Obvious change in a mole or a wart on the body
- Persistent indigestion or difficulty in swallowing
- A change in the condition of bladder or bowel actions, particularly bleeding
- A thickening or lump in the breast or any other specific area
- A persistent cough or hoarseness.
**Prostate cancer:** Prostate cancer is the second most common cause of death in men and affects one in every nineteen men. Prostate cancer is more common in men with a family history of prostate cancer, but if detected early can usually be treated successfully. The likelihood of developing an enlarged prostate or prostate cancer increases as men get older. Over the age of 50, 30% of all men suffer from an enlarged prostate. Half of all 60-year-old men will have some degree of prostate enlargement, and, for those aged over 80, four men in five will have some symptoms. More than 90% of enlarged prostates are non-cancerous (Source: Australian Prostate Health Council).

**The signs and symptoms of prostate problems include:**
- A desperate desire or urgency to urinate, with difficulty in starting inability to have a clear flow of urine, resulting in dribbling of urine
- A feeling of not having completely emptied the bladder
- Pain or burning during urination.

Any male client who experiences any of these symptoms should be advised to go to the GP immediately for a checkup. Older men may find it embarrassing to discuss problems of this nature, but they should be reminded that doctors are used to dealing with them, and embarrassment is not necessary.

**Lung cancer:** Cause of most cancer deaths for males. Second leading cause of death for females (after breast cancer).

**Diabetes:** Diabetes is a common health problem in which the supply of insulin is insufficient for the body’s needs. Insulin stimulates the passage of glucose from the blood, through cell membranes into the cells, to be utilised as fuel. In the absence of insulin, the muscles are deprived of fuel, and sugar accumulates in the blood and is excreted into the urine, taking much water with it. The result is excessive urination, dehydration and great thirst.

As we age, the risk of developing diabetes increases and 11% of people over 65 years have it. There are two types of diabetes, the one affecting older people generally being Type II, or maturity-onset diabetes. This may be treated by weight reduction, diet and/or the use of drugs which prompt the pancreas to produce more insulin. The greatest difficulties with the symptoms of diabetes are that they are often considered, or are passed off as, just being part of growing old.

**The major symptoms include:**
- Increased thirst
- General fatigue
- Blurred vision
- Having to urinate more frequently
- The slow healing of wounds
- Skin infections
- Tingling or numbness of the feet.

Any symptoms which may indicate diabetes should be followed up immediately. If the condition is left untreated it can lead to a stroke, blindness, kidney failure, limb amputation or heart disease.
Arthritis: Arthritis is a disease that involves inflammation of one or more joints. Arthritis is not restricted to age, and affects people of all ages, from young babies through to the oldest members of society. No one really knows what causes arthritis, and there are around 150 forms of the condition. The two most common forms are osteoarthritis and rheumatoid arthritis. Osteoarthritis is suffered when the cartilage padding of the joint breaks down. This type of arthritis is more likely to occur later in life and in people, who have put heavy demands on their joints throughout their lives, e.g.: playing sports, labourers and people who are overweight. The most likely joints to be affected are the hips, knees, spine and hands.

Rheumatoid arthritis: Rheumatoid arthritis is an inflammation of the joints. It can affect people of all ages but usually starts when people reach middle age. It appears to be some type of allergic response by the body and is often associated with a general feeling of fatigue and of being unwell. The joints most likely to be affected by rheumatoid arthritis are the fingers, wrists, shoulders, knees and feet. Rheumatoid arthritis tends to flare up during an attack and then settles down again. Sufferers should be encouraged to rest during flare-ups and to exercise moderately when the condition settles down.

Chronic Obstructive Pulmonary Disease (COPD): Chronic Obstructive Pulmonary Disease is a long-lasting obstruction of the airways that occurs with chronic bronchitis, emphysema, or both. This obstruction of airflow is progressive in that it happens over time. It is also known as COAD (Chronic Obstructive Airways Disease), COLD (Chronic Obstructive Lung Disease) or CAL (Chronic Airways Limitation) and it cannot be cured or reversed, but it can be managed and prevented. Symptoms include intense coughing and a build-up of phlegm in the lungs, feeling puffed or short of breath when doing things like climbing stairs, walking up a hill or even having a shower.

Depression: Up to 20% of elderly people can suffer some form of depressive illness in their later years. This can be the result from a combination of increased loneliness, brought about by the loss of loved ones, accompanied by less physical, social and recreational abilities. While low levels of depression and grieving are a natural part of overcoming a loss, in its extreme form, depression is classified as an illness that requires medical attention.

The symptoms of severe depression include:

- Difficulty in sleeping
- Pessimism or a negative attitude
- Lower levels of activity
- Loss of appetite and weight
- Neglecting self-care or grooming
- Lower resistance to illness
- Continual tiredness, waking up early and feeling anxious or irritable
- Mood swings and uncharacteristic emotional outbreaks
- Withdrawing and reducing any emotional expression
- Recurring thoughts of suicide.
Osteoporosis: Osteoporosis is a condition where the bone structure becomes weaker due to loss of calcium. Physiologically there is a progressive loss of calcium as we age, but this should be distinguished from the pathological disease of osteoporosis where the reduced bone mineral density also reduces the bone strength. The size of the bone will stay the same; however the structure of the bones is weaker. As a result there is a greater risk of fracture.

The condition of osteoporosis is more common in women who have gone through menopause. It is thought that the loss of oestrogen during menopause is responsible for an imbalance of calcium in the body and bone tissue. Osteoporosis does not normally cause any obvious symptoms unless it occurs in the backbone. If it affects the backbone, the sufferer will have frequent backaches, and become shorter with rounded shoulders. The bones that are most commonly affected by osteoporosis are the wrists, leg bones, shoulder and pelvis. The symptoms tend to be recognised only after the bone has broken or fractured due to weakening.

Dementia: It seems that these days more and more people are developing dementia and the reason for that is simply that more people are living longer. Dementia is more common among the very old although it can occur in younger people. Despite media attention, dementia is still, in fact, comparatively uncommon, affecting approximately one in 10 people over the age of 75 years, with the incidence increasing, especially for people who are aged 85 years or more.

Parkinson’s disease

Parkinson’s disease is the condition that leads to problems with the coordination of movement. Men are slightly more likely to get this disease than women, and people over the age of 50 are more likely to get it than are younger people.

The symptoms of Parkinson’s disease include:

- Slowness of movement
- Stiffness
- Tremors.

The symptoms are caused by the gradual loss of nerve cells that control many of the automatic or subconscious controls of movement and posture. People with Parkinson’s disease are often not able to control movement, may freeze suddenly and be unable to move, and/or move very slowly. People with Parkinson’s disease may shuffle rather than walk normally, and their facial expressions may become rigid and immobile. Some of the symptoms of Parkinson’s disease can be controlled with medication. Physiotherapy and other therapies may also prove to be helpful. While there is no cure for Parkinson’s disease, it is not life-threatening. However, the disease causes physical changes leading to social and emotional problems. People with the disease are still able to understand, and more importantly experience the same emotions as they always had.
Other common health issues

Foot issues: Problems with the feet need not be an inevitable part of growing old, either. Foot problems have serious implications. If an older person can’t walk without pain, they can quickly become socially isolated. This can contribute to problems with incontinence, by delaying a person from getting to the toilet on time.

Foot care is a simple procedure that should be followed each day. Points to remember include:

- Washing the feet every day
- Drying the feet carefully, especially between the toes
- Using a little moisturising cream or talcum powder daily (use talcum powder cautiously, i.e.: not on soles if walking in bare feet on tiles, or lino)
- Making sure to have clean socks or stockings each day
- Wearing well-fitting shoes
- Keeping shoes in good order so they give support in standing and walking
- Cutting the toenails regularly, however if the person is unable to do this independently, is diabetic or has circulatory problems of the lower limbs, they should have a podiatrist attend to their foot and nail care
- Never ignore minor problems with the feet, they won’t go away, and they may get worse.

Alcohol and tobacco considerations: If an older person is still smoking, they can be encouraged to seriously consider quitting. The benefits are they will save money and may feel better and more energetic. As we grow older our bodies cope less well with alcohol. If an older person is drinking alcohol regularly to excess, it is important the underlying problem is investigated. It may also so the older person dulls the edges of pain, both physical and emotional; or to escape because they are unhappy with their surroundings, or their lack of social contact.

Some older people use alcohol to try to get to sleep. If, as a carer of an older person, you suspect there is an alcohol problem; your client should be encouraged to discuss drinking, with their medical practitioner. Remember that upholding your client’s right of choice is a paramount aspect, of your care-giving role. We may think that as workers we know what is best for our client; however the person may not agree. It is a basic human right to choose.
If weight is an issue: People tend to forget that as we grow older we don’t need to eat as much. We certainly don’t need to eat as much fat and sugar. It should be remembered that in earlier life, the food you consume is fuel for activities and to replace and renew cells that in the older years are no longer going to be replaced.

Dental care issues: Losing teeth need not be an inevitable part of growing old. It is really important for people to take care of their teeth throughout life. Teeth are not only important for eating but also for clear speech and self confidence.

The basic rules of maintaining dental health are:
- Eating a healthy balanced diet
- Following preventative dental care (including regular visits to the dentist)
- Avoiding sweets and lollies.

Medication issues: It has been shown in various studies that 90% of people over 65 use some kind of medicine. Not only are older people prescribed more medicine than younger people, they also take a lot of over-the-counter drugs and remedies. While taking more medicines, older people are also more sensitive to the effects and side effects of medicines. As our bodies age it is more difficult to remove toxins and to metabolise drugs. A number of older people are actually ill because of the drugs they take.

Many older people are reluctant to question their medical practitioners about diagnosis, treatment and medication. They may be unaware of how and why their medications work, how they interact with each other and what the potential side effects may be. They may not know about complementary therapies or dietary adjustments that may assist them. Family members and caregivers can help older people in understanding their medication regime in a number of ways.

These might include:
- Talking about and writing down questions they might want to ask their doctors
- Accompanying them to medical appointments and encouraging them to read all instructions and information that comes with each drug
- Asking the dispensing pharmacist for information – aim to use one pharmacy/pharmacist to build trust and knowledge of health condition
- Making sure they keep records of their personal medical history and medication regime
- Exploring natural health and herbal remedies, after consultation with the medical practitioner that may be used in conjunction with or instead of traditional medication.

Medication should never be changed or stopped, or new treatment added without consultation with the person’s medical practitioner.

Guide to safe management of medicine: As care workers, we do not dispense medications. But there are a number of ways in which we can assist the client in managing their medication.

Helping a client find out:
- How often the medicine should be taken
- What exactly four-hourly means, if this includes during the night
- How the medicine should be taken – with a meal, with water, after a meal, should it be swallowed whole or chewed, can it be crushed, should the medication be applied in some other way?
- If alcohol or specific foods should be avoided while taking these medications how the medicine should be stored for safety.
Help the client think about questions which will help clarify the name, purpose and effect of any medication prescribed for them:

- What is the correct name of the medicine?
- What is it for?
- How will it help?
- Are there any known side effects?
- What should be avoided while taking this medication, e.g.: driving, alcohol, being in the sun, food, other?
- When should the medication be discontinued?

**Note:** Older people should be encouraged to tell their doctor about any other medicine they are taking (e.g.: herbal or over-the-counter medications), apart from their prescription medicines. There are medicines which interact if taken together, and this could have a serious impact on the individual.

**Insomnia:** Many older people suffer from some degree of insomnia.

**Insomnia can mean a number of things, including:**

- Difficulty with falling asleep
- Early morning waking, e.g.: waking at 3.30 every morning
- Waking, but not feeling refreshed after a night’s sleep.

It is a fact that as you grow older you need less sleep. Not sleeping as much as they used to, is not a problem for some people when they still feel healthy, relaxed and happy. However, if reduced sleep is leaving a person feeling tired and unwell, they may need to have a look at their lifestyle.

**Consider the following:**

- Are they falling asleep in front of the television, and then waking later in the evening to go to bed, only to find they cannot fall asleep?
- Are they taking an afternoon nap? If this is the case and it results in reduced sleep at night, it might be more valuable to change the daily pattern?
- Is the bedroom warm enough or too warm?
- Does the person need to get up and go to the toilet during the night? Some people are able to do this, get back into bed and fall asleep immediately. However, if the person is finding that once they get up they can’t get back to sleep, they should look at their caffeine and alcohol intake. (Note: caffeine and alcohol are natural diuretics and stimulants.)
- If the person is feeling depressed or anxious, this can eventually lead to sleeplessness.
- Insomnia is a symptom not a disease, and it is important to ensure that the underlying cause is identified.
Issues of stress and older people

Various published stress scales (measures of the stress imposed by various factors in peoples’ lives), consistently place the death of a spouse at the top of their lists as being the most stressful event that can take place.

Other factors which rate highly on these scales include the following:

- Death of a close family member
- Personal injury or illness
- Retirement
- Changes in the health of a family member
- Sex difficulties
- Changes in financial state
- The death of a friend
- Spouse stopping work
- Changes in the living environment
- Changes in personal habits
- Moving house
- Less recreation
- Poor diet
- Changes in sleeping habits.

Urinary incontinence

This is the inability to control the excretion of urine.

There are a variety of causes, which are as follows:

- Urinary tract infection
- Tumours
- Impaired consciousness or awareness
- Medication
- Difficulty in accessing a toilet
- Constipation.

Urinary incontinence is described in three ways depending on how it presents:

- **Total incontinence**: is the constant involuntary loss of control of the bladder.
- **Stress incontinence**: is a small leak of urine associated with a physical activity such as sneezing, coughing, laughing or physical exertion. It can also occur when lifting something heavy. Exercise such as running, dancing or jumping can also cause stress incontinence. The cause is weak pelvic floor muscles.
- **Urgency incontinence**: is a leak of urine associate with the feeling of needing to go to the toilet. The feeling is very strong and the person just cannot make it to the toilet on time
- **Overflow incontinence**: is a small leak of urine associated with an over-full bladder that does not empty properly.
Symptoms can be:
- Dribbling
- Frequency
- Poor stream
- A feeling of incomplete emptying
- Dribbling after finishing
- Nocturia.

When caring for someone who has urinary incontinence there needs to be awareness of the person’s dignity and self-esteem needs. This is a difficult and often distressing situation. Therefore understanding and patience are very important. Incontinence may develop or worsen in unfamiliar surroundings, or worsen during periods of depression, anxiety or stress.

**Outflow obstruction**

Outflow obstruction is when there is a reason why a person can’t empty their bladder properly.
- When you have no-one to talk to about the problem.
- When you let things get in the way of seeking help.
Body Systems associated with Ageing

There are changes which occur in the body due to age. These cannot be avoided. They do not necessarily mean illness but can cause some functional problems which if managed well, do not necessarily change or restrict the person’s lifestyle dramatically. Several organs working together form a system. For example the urinary system is made up of the kidneys, bladder and ureters.

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>ORGANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARDIOVASCULAR</td>
<td>Heart, blood, vessels</td>
</tr>
<tr>
<td>RESPIRATORY</td>
<td>Nose, pharynx, trachea, bronchus, bronchiole, lungs, alveoli</td>
</tr>
<tr>
<td>MUSCULOSKELETAL</td>
<td>Muscles, joints, bones</td>
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<tr>
<td>INTEGUMENTARY</td>
<td>Skin</td>
</tr>
<tr>
<td>NERVOUS</td>
<td>Brain, spinal cord, nerves</td>
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<tr>
<td>DIGESTIVE</td>
<td>Tongue, oesophagus, stomach, liver, pancreas, gall bladder, small intestine, large intestine, rectum, anus</td>
</tr>
<tr>
<td>URINARY</td>
<td>Kidneys, ureters, bladder, urethra</td>
</tr>
<tr>
<td>REPRODUCTIVE</td>
<td>Male: Testes, scrotum, vas deferens, seminal vesicle, prostate, ejaculatory duct, urethra, penis, glans, perineum</td>
</tr>
<tr>
<td>ENDOCRINE</td>
<td>Glands: pituitary, hypothalamus, pineal, parathyroid, thyroid, adrenals, pancreas, And gonads: ovaries ♂; testes ♂, and their hormones.</td>
</tr>
<tr>
<td>LYMPHATIC/IMMUNE</td>
<td>Lymph glands and vessels, lymph, lymphocytes, T and B cells.</td>
</tr>
</tbody>
</table>
The Skeletal System

The skeletal system consists of bones, cartilages, tendons and joints, and its major function is to form a framework for the body that the skeletal muscles, can use to cause movement. Some of the bones also provide protection for internal organs, and the formation of blood cells occurs in the bone marrow.

Some of the effects on the skeletal system with the ageing process are:

- Thinning of bones
- Arthritic changes
- Changes in intervertebral discs
- Fractures more common
- Stiff and painful joints
- Loss of mobility.

Bones

During the ageing process the bones:

- Become more brittle and less dense as a person ages. As a result fractures can occur more easily.
- Calcification in the joints can cause restricted movements and joint pain.
- Osteo-arthritis occurs to some degree in most aging bodies.
- Decreased calcium absorption means possibility of osteoporosis.
Joints

The amount of lubricating fluid inside your joints (synovial fluid) decreases as you age, and articular cartilage (the cartilage that lines your joints) becomes thinner, so joint movement is not as smooth as it used to be. Ligaments also tend to shorten and lose some flexibility, making joints feel stiff. Although age-related joint changes vary from person to person, nearly everyone who is aged 80 or more has some degree of joint degeneration.

The Muscular System

The body has literally hundreds of muscles. The muscles either move things or help to hold parts of the skeleton in balance, such as when standing. These muscles are attached to the skeleton by tendons. Muscle tissue is classified as skeletal, and cardiac. Skeletal muscles are attached to the bones, and contract to cause movement of the body. Smooth muscle forms most of the walls of hollow organs and blood vessels, and enables the passage of substances within the body. Older people tend to have weaker muscles than they were young.

Effects on the muscular system of the ageing process are:

- Progressive muscle atrophy
- Tendency for muscle cells to be replaced with fibrous tissue

The immune and the lymphatic system
As people age, the immune system becomes less effective. But the change is so slight that most people do not notice it. Most people notice that the body is less able to fight infections only when infections linger or become severe. People who are infected with tuberculosis during early adulthood may have no symptoms until old age. Then, symptoms develop because the immune system is weaker. The immune system may be less able to distinguish the body's own cells from foreign substances that invade the body. Consequently, disorders in which the immune system attacks some of the body's own cells (autoimmune disorders) become more common.

The cells of the immune system destroy cancer cells, bacteria, and other foreign substances more slowly. This slowdown may be one reason that cancer is more common among older people. Also, vaccines tend to be less protective in older people. These changes in the immune system may help explain why some infections, such as pneumonia and influenza, are more common among older people and result in death more often. Changes in the immune system may have one beneficial effect. Allergy symptoms may become less severe.

**The Skin or Integumentary System**

The skin has several very thin layers the outer one is tough and waterproof, but the others are more sensitive and contain sensory nerves for (feeling touch and pain) and blood vessels. The skin keeps infective germs out of the body, sweats to cool the body down and secretes oils to keep the skin supple. It also makes vitamin D in sunlight.

**Effects of the integumentary system with the ageing process are:**

- Changes include loss of pain/hot/cold sensation that may result in injury
- Skin becomes drier and less elastic increases chances of skin tearing
- Sweat glands decrease creating difficulty in maintaining body temperature
- Loss of elasticity
- Atrophy of sweat glands
- Number of blood vessel decreases
- Thinning and loss of hair, hair colour loss
- Thickening of nails
- Pigmented or non-pigmented lesions may appear
The nervous system is comprised of the brain, spinal cord and nerves and is responsible for coordinating the functions of all other systems. Closely related to the nervous system are the special sense organs; the ears, eyes, nose, tongue and the skin. These organs receive sensations from the environment and relay them to the brain for interpretation.

During the ageing process:

- It can take longer to process and respond to messages received. This can result in lowered reactions, responses and reflexes. Poor balance and reflexes mean increased risk of falls.
- Memory loss may occur.
- Dementia is mainly an age associated condition with 17 per cent of the population over 75 years suffering with it
- Sleep may become an issue for many older people as they need less sleep.
Brain

The brain is a mass of soft nerve tissue, which is encapsulated within the skull. It is made up of grey matter, mainly nerve cell bodies, and white matter which are the cell processes. The grey matter is found at the periphery of the brain and in the centre of the spinal cord. White matter is found deep within the brain, at the periphery of the spinal cord and as the peripheral nerves.

The brain is divided into:

- **Cerebrum**: the largest part of the brain. It is the centre for thought and intelligence. It is divided into right and left hemispheres. The right controls movement and activities on the left side of the body. The left controls the right side of the body. Within the cerebrum are areas for speech, hearing, smell, sight, memory, learning and motor and sensory areas.

- **Cerebral cortex**: the outside of the cerebrum. Its function is learning, reasoning, language and memory.

- **Cerebellum**: lies below the cerebrum at the back of the skull. Its functions are to control voluntary muscles, balance and muscle tone.

- **Medulla**: controls heart rate, breathing, swallowing, coughing and vomiting. Together with the pons and the midbrain, the medulla forms the brainstem that connects the cerebrum to the spinal cord.

The Cardiovascular System
The cardiovascular system consists of the heart, arteries and the veins. The right side of the heart pumps blood through the arteries to the lungs for oxygen. It then returns to left side of the heart which pumps the oxygen rich blood to the body through the arteries. The blood returns to the right side of the heart through veins. If any part of the body is left without oxygen it dies.

Some effects in the cardiovascular system of the ageing process are:

- Cardio-vascular system becomes less effective and less blood is pumped
- Blood vessels become less elastic and narrower. Blood pressure readings indicate changes related to medications and/or disease
- Poor circulation to the hands and feet cause pain, discomfort and less mobility
- Lack of blood supply to the skin and tissue may result in ulcers that are difficult to heal
- Hardening of the arteries (atherosclerosis) occurs
- A block in an artery restricts blood supply and can have terrible results.

Heart and Blood Vessels

As people age, the heart and blood vessels change in many ways. The walls of the heart become stiffer, and the heart fills with blood more slowly. The walls of the arteries become thicker and less elastic. The arteries become less able to respond to changes in the amount of blood pumped through them. Thus, blood pressure is higher in older people than in younger people.

Despite these changes, a normal older heart functions well. At rest, the differences between young and old hearts are trivial. The differences become apparent only when more work is required of the heart, as occurs when a person exercises vigorously or becomes sick. An older heart cannot increase how fast it beats as quickly or as much as a younger heart. Regular exercise can reduce many of the effects of aging on the heart and blood vessels.
The Respiratory System

This is the airway from the mouth and nose down into the lungs (the trachea) and the lungs themselves. The trachea divides into smaller tubes (bronchi) to different sections of the lung. The lungs are made up of millions of tiny balloons like sacs called alveoli. Air is drawn into the lungs when the chest expands, oxygen enters the blood and waste carbon dioxide is breathed out.

Some effects in the Respiratory System of the ageing process are:

- Elastic tissue in the lungs does not expand as well and less oxygen is taken in
- The chest wall does not expand as much as a younger person. This results in less air entry in to the lungs and less oxygen is absorbed
- Chronic bronchitis
- Tendency to develop pneumonia
- Reduced lung capacity.

Breathing difficulties

Various conditions cause breathlessness. The most common are severe heart and chest diseases.

Some guidelines to follow in caring for a person with breathing difficulties are:

- People find it easier to breathe when sitting upright. A backrest and pillows are useful and add comfort
- Keep the room well ventilated at all times
- Avoid giving dry foods as this can cause coughing
- Any sudden breathlessness or change should be reported to the doctor who can recommend treatment.
The Urinary System

The structure

Male urinary system

The Urinary system consists of the kidneys, ureters, urinary bladder and the urethra. It is responsible for the excretion of wastes products in urine. The concentrated urine passes down two urethras to the bladder where it stored until a person goes to the toilet. A person can live with only one good kidney. The function of the kidneys as a filtration system for taking harmful waste products from the blood is less effective. The bladder becomes less elastic and thus less efficient as a collection vessel for the urine.

Some effects on the Urinary system with the ageing process are as follows:

- Kidney function decline may result in fluid retention, less efficient at storage of essential body salts and less efficient removal of toxic waste.
- Urinary incontinence may result from muscle weakness or loss of sensation to nerve endings.
- Increased risk of Kidney stones
- More frequent voiding
- Bladder capacity reduced.
The Digestive System

The digestive system tends to slow down. Teeth are not as efficient in chewing food, the upper bowel and associated organs are not as effective in extracting nutrients from food and the lower bowel is slower in discarding waste. The digestive system consists of the alimentary canal (or digestive tract) and the accessory organs of digestion. The alimentary canal is comprised of the mouth, oesophagus, stomach and the small and large intestine. The accessory organs comprised of the salivary glands, the pancreas and the liver. It secretes substances into the alimentary canal that assists the process of digestion.

Effects on the digestive system of the ageing process

- Nutrition from food may not be absorbed resulting in malnutrition
- Delay of movement of waste can result in constipation
- Atrophy of gum and bone tissue
- Reduction of saliva
- Decreased secretion of digestive juices
- Decreased intestinal motility
- Decreased sense of smell
- Reduced weight and regenerative capacity of the liver.
The Endocrine System

The Endocrine system together with the nervous system is responsible for the control of the normal activities and functions of the body. Some people hypothesise that the endocrine system contains the “ageing clock” of the body. The hypothalamus and pituitary glands are in the brain, and they control numerous body functions, including other glands. The thyroid gland is at the base of the front of the neck, while the adrenal glands are on the top of the kidneys.

**Hormones:** Hormones are chemical substances secreted by endocrine glands directly into the blood. Hormones are classified as proteins and steroids. Hormones are aimed at the ‘receptors’ of target organs. These receptors are located on the outer surface of the cells of those organs. Hormone secretion is controlled by three mechanisms: negative feedback, biorhythms and the central nervous system (Herlihy et al. 2000).

**Glands**

<table>
<thead>
<tr>
<th>GLAND</th>
<th>FUNCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADRENAL</td>
<td>Regulates salt and water in the blood assists body in coping with stress.</td>
</tr>
<tr>
<td>PANCREAS</td>
<td>Regulates blood glucose levels.</td>
</tr>
<tr>
<td>OVARIES</td>
<td>Affect the formation of the ova and the development of the female sex characteristics.</td>
</tr>
<tr>
<td>PARATHYROID</td>
<td>Regulates the metabolism of calcium and phosphates.</td>
</tr>
<tr>
<td>PITUITARY</td>
<td>Master gland.</td>
</tr>
<tr>
<td>TESTES</td>
<td>Affect the formation of sperm and development of male sex characteristics</td>
</tr>
<tr>
<td>THYMUS</td>
<td>Aids in the formation of lymphocytes.</td>
</tr>
<tr>
<td>THYROID</td>
<td>Controls rate of the body’s metabolism and influences growth and development.</td>
</tr>
</tbody>
</table>
The Immune and the Lymphatic system

The pancreas is near the stomach and the ovaries are each side of the female’s womb. A man’s testicles hang between the legs as most people know. These glands work by releasing chemicals into the blood to control many automatic body functions. There are age related changes which can occur in the endocrine glands.

These are:
1. Anatomical
2. Functional
3. Pathological

Some of the effects are:
- Decreased size and weight of pituitary gland.
- Delayed insulin release.
- Adrenal gland slows.
- Metabolism slows down.
- Weight gain.
The Reproductive system and Reproductive organs

Female
The effects of aging on the reproductive system are more obvious in women, than in men. In women, most of these effects are related to menopause, when the levels of female hormones (particularly oestrogen) decrease, menstrual periods end permanently, and pregnancy is no longer possible. The decrease in female hormone levels causes the ovaries and uterus to shrink. The tissues of the vagina become thinner, drier, and less elastic (a condition called atrophic vaginitis). The breasts become less firm and more fibrous, and they tend to sag. Some of the changes that begin at menopause may interfere with sexual activity. However, for most women, aging does not significantly affect sexual activity.

Male
In men, the changes in the reproductive system are less dramatic. Most men remain fertile until death, even though testosterone levels decrease, resulting in fewer sperm and a decreased sex drive (libido). Most men can continue to have erections and reach orgasm throughout life. However, erections may not last as long or may be slightly less rigid. In addition, the time needed to achieve a second erection may increase markedly. Erectile dysfunction (impotence) becomes more common as men age.
Five

Working with the person to identify physical and social enablers and disablers impacting on health outcomes and quality of life

1. What are some common physiological, chronic and age related conditions that older people may experience?

2. Based on age related changes that you have identified, what can you as a care worker do to support an older person maintain their quality of life?

3. Explain the importance of determining where possible whether changes are associated with normal aging or represent disease.
4. In bullet point form write down the common age-related changes that occur in the following Body systems:
   
a) Cardiovascular System.

   

   

   

   


   b) Respiratory system.

   

   

   

   


   c) Gastrointestinal system.

   

   

   

   


   d) Endocrine System.

   

   

   

   


e) Nervous system.

f) Immune system.

g) Urinary system.
h) Musculoskeletal system.

i) Reproductive system.

j) Sensory system.
Encouraging the person to adopt a shared responsibility for own support as a means of achieving better health outcomes and quality of life

Sometimes people are unable to take responsibility for their own lives because of factors that are, or they believe to be, beyond their control. Older people can be empowered through learning about ways of taking control of some or all of these factors. Empowerment also means ‘enabling’. You have an important role to play in empowering older people. Your role is to assist people to gain the skills and abilities necessary for them to take control of their own lives. The ultimate aim of empowerment is for people to consider choices and make good decisions for themselves, their families and the wider community. A crucial element of taking responsibility for personal choices and decisions is the ability to effectively communicate.

Outcomes of decisions: good and bad – help us learn and grow as individuals. Through involvement in decision making we can gain experience, confidence and knowledge which enrich our lives. Making and being involved in decisions also allows us to participate in our communities and broader society. Through this active participation we feel greater connection to and responsibility for our communities. A sense of control in home life and at work is also linked to better health and wellbeing outcomes. Where people are denied the right to make decisions, or are restricted by others as to the type of decisions they can make, they are potentially being denied their human right.

The ultimate goal of maximising the well-being of aged care clients is to maintain or improve their ‘quality’ of life. As people age they need to make changes to the way they live, but that does not mean that they should stop enjoying life, having fun or participating in the things that are of interest or importance to them. Every individual including older people and those with disabilities, in the community have the right to achieve maximum independence within that community.

What older people need to maximise their independence

Older people, like people of any age, want to be listened to:

The following are the things which are known to be important to older people:

- To manage and maintain their own health and independence for as long as possible
- To remain stimulated, involved and challenged by life
- To be informed so they are aware of the choices open to them
- To be recognised and respected as contributors to, not burdens on society
- To continue to be valued in society, either through the paid workforce or through voluntary activity
- To fight for the things they believe in.

In order to promote the well-being of aged care clients, you need to understand and acknowledge their complete lifestyle, including:

- Daily living skills
- Social contact and networks
- Background-cultural, religious, spiritual educational
- Emotional needs
- Financial position
- Recreational activities
Element 2: Provide services to older people

Identifying and discussing services which empower the older person

Ageing is a time of change – for many, a time of loss, of adaptation to altered circumstances, of compromised capacity. One of our key work roles is in working with the client, and available programs/organisations/resources, to develop strategies that maximise options and choice, while maintaining client dignity and independence. The specific strategies developed will vary, and will be assessed and implemented under a care management plan. The strategies adopted to meet these objectives will be developed in consultation with the client, and through the care planning process. Where the individual worker fits in to this process will vary, from one organisation to another.

Regardless, the characteristics of effective strategies include the following:

- Flexibility in strategy development
- Variety of assistance
- Accessing a range of appropriate services and service providers
- Flexibility of service delivery, as required.

A range of aged care services are available to provide support and assistance to older people. A large proportion of these services are community-based, such as meals on wheels, home nursing, and domestic assistance, and are provided in the older person's home. Otherwise, if unable to be supported to live at home, older people may move into residential aged care. People who live in residential aged care are potentially disadvantaged by many factors, including disability, mental incapacity, and living in a somewhat restricted, regimented institutional environment where their lives are largely regulated by the staff and management of their facilities.

It is also important to understand that while some people move into aged care facilities as the result of choice and planning, many people move into facilities quite suddenly, as a result of a fall or accident. This relocation can be a stressful experience accompanied by multiple losses, including the loss of independence, home, possessions, family relationships, and pets (Nay 1993).

Delivery Framework of Aged Care Services

The aged care industry is based on two models:

1. Residential care.

2. Home Care (consumer directed care) and Community Care (HACC), the latter being where older people are supported in their homes.

Residential aged care is financed and regulated by the:

- Commonwealth Government and provided primarily by the non-government sector (religious, community and private providers).

- State Governments, with funding from the Commonwealth Government, operate a small number of aged care facilities, and so do some local government bodies.
Residential care

Residential aged care in Australia is no longer grouped into two major categories - high-level care (previously called ‘nursing homes’) and low-level care (‘hostels’). The funding ratio for facilities is based on a calculation of the number of residents requiring various levels of support. The industry is regulated by National Accreditation Standards linked to a funding formula. Although the standards do not mandate necessary qualifications for personal care workers, it would be difficult for a facility to achieve the standards without a staff training strategy focusing on key areas. The current care models introduced in 2013 in ageing in place aged care.

The following improvements have been implemented in residential care.

- A new means test (income and assets) in residential care to help determine a person’s fair contribution, if any, to their care and accommodation. New income test arrangements also apply to home care
- Greater choice and flexibility for how they pay for accommodation and services, with 28 days to decide how they would like to pay
- Transparent accommodation prices and services, with all residential aged care providers required to publish the maximum amount they charge for accommodation and extra services
- New capping arrangements help make the system more affordable overall for individuals
- Establishment of the Aged Care Pricing Commissioner, an independent, statutory office holder appointed under the Aged Care Act 1997
- Better support to build more residential care facilities, and enhanced quality and amenity of accommodation for residents
- Consolidating and modernising the Schedule of Specified Care and Services.
- Removal of the high care low care distinction, resulting in flexible and more transparent arrangements in permanent residential aged care, reducing red tape for consumers and providers without compromising levels of care provided to residents
- Implementation of the Transitional Business Advisory Service to assist residential aged care providers in relation to the accommodation payment changes.
Conditions of allocation on residential places: The Secretary of the Department of Social Services amended conditions of allocation on existing permanent residential aged care places to remove any low care or high care conditions of allocation with effect from 1 July 2014. You’d not need to do anything for this change to occur. Future allocations of permanent residential aged care places will not have low care or high care conditions of allocation.

Approval of care recipients: From 1 July 2014, new permanent residential aged care approvals are not restricted to a care level. Low care and high care permanent residential aged care approvals valid on 1 July 2014 became permanent residential aged care approvals without any restriction to a particular level of care. Any person with a permanent residential aged care approval may now be admitted to any residential aged care place, subject to availability and the provider’s agreement. All residential aged care approvals valid on or from 1 July 2014 are indefinitely valid, unless approval is for a specific period.

Providing ‘ageing in place’: With removal of the distinction between low care and high care in permanent residential aged care, all permanent residential aged care is provided on an ‘ageing in place’ basis from 1 July 2014. All permanent residents will have the right to indefinite residence, unless the conditions are met for asking a resident to leave residential aged care as set out in the User Rights Principles.

Residential Care Facilities

Residential aged care facilities provide residents with accommodation, personal care, including food and support services, health promotion and lifestyle activities, nursing care and allied health services. Services are mainly provided by staff of the facility with extra input when required from other service providers.

The accommodation offered may vary from a single private room with ensuite bathroom to shared rooms or small wards. Older people can enter residential care if an ACAT assesses them as having physical, medical, social and psychological needs that require the provision of care, and those needs cannot be met more appropriately through non-residential care services. If both partners are living and only one is assessed as needing this kind of care, some residential facilities may offer places to both partners as co-habittee. The same can apply to an older person who has been living with a brother or a sister and only one of them needs residential care. If one partner dies the other can often remain in the facility for as long as they want. It should be stressed that this occurs only by negotiation, and where the facility has the appropriate resources to offer the service.
Aged Care Funding Instrument (ACFI)

Classification of residents

From 1 July 2014, new and continuing permanent residents cease to be classified as low care or high care recipients. Permanent residents continue to receive an Aged Care Funding Instrument (ACFI) classification, except that the ‘interim low’ ACFI classification has ceased.

The ACFI as a calculator of the Residential Aged Care Subsidy

Three components of residential care subsidy are determined by the ACFI.

These are:

1. **Activities of Daily Living**: ratings on nutrition, mobility, personal hygiene, and toileting and continence questions are utilised to determine the level of the basic subsidy.

2. **Behaviour Supplement**: ratings on cognitive skills, wandering, verbal behaviour, physical behaviour and depression questions are utilised to determine the behaviour supplement.

3. **Complex Health Care Supplement**: ratings on medication and complex health care procedure questions are utilised to determine the complex health care supplement.

The amount of each of these that is payable in respect of a particular resident depends on the ratings (A, B, C or D) for each of the ACFI questions (1 – 12). Other data such as diagnosis may be relevant to the calculation of subsidy for some questions.

Difference between ACFI and Accreditation

Accreditation assesses quality of care (and therefore will still assess nursing care plans). ACFI only assesses funding needs.

Documentation and ACFI: An important part of ACFI is supporting documentation. Any assessment information must be verified in progress notes and care plans. For example: if the registered nurse assessing a resident as level B immobility, the care plan would have to specifically state “resident requires assistance for transfers between bed and chair”. The progress notes would also need to indicate this.

Admissions: One area that needs a significant honing of skills and abilities is the process of admission and the flow of information that can be used from it. The team leader needs to place a watchful eye on the QDMS and the validation of data that is collected during an admission.
Assessing client eligibility: (Aged Care Assessment Team (ACAT))

The Australian Government provides grants to State and Territory Governments to operate Aged Care Assessment Teams (ACATs), or Aged Care Assessment Services in Victoria, under the Aged Care Assessment Program. ACATs may include:

The ACAT may include:

- A doctor or geriatrician who specialises in the medical diagnosis and care of older people
- A nurse who assesses the nursing care needed by older people
- A social worker who looks at their social functioning and welfare needs
- An occupational or other therapist who looks at their physical functioning, mobility, physiotherapy or speech therapy needs.

Their role is to assess the care needs of frail older people and help them receive the most appropriate care and support in accordance with the aged care legislation and Aged Care Assessment Program: Operational Guidelines (DoHA 2002a). This may involve simply referring clients to community care providers such as those available under the HACC program. Alternatively, they may approve their eligibility for residential or community care services (DoHA 2007h).

ACATs are usually based at hospitals, geriatric centres and community health centres. In rural areas the members of the team may work from a range of locations to ensure that at least one member of the team covers the more remote and isolated areas.

Like HACC services, ACAT differs from area to area. In most areas there are strong links between HACC and the local ACAT, both often identifying older people who are at risk of institutionalisation and working as a team to give the most appropriate level of support. The ACAT do a holistic assessment of an older person’s overall care needs. They assist the older person in choosing the most suitable care available. They do not put older people in homes. They will consider and discuss all care alternatives with the family.

After they complete their assessment, they will make various recommendations:

- If the ACAT has assessed the older person as not being eligible for residential care, it should be able to tell them about available Home and Community Care services and make referrals to the services with the older person’s knowledge and permission
- The ACAT will provide limited care management services if the older person is going to continue living at home and has complex or special needs for multiple services
- It will determine whether the older person is eligible for low level residential care
- The ACAT is not responsible for finding a place for them. This remains their choice.
- It will determine if the older person is eligible for high level, nursing home style care. As with low level care, the ACAT does not find a place for them
- The ACAT will determine whether the older person needs low level care or high level care, in a residential care facility
- They can also assess if a person is suitable for a Community Aged Care Package (CACP) or an Extended Aged Care at Home (EACH) package. They can also help with respite care.

It is very important that the older person knows and understands what is happening at every step of the procedure. Everyone involved should take time to discuss what is happening with them and explain anything they don’t understand. Interpreter services are available for those who need them.

In some instances, the ACAT will do a joint assessment with a HACC service, especially if there is a feeling that home and community care services may be more appropriate to the older person, or if they are on the borderline of eligibility for residential care. The ACAT will ask a series of questions to determine the older person’s mental state and Memory (mini-mental test), which affect decision making and level of insight in each individual.
Home Care (consumer directed care) and Community Care services

Home Care services are designed for people who need support to continue living in the community and who are older and frail or who have a disability. So if you have difficulties with everyday tasks, such as getting dressed or showering, this could well be the extra support you need. HACC services are designed to reach people with the greatest level of need, as decided by HACC service providers.

To be eligible for the HACC Program you must:

- Be living at home, be an older and frail person, or a person with a disability and have difficulty doing everyday tasks such as dressing or preparing meals
- Be a carer of a frail older person or person with a disability, or,
- Be likely to need to go into an aged care home or a hospital for care if you were not being provided with support from HACC.

(HACC) Home and Community Care services

The HACC funded Home Care service maintains a safe, secure, healthy home environment for frail older people and people with disabilities, and their resident carers.

Home based services can provide the following:

- Workers can prepare meals, do shopping, undertake small errands, and pay bills as required
- Workers can also escort consumers to do shopping and pay bills, or to attend medical and related appointments
- The service undertakes essential house cleaning of areas regularly used by the consumer. These include: bathrooms, toilets, kitchens, laundries, living areas, and bedrooms
- Provide housekeeping services appropriate to the individual’s level of physical functioning and their cultural norms
- Provide services which enhance and maintain the abilities and independence of the consumer
- Support carers of frail older people and people with disabilities by undertaking activities necessary to maintain a safe, comfortable and healthy home environment
- Monitor the well being and other circumstances of consumers.

While cleaning tasks form an essential part of Home Care, it is more than a cleaning service. It is focused on enhancing consumer’s independence by providing housekeeping, assistance with personal administration, monitoring and escorting.
Shopping services: HACC funds a range of services that can assist with shopping. For mobile clients, community transport services operate a number of shopping trips to the larger retail centres. Transport services use HACC funds to buy mini-buses and, for a small charge, will pick up passengers from and return them to their homes. Some provide shopping trips for older people from different cultural backgrounds. Like food services, community transport buses are generally relatively easy to access. They don’t have restrictive assessment practices and may simply take some basic details over the phone to ensure eligibility.

Food services: Most people will already be aware of the Meals-on-Wheels services, however, most people also have a mistaken idea of what this organisation offers. This community-based service has changed rapidly in the past few years, as the importance of a balanced diet in keeping older people healthy has been recognised. Meals-on-Wheels agencies are often the first services that older people will use.

In the past a doctor or nurse’s referral was required in order to access the service. Today, however, individuals can ‘self refer’ simply by ringing the local service. The response is usually fairly quick, as Meals-on-Wheels services have many years of experience in starting individual service on short notice. The service offered by Meals-on-Wheels varies from area to area.

Most of the larger metropolitan and urban services will deliver a nutritionally balanced meal five times a week, with a seven-day service available in some areas. Smaller rural services may only deliver three days a week and will usually bring extra meals for the other days. A typical meal will consist of soup, a main meal, dessert and a vitamin supplement such as a piece of fruit or juice. The service should also be able to provide modified diets or special meals for diabetics, vegetarians and people with other dietary needs.

Clients or potential clients should tell the service what they can and cannot eat. Most Meals-on-Wheels services and some local community services, such as Neighbour Aid, also have outlets for frozen meals. Frozen food services offer a wider menu choice than do the delivered meal services. They usually deliver weekly to the home. In some cases additional frozen meals can be ordered for storage so that people have something in the freezer for visitors.

It should be noted that there is more to food than just diet. Meal times are also times for socialisation and conversation. It is lonely to always eat alone. Many older people lose interest in food for this very reason. HACC funds a number of more social food options, called centre-based meals and some Home Help services will also cook meals in the home and employ personal carers who will assist feed people with disabilities. The local Meals-on-Wheels service should also have information about other food services available in your area.

Transport services

Usually transport services help with shopping and essential appointments with hospitals and doctors. Some agencies offer a limited service within a local area, while others go further afield. The availability of vehicles and numbers of volunteers can impact on how the service operates. Many community transport buses now have wheelchair lifts and senior citizen centres, day activity centres and churches often have mini-buses that they use for excursions. It is important that you find out everything that is available in your area if you are going to be able to inform your clients about services available to them.

Home nursing services: Home nursing services have been operating through local councils and State Departments of Health for years. These services operate under a variety of names including: Home Nursing Services, Community Nursing Services, Mobile Nursing Services or Domiciliary Nursing Services. Community nurses assist with a range of daily hands-on nursing services for people who are house bound. This may include monitoring health, changing dressings, giving injections and medication, and showering and bathing. The service may be supplied for a limited time immediately after discharge from hospital or indefinitely. The eligibility criteria for nursing services is somewhat more restricted than the criteria for the types of services discussed above. Service does not automatically start on request.
Home help: Home Help or Home Care Services can provide a home aid to help with normal household tasks, eg: basic house cleaning, washing, changing linen and ironing. In addition to government funded services, there are now numerous private agencies offering regular housekeeping services. If an older person approaches a government service and finds they are ineligible, they should ask for details of any private services operating in their area the government agency can recommend. A person can self refer to a HACC funded home help service and an holistic assessment will be conducted.

Personal care: Many HACC clients need more than one type of service. There is a growing trend towards flexible personal care services, where one person who is multi-skilled performs a number of different tasks rather than each task being performed by a different person. Personal care services are particularly valuable for people with dementia or multiple disabilities. People with dementia can become frightened and agitated if a number of different or unfamiliar people are coming into their homes.

Personal care agencies provide a flexible range of services which may include assistance with showering, toileting, skin care, grooming, medication, transferring people to beds and chairs, mobility therapy, food preparation and eating. Assessment is thorough and considers how able the person is to do all the tasks of daily living, down to shaving, doing up buttons and brushing the hair. Most people who receive personal care have high support needs. They are a priority for HACC services. Those receiving such services can be expected to be regularly re-assessed as needs can change significantly over time.

Home care packages

The Australian government introduced new Home Care Packages on August 1, 2013, as part of its Living Longer Living Better reform package. A Home Care Package provides services that will help you to remain at home for as long as possible, as well as providing choice and flexibility in the way that the care and support is provided.

Eligibility

Unlike services provided under the Home and Community Care program, to receive a Home Care Package you will need to be assessed by an Aged Care Assessment Team (ACAT). The ACAT helps the elderly, and their carers, determine what kind of care will best meet their needs, when they are no longer able to manage on their own.

A member of the team which may include a doctor, nurse, social worker, and/or other health professional will meet with the person to assess their care needs and how well you are managing at home. They will identify the right services for a client needs and the level of care a person requires. The ACAT will give you a letter stating the types of subsidised services you have been approved for and might also put you in contact with organisations in your area that can deliver these services.

What services are provided?

Home Care Package services are based on a persons individual needs. Your provider coordinates the care and services to support you at home and these are agreed between you and your provider.
The services may include:

- Transport for shopping or appointments
- Social support by taking you shopping, banking or just providing company for a chat
- Domestic assistance for household jobs like cleaning, clothes washing and ironing
- Personal care assistance with bathing or showering, dressing, hair care and going to the toilet
- Home maintenance for minor general repairs and care of your house or garden
- Home modification ie installing safety aids such as alarms, ramps and support rails
- Nursing care where a qualified nurse comes to dress a wound or provide continence advice
- Food services such as providing meals at a community or day centre, preparing and storing food and delivering meals to your home
- Medication help in taking your medications.

Types of packages available

There are four levels of Home Care Packages.

1. **Level 1**: supports people with basic care needs
2. **Level 2**: supports people with low level care needs (formerly community aged care packages)
3. **Level 3**: supports people with intermediate care needs
4. **Level 4**: supports people with high level care needs (formerly Extended Aged Care at Home and Extended Aged Care at Home Dementia packages).

Package supplements – the Dementia Supplement for people with dementia and the Veterans Supplement for veterans with an accepted mental health condition – are available with any of the four levels of Home Care Packages. A care provider will apply for the subsidies and ensure you meet the eligibility criteria. For people receiving care services through the previous Community Aged Care Package, Extended Aged Care at Home or Extended Aged Care at Home Dementia package will continue to receive these services, but they will have a different name.

**Level 2 CDC (formally Community Aged Care Packages (CACPS))**: support people who prefer to remain at home but who require equivalent care to the low care provided in a residential aged care. People who require care equivalent to low-level residential care can remain at home with a CAP. The service provides a case manager and funding to purchase the right levels and mix of community services that will support the older person at home. There is also a pilot program called the Extended Aged Care At Home (EACH) trialling this type of service for high level equivalent care. This is currently being reviewed and could possibly be extended.

**CDC Level 3 formally (EACH) Extended Aged Care at Home Packages**

The Extended Aged Care at Home Package pilot was established to test whether it is possible to provide care in a person’s own home at the level currently provided in a high care residential facility. The Extended Aged Care at Home (EACH) program assists frail aged people to remain at home in their homes, supported by high-level care through an approved service provider. Packages are flexible and coordinated to suit the individual's particular needs, and may include services such as nursing, domestic assistance, in-home respite, personal care, transport and social support.

The EACH program is established under the Flexible Care Subsidy Principles 1997. These Principles provide for a payment agreement between the Department of Health and Ageing and the approved provider. This agreement regulates the EACH program by specifying a range of conditions that must be met by the approved provider for EACH subsidy. To access an EACH package, an older person must be assessed as eligible for high-level residential care by an Aged Care Assessment Team (ACAT).
What services are available under the EACH Program?

A person who requires high level care could be eligible for an EACH package, and the types of services that may be provided as part of an EACH includes:

- Registered nursing care
- Care by an allied health professional such as a physiotherapist, podiatrist
- Other type of allied health care
- Personal care
- Transport to appointments
- Social support
- Home help; and
- Assistance with oxygen and/or enteral feeding.

Day therapy centres: Day Therapy Centres offer physiotherapy, occupational and speech therapy, podiatry and other therapy services to older people in a community setting. There are 148 Commonwealth funded Day Therapy Centres (DTCs) operating nationally. The centres vary in size and in the range of therapy services that they provide.

Therapy services, which may include physiotherapy, occupational therapy, speech therapy and podiatry, can be provided to frail aged people who are living in the community or who are residents of Commonwealth funded aged care homes. The aim of the program is to assist people to either maintain or recover a level of independence, which will allow them to remain either in the community or in low level residential care. Usually the DTC will develop an agreed care plan for the client and this may include recommendations for therapy and referrals to other service providers where necessary.

Department of Veterans Affairs (DVA) Home Care Program: In January 2001 the DVA introduced the Veterans Home Care Program. The program offers a range of services to enable veterans and war widows to remain living in their own home. New services now offered include domestic assistance, personal care, home and garden maintenance and respite care. This extends the range of care services already provided by DVA which includes community nursing, in home and residential respite care, allied health services, home modifications and transport for health care.

Voluntary work: Voluntary work includes providing informal assistance to family members, and friends, and more formally to others through an organisation or group.

Informal Carers: The majority of older people who require care in their own homes receive most of this from informal carers who may be partners, relatives, friends or neighbors. However sometimes it is not possible for these informal carers to bear the full responsibility for the level of care required. The Federal Government and many State Governments have created a range of assistance specifically to support the needs of carers of older people and younger people with disabilities. Support is mainly provided via carer respite Centres and Carer Resource Centres, which provide information, advice and assistance to access respite care services.

Transition Care program: Transition care is a form of flexible care for an older person that is provided at the conclusion of an admission to hospital. It helps to restore a client to their maximum level of health or strength. It provides a package of services that include therapies, eg: physiotherapy and occupational therapy, and either nursing support or personal care. Transition Care can be provided in either a community or residential setting, but to be eligible, a client must be assessed by an Aged Care Assessment Team. They must be assessed as requiring at least low level residential care. The aim of the program is to help older people reach their optimal level of functioning while assisting them and their family or carer to make (if required) long term care arrangements, eg: home care or residential care. It is estimated that the period of transition care would last for approximately eight weeks after discharge from hospital.
Six

Identifying and discussing services which empower the older person

Based on the following limited information, what kind of residential care would best suit the following clients? Give reasons for your answer.

Scenario 1:
Mr. Bright has been living at home with the support of a formal carer and a care package of services. However he is becoming increasingly forgetful and confused as he is in the early stages of dementia. He finds preparing any meals increasingly difficult and frequently forgets to turn off the stove. He is fiercely independent and still lives in the family home which is quite large. Although he is frail, he is reasonably mobile and occasionally uses a walking frame. He can manage most of his personal routines himself with some prompting and direction but needs supervision when bathing.
Scenario 2:

Mr. Corrigan lives with his wife in their own home. They have been managing well with regular support from a close family member. However, while trying to change a light bulb Mr. Corrigan fell and broke his hip. He was hospitalised for a while during which time his overall condition gradually deteriorated. His doctors and other family members became concerned about his mobility, his emotional state and his general failure to recover.
Supporting the older person to express their own identity and preferences without imposing own values and attitudes

Personal preferences

Each of the clients that you work with is an individual with their own personality, and life history. As a result they have their own attitudes, beliefs and preferences that have been established and maintained over a long period of time. It is important in your role as a care worker, that you take into account the individual preferences of each of the clients you work with. Although some may be shared by clients, many of them will be individual preferences. You need to understand the preference and respect the individual’s rights.

Individual preferences are formed over a long period of time throughout our life. Some may have remained with the individual throughout their life, others may be new preferences that have been adopted as they have adjusted their life and lifestyle to changes over time. Individual preferences may be as simple as the clothes a person wants to wear, the food they want to eat, their religious requirements or their social desires. It is important that you remember the complexity of the history of the individual while you are learning to understand their preferences. On a day-to-day basis in your work you will come across a variety of different personal preferences. Each individual will have different needs in all aspects of their lives.

You may find preferences in their daily living in areas of:

- Communication
- Eating and drinking
- Mobility and transferring
- Grooming and personal hygiene
- Dressing and undressing
- Spiritual needs
- Relationships with others
- Emotional needs
- Expressing sexuality.

In all of these areas each individual will have their own preferences that you need to be aware of, eg: one client may prefer to be transferred from wheelchair to toilet in a completely different way to another client. Clients may also have their own preference in order of dressing in relation to which items should be put on first. The same could occur with undressing. It is therefore important that you know the individual and understand their personal preferences in order to fulfil their needs through the plan of care. Many clients will also have different personal preferences in relation to physical activities of daily living.
You may find differences in personal preferences in the areas of:

- Accessing education and employment
- Accessing financial resources and allowances
- Paying bills
- Regular outings
- Shopping
- Preparing meals
- Climbing stairs
- Maintaining the household, including cleaning and repairs
- Travelling by private and public transport
- Interacting with others and socialising
- Accessing leisure, recreational and sporting activities.

It is important again that you remember that each individual have their own personal preferences in these areas, eg: one client may have an interest in photography while another one may prefer to watch a sporting game on television. It is also important that you understand that each client will have preferences in relation to their physical comfort and rest. While one client may find it more comfortable to sit in an upright chair, another client may find it much more comfortable to sit in a recliner. While attempting to accommodate personal preferences of each individual you work with, it is essential that you always remain within the guidelines of the organisation for whom you work. These guidelines are in place for reasons, especially those of safety concerning yourself, your client and others.

Understanding preferences: You may be confronted with clients with preferences that you do not understand or you do not believe are logical. You must remember that we are all individuals and each person has their own way of doing things. Although we might not understand the preferences of other people it is important that we do respect them. To fully understand the preferences of an individual, it is essential that you clarify the information you have been given to make sure you have it correct. It is easy to make a mistake or overlook preferences if you do not understand the reasons behind them.

Encouraging your client: While continually communicating with your client it is important to encourage them to maintain independence. This will help them to have a positive outlook on life and raise their self-esteem. You can encourage independence by sharing tasks with your clients depending on their capabilities and by making sure their preferences are met.

Reading and writing: In many cases you need the communication skills of reading and writing in order to fulfil the personal preferences of your clients. They may require you to read a letter that has been sent to them, or even to look up some information that they may want. Some clients may also need assistance with reading bank statements and other literature. If you are unfamiliar with such documents, you should explain this to your client, and undertake to find another staff member who can assist or encourage client to use a family member/guardian, if appropriate.

Ensure you adhere to organisational policy and procedures. You may find yourself in the position where you need to write either a message, a shopping list or a letter for your clients. It is therefore important that you know how to write letters and respond to other items correctly in order to fully assist your clients. to ask for help, either from someone appropriate in your organisation or even your client. They would much prefer you to ask them rather than sign their name to a letter with mistakes. Remember your clients are people too, and will generally understand that everyone has their own strengths and weaknesses.
**Paying attention through observation:** You can learn a lot of information about your clients by observing what they do for themselves and how they do it. You can also gain information from their surroundings and their personal belongings. Be careful though that you do not go through personal belongings or encroach on the privacy of your clients. Always remember that there are often hidden reasons such as health matters or level of capabilities that have an impact on the personal preferences of the individual.

There may be times when a client finds it difficult to provide you with factual information about their personal preferences. This could be due to sensory impairments, personality differences or cultural factors. It is therefore important that you turn to other sources in order to gain factual information about clients' personal preferences.

**This information could be provided by consulting:**
- Their care plan
- Your supervisor
- Other care workers
- Their medical practitioners
- Family members.

**The client’s care plan**

A care plan for each individual will have been developed by the assessment team and will provide a lot of information about the individual. All relevant information about the client is listed on their care plan and this includes their personal preferences. There may be times when you need to update this information because you are working with them on a one-to-one basis. However, when you first start to work with the client you will find this a source of vital information.

The information on the care plan is gathered from a variety of sources. It is important that you as a carer also document and report any information that may be relevant to the individual’s care plan. Remember that the care plan is continually evaluated and updated to accommodate changes in the individual’s abilities and needs.

**Consulting your supervisor:** If you are dealing with a client who is reluctant to provide you with information about their personal preferences, it may be necessary for you to consult your supervisor, to work out a method of approach. Your supervisor may give you guidelines on how to elicit factual information from your client, or decide it is more appropriate to refer the client to someone else who can help determine their personal preferences.

**Consulting other care workers:** It is important in your work that you maintain regular contact with other care workers who have more experience than you. You will find that there are other care workers who may have worked with your client before or have worked with clients in similar situations. They may have experience in eliciting information about the client’s personal preferences.

**Consult family members:** Always ask the client if they would like their family in the discussion (permission must be obtained). Family members can often be quite helpful in providing you with information about your client’s personal preferences. Whilst discussing your client’s personal preferences with family members, keep in mind that some family members may not have lived with your client for some time, and may not, therefore, be aware of their current preferences. Even so, family members can often be very helpful when determining personal preferences about interests, activities and hobbies. They may be aware of personal preferences in relation to foods, social activities and daily tasks of life.
Personal values, belief and attitudes

As human beings, we all have our own values, beliefs and attitudes that we have developed throughout the course of our lives. Our family, friends, community and the experiences we have had all contribute to our sense of who we are and how we view the world. As community services workers, we are often working with people who are vulnerable and/or who may live a lifestyle that mainstream society views as being different or unacceptable. If, as community services workers, we are to provide a service that meets the needs of our target groups and helps them to feel empowered, we need to be aware of our own personal values, beliefs and attitudes and be prepared to adopt the professional values of our industry—and not impose our own ideas on our clients.

What are values?

Values are principles, standards or qualities that an individual or group of people hold in high regard. These values guide the way we live our lives and the decisions we make. A value may be defined as something that we hold dear, those things/qualities which we consider to be of worth.

A ‘value’ is commonly formed by a particular belief that is related to the worth of an idea or type of behaviour. Some people may see great value in saving the world’s rainforests. However a person who relies on the logging of a forest for their job may not place the same value on the forest as a person who wants to save it. Values can influence many of the judgments we make as well as have an impact on the support we give clients. It is important that we do not influence client’s decisions based on our values. We should always work from the basis of supporting the client’s values.

Where do values come from?

Our values come from a variety of sources. Some of these include:

- Family
- Peers (social influences)
- The workplace (work ethics, job roles)
- Educational institutions such as schools or TAFE
- Significant life events (death, divorce, losing jobs, major accident and trauma, major health issues, significant financial losses and so on)
- Religion
- Music
- Media
- Technology
- Culture
- Major historical events (world wars, economic depressions, etc).

Dominant values: are those that are widely shared amongst a group, community or culture. They are passed on through sources such as the media, institutions, religious organisations or family, but remember what is considered dominant in one culture or society will vary to the next.
Using the sources listed above, some of your values could be:

- **Family**—caring for each other, family comes first
- **Peers**—importance of friendship, importance of doing things that peers approve of
- **Workplace**—doing your job properly; approving/disapproving of ‘foreign orders’ (doing home-related activities in work time or using work resources for home related activities)
- **Educational institutions**—the valuing or otherwise of learning; value of self in relation to an ability to learn (this often depends on personal experience of schooling, whether positive or negative)
- **Significant life events**—death of loved ones and the impact on what we value as being important; marriage and the importance and role of marriage and children; separation and divorce and the value change that may be associated with this (valuing of self or otherwise)
- **Religion**—beliefs about ‘right and wrong’ and beliefs in gods
- **Media**—the impact of TV, movies, radio, the internet and advertising on what is important in our lives, what is valued and not valued
- **Music**—music often reflects what is occurring in society, people’s response to things such as love and relationships which may then influence the development of our values
- **Technology**—the importance of technology or otherwise; the importance of computers and developing computer skills
- **Culture**—a cultural value such as the importance of individuality as opposed to conforming to groups
- **Major historical events**—not wasting anything, saving for times of draught, valuing human life, patriotic values.

It is important that you develop an awareness of what you value, as these values will be important in informing your relationships with clients, co–workers and employers.

**What is an attitude?**

The word ‘attitude’ can refer to a lasting group of feelings, beliefs and behaviour tendencies directed towards specific people, groups, ideas or objects. An attitude is a belief about something. It usually describes what we think is the ‘proper’ way of doing something. The attitudes that we feel very strongly about are usually called values. Other attitudes are not so important and are more like opinions. Sometimes our own attitudes can make us blind to other people’s values, opinions and needs. Attitudes will always have a positive and negative element and when you hold an attitude you will have a tendency to behave in a certain way toward that person or object.

You will need to be aware of your own personal values, beliefs and attitudes and how they might impact on your work. It is important to consider the mapping of your own life – what have been some significant events that have shaped you, what qualities you admire in yourself and others, what beliefs are important to you, what you value and so on. Some examples of these may be personal features such as strength of character, helping people, respect, honesty, wealth, success, health etc.

What we believe are important qualities, or what qualities we admire in ourselves and others, generally reflect our life experiences and the values which we established in our early years through the influence of family, teachers, friends, religion, our culture, our education.

Given that all of us have differences which have been shaped by our life experiences, we can understand that we will all have different sets of values and beliefs. We do not all think about issues in the same way! To work effectively it is critical to understand your own values and beliefs and to understand the importance of not allowing them to affect the way in which you work with clients. Remember they are your values and may be quite different to the values held by your clients.
In order to remain professional it is necessary to leave your personal values out of the client/worker relationship. This means that it is important that you allow clients to make decisions based on their own values and beliefs rather than decisions that reflect what you think they should do. When we are carrying out our daily duties at work we rarely think about our attitudes, we are immersed in work itself and often remain unaware of just how different our attitudes could be to others around us.

**What is a belief?**

Beliefs come from real experiences but often we forget that the original experience is not the same as what is happening in life now. Our values and beliefs affect the quality of our work and all our relationships because what you believe is what you experience. We tend to think that our beliefs are based on reality, but it is our beliefs that govern our experiences. The beliefs that we hold are an important part of our identity. They may be religious, cultural or moral. Beliefs are precious because they reflect who we are and how we live our lives.

**Pre-existing beliefs:** As a care worker in the community services industry, the pre-existing beliefs you may have could be related to stereotypes that have developed for you around issues like sexuality, alcohol and other drugs, ageing and disabilities, independence, health, the rights of people, your idea of health and what it’s like to be older and/or disabled.

These stereotypes could affect the way you interact and work with clients. This is because you have assumptions about what your clients can and can’t do for themselves, the way they should think about issues and what is best for them. If you make assumptions as a worker then you are denying clients their rights, respect and dignity. As a worker this would be regarded as a breach in your duty of care towards clients.

**The impact of community values and attitudes regarding sexuality, ageing and disability**

Older people have sexual desires just as younger people do. The belief that they lose interest and are no longer to maintain a sexual relationship is a myth. Basically there is little deterioration in the aged person’s capacity to enjoy a fulfilling sexual life as they grow older. Residents who form relationships may be content to simply enjoy talking and participating in activities together. Companionship may be all that is sought and needed. However, there may also be a desire to express mutual affection in physical ways.

Therefore, the aged care team needs to be aware of residents’ requirements regarding intimacy and sexuality. For instance, residents need to have appropriate privacy to ensure their intimacy needs are met. In a study of older female residents, by Butts found that comfort touch (i.e. back rub, massage, hand holding, a friendly hug) improved residents’ perceptions of themselves.

As awareness of ageing is strongly ingrained in our society, most people are very conscious of the kinds of behaviour expected at a certain age. This would not be a problem if such beliefs did not result in the acceptance of stereotypes about older people and lead to discrimination on the basis of age. The way we talk, the clothes we wear, even the sport and exercise we undertake may indicate ‘age appropriate’ behaviour. After all, we make sense of age through recognising significant milestones, such as birthdays and anniversaries.
Consider some of the more common myths and attitudes in relation to sexuality and ageing.

**Older people don’t have sexual desires/older people don’t participate in sexual activity**

One recent survey of married people and sexual activity found that married couples over 60 years of age engaged in sexual intercourse, at least once a month, in the following patterns:

- 60-65 age group, 65%
- 66-70 age group, 55%
- 71-75 age group, 45%
- 76 and older, 24%

**Sexual desires decrease (or disappear) with age:** We are all different. For some, sexual desires may decrease with age. A man may have more difficulty achieving or sustaining an erection. A woman may have less interest in sexual intercourse, and more interest in cuddling and fondling. Older people may have less need to express their sexuality in spontaneous acts of love-making, often typified by the spontaneity of youth. For others, sexual desires may take on new meaning, eg: the expression of sexuality without the pressure of raising a family, earning a livelihood, attending to the business between 9.00 am and 5.00 pm every day. The expression of sexuality may be different – more considered, less hasty, smoother or more seamless in participation, more considering of ‘the other’. Sexuality may be expressed through different means and activities.

**If older people DO have sexual desires, they shouldn’t express these desires:** Some people have the attitude that if older people do have sex, they shouldn’t. It is seen as somehow unseemly, undignified or indecent. At best, it is considered ‘cute’. ‘Isn’t it sweet the way those two people keep sneaking off to each others’ rooms. And the way they always hold hands, whenever they think no-one is looking?’.

**Older people don’t enjoy sex:** Research indicates that people who have experienced an active and satisfying sexual life will continue to feel this way in later life. Many people have commented that later-in-life sexual activity can be the most satisfying expression of sexuality. As an example, some women have reported experiencing their first orgasm after menopause. For others, the time and space for relaxed love-making, the wealth of experience of a life-time of relating, of sexuality, brings a new dimension of intimacy to sexual relating.

**Older people aren’t attractive:** Consider the myths of attractiveness. Our society promotes an attitude or value that indicates ‘attractiveness’ is the domain of the young (and preferably falling within the tight parameters of body size X, hair colour Y and personality type Z). We need look no further than the billboards and advertising hoardings that adorn our roads, the percentage of gross domestic products devoted to anti-ageing creams and ‘stay young’ cosmetics and the tragedy of anorexia and bulimia. Our culture is one highly oriented towards body consciousness – within tight constraints.

Is it possible that, as society (and the individuals that make up that society) mature, we will come to consider ‘attractiveness’ as something more than skin deep? That we will consider such attributes as charisma, wisdom, personal magnetism, dignity, curiosity, enthusiasm for living, a positive approach to all endeavours, are all indicators of attractiveness? It is also worth considering that the images portrayed in the mainstream media are painted by those not yet old. Old age is seen as being a time of infirmity, of contraction, of illness and decrepitude. Rarely is ageing seen as a time of expansion, of wisdom, of open-hearted joy or sexual fulfilment.
Sexual changes associated with ageing

The following are some of the physiological and Psychological changes may affect an older person’s sexuality:

**The physical changes are:**

- The time for foreplay increases
- The frequency of intercourse decreases
- The lubrication of the vagina diminishes
- The intensity of orgasm diminishes in men and in some women
- The level of interest in sex in women often increases after menopause because they no longer fear pregnancy
- The use of drugs such as anti-depressants, alcohol, tranquilizers, blood pressure medication affects sexual performance.
- Illness or admittance to a Residential facility can affect an older person’s sexuality

**Psychological changes that affect sexuality in older people are:**

- The sense of helplessness that the aged feel when they cannot function as independently as in the past.
- The fear of losing one’s sexuality as a result of physiological changes
- The level of self-esteem is affected when physiological changes occur
### Seven

**Supporting the older person to express their own identity and preferences without imposing own values and attitudes**

1. How can aged care workers assist clients in maintaining what they consider to be normal lifestyles?

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<tr>
<th>MAINTAINING LIFESTYLES</th>
<th>WAYS TO ASSIST</th>
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<td>Keep client involved in social activity groups/ services</td>
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<td>Physical fitness</td>
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<td>Personal hygiene</td>
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2. Why are a worker’s personal values and attitudes as an aged care worker an influencing factor when it comes to supporting the philosophy of ‘positive ageing’?
Adjusting services to meet the specific needs of the older person and provide services according to the older person’s preferences

While most people receiving care in their home or an aged care facility appreciate being cared for, workers must be aware of the need to encourage the person’s independence by balancing providing care with encouraging the person in performing activities independently. It is vital that the person retains and continues to practise skills required for their daily routines. In practice it can be quicker to take over the task rather than encouraging and supporting their efforts, however it is critical that all care is tailored to maximise the person’s abilities. Therefore it is important that workers assist the client to evaluate their existing skill level and the need to maintain or increase their current level.

This is because:

- If the person is involved in the process from the beginning, adjustments to skill levels can be designed by the person themselves with assistance from others as needed
- Adjustments to skill levels may require the person to make changes or modifications to routines. Any adjustments need to suit the person’s preferences. People who are involved in these types of adjustments are more likely to be accepting of such adjustments. This has a positive impact upon the effective implementation of goals relating to the adjustments
- It is empowering to the person to be involved in any adjustment to existing skill levels, and increases his or her sense of control over any changes made in response to increasing age and decrease in functional skills
- The process of evaluating and selecting whether to maintain or increase existing skill levels involves summarising information and presenting it in a way that all parties can compare options and arrive at the best decision
- Summarising and presenting information includes providing written information and supporting this with descriptive information or explanations about what maintaining or increasing skill levels involves. Group discussions and one-to-one discussions can also be helpful in making sure that all parties have a chance to gain all the information they need, and to have their say.

Deciding whether to maintain or increase skill level

When comparing options, in order to choose, it is helpful to compare them in relation to practical aspects. Considerations such as costs and requirements in terms of staff are only two aspects that strategies may be compared. There are many other aspects that need to be considered.

Decisions need to be selected on the basis that maintaining or increasing existing skill levels:

- Are safe
- Will be of positive benefit to the person
- Will not be of harm or unduly limit the person’s opportunities
- Are in line with the Disability Service Standards and the Disability Services Act or Aged Care Standards
- Promote independence
- Promote extension of skills that may be used to support other areas that are weaker
- Are possible within existing or potential resources
- Are achievable
- Do not reduce the person’s opportunities to participate to the highest possible level in the community
- Are favoured by the person.
Discussing decisions

Attitudes, beliefs and values will impact upon the discussion of strategies. Therefore it is important to maintain certain values when discussing any adjustments.

Such values may include:

- Upholding the value of the person as an individual and rights to choice and self-determination
- Providing opportunities for increasing the individual’s competence and confidence
- Meeting the identified need of the person.

The following strategies can help in such discussions:

- Allowing extra time for the discussion, particularly for people who have complex communication needs, who have hearing difficulties, or who have difficulties concentrating on new information
- Providing communication supports to help the person to understand the information (e.g., pictures, diagrams, photographs)
- Being prepared to rephrase and repeat information as necessary for people who take longer to integrate and understand new information with what they already know
- Using plain English or simple language to explain options
- Giving many opportunities for the person to ask questions or to clarify what is being discussed
- Describing the several options or choices and laying these out in a clear way that promotes discussion without confusion
- Demonstrating and showing the person through experience what the strategy will involve
- Giving the person the opportunity to have more information and ask questions
- Providing reassurance and encouragement to try new things
- Building small steps into a strategy so as to build competence and confidence
- Providing a mechanism for review or changing the strategy
- Building in a ‘trial’ period
- Giving clear feedback about progress during any trial of a strategy
- Being prepared to alter the strategy to suit the individual’s needs
- Starting small and having a long-term vision for later steps.
Providing services according to organisation policies, procedures and duty of care requirements

Policies and procedures
Organisational policies and procedures exist to ensure a high standard of service is provided in a safe manner and client rights are respected.

Organisational guidelines should cover:
- Access and equity
- Client rights
- Cultural diversity
- Client participation in care plans
- Consideration for clients’ special needs
- Security and privacy of clients and their information.

Organisational guidelines must be clearly documented and accessible by staff and clients.

A care worker must:
- Follow the policies and guidelines
- Consult with the supervisor if unsure of role or best course of action in a situation
- Understand work roles and responsibilities
- Report accidents, incidents and errors immediately to the supervisor
- Know emergency procedures and act immediately if required
- Keep accurate and regular records as per documentation requirements
- Provide information to other services providers as required but maintain the boundaries of privacy and confidentiality
- Use appropriate skills to successfully work in a multi-disciplinary team
- Be open to advice and guidance from others.
Legislative framework

Legislation related specifically to aged care, child care, palliative care, youth services and to the care of people with disabilities etc will be relevant according to the community service sector in which the organisation operates. Workers also need to know their rights and responsibilities under the industrial legislation that applies in their state or territory. Industrial legislation, statutes and regulations impact on work conditions, wages, working hours and the obligations of employers and employees.

Work Health and Safety Bill 2011: Work health and safety is the responsibility of everyone. Your employer has a duty of care for occupational health and safety to provide a safe working environment for workers and clients. All employers are required to consult with staff on any issues which may affect their health and safety.

Under the Work Health and Safety Bill 2011, each state and territory regulates its own health and safety legislation. There should only be very slight variations to that legislation between the states and territories. All states and territories and the Commonwealth have worked together to develop and implement model Work Health and Safety (WHS) legislation as the most effective way to achieve harmonisation of WHS laws in Australia. By reducing costs and eliminating unnecessary administrative processes, harmonisation is designed to make it easier for workers and for employers who conduct business across multiple states.

Disability Discrimination Act 1992: The Disability Discrimination Act 1992 prohibits discrimination against people with a disability in a range of areas including transport, education, employment, accommodation and public premises. While the Building Code of Australia contains specific provisions for access to and around new and existing buildings for people with a disability, the Disability Discrimination Act does not provide any technical details on how to provide that access.

Mental Health legislation: The Mental Health Act states that interference with the rights, privacy, dignity and self-respect of people with mental illness must be kept to the minimum necessary in the circumstances. The Act also establishes the procedures for beginning involuntary treatment, by making involuntary treatment orders and through independent review.

The current legislation in the states and territories is:

- New South Wales: Mental Health Act 2010
- Victoria: Mental Health Act 1986
- Queensland: Mental Health Act 2000 – subordinate legislation: Mental Health Regulation 2002
- Western Australia: Mental Health Act 1996
- Tasmania: Mental Health Act 1996
- Australian Capital Territory: Mental Health (Treatment and Care) Act 1994

Medication Legislation and Regulations: The State and territory Legislation relevant to the aged care sector could include the following areas of Legislation, Regulations and Standards:
Relevant legislation is:

**Drugs, Poisons and Controlled Substances Regulations:** The Drugs, Poisons and Controlled Substances Regulations (1995) apply to the administration of medications in health services. These Acts vary from state to state, so it vital that community care workers are familiar with the specific requirements of the Act administered in the state in which they are employed, if part of their position description requires that they supervise the taking of medication.

**Therapeutic Goods Act 1989:** The Therapeutic Goods Administration (TGA) is Australia's regulatory agency for medical drugs and devices. The primary objective of the Therapeutic Goods Act is to establish a system of controls relating to the quality, safety, efficacy (how effective therapeutic goods, including medicines, are) and timely availability of therapeutic goods used in Australia or exported from Australia. Some provisions such as the scheduling of substances and the safe storage of therapeutic goods are covered by the relevant state or territory legislation.

**NSW legislation**
- Therapeutic Goods and Poisons Act (1966)


**Equal Opportunity 2010 (VIC):** Equal Opportunity legislation dictates regulations regarding equal treatment of staff and users of the service without discrimination on the grounds of race, sex, ethnic origin, pregnancy, marital status, age or religion. There are specific provisions that forbid sexual harassment. Harassment may not always be physical. Your organisation will have policies that reflect the requirements of the Act. Equal Employment Officers are trained to ensure that there is no discrimination or harassment in the workplace and that people who want to make a complaint are informed of the procedures to do so. Make yourself familiar with Equal Opportunity procedures that apply in your workplace and who the EEO contact person is.


**Sex Discrimination Act 1984 (Commonwealth. No. 4, 1984):** An Act relating to discrimination on the ground of sex, marital status, pregnancy, potential pregnancy or family responsibilities or involving sexual harassment.


**Freedom of Information Act 1982:** The Freedom of Information Act 1982 creates a general right of access to information in documentary form in the possession of Ministers and agencies limited only by exceptions and exemptions necessary for the protection of essential public interests and the private and business affairs of persons in respect of whom information is collected and held by agencies.

**Guardianship and Administration Act 1986:** The Guardianship and Administration Act 1986 establishes a legislative regime to enable persons with a disability to have a guardian or administrator appointed when they need a guardian or administrator. The Guardianship and Administration Act also governs the performance of medical and dental treatments, special procedures and medical research procedures on people aged 18 years or older who have a disability (intellectual impairment, mental disorder, brain injury, physical disability or dementia), where that person is incapable of deciding whether to consent to the procedure.
Health Records Act 2001: The Health Records Act 2001 creates a scheme to regulate the collection and handling of health information in Victoria. The Health Records Act does not override other legislative regimes for confidentiality (such as section 120A of the Mental Health Act) or access to information (such as freedom of information), but rather complements and supplements those regimes. The Health Services Commissioner administers the Health Records Act.

Aged Care Act (1997): Based on this Commonwealth Act the industry develops standards and guidelines:
- Standards and Guidelines for Residential Aged Care Services
- Home and Community Care National Service Standards
- Aged Care Accreditation Standards
- Disability Service Standards.

Home and Community Care Act 1985: The Commonwealth provides funding under the Home and Community Care Act 1985 (HACC Act) for a range of personal, health and domestic services to help frail aged and other people with disabilities and their carers. These services are intended to help people with moderate, severe or profound disabilities to maintain independence in their homes and in the community.

The program developed from a consolidation of a number of Commonwealth and state- and territory-funded programs in 1985. As a result, there were numerous differences between the states and territories in its early operations, many of which persist. The variations have significant implications for Health in developing mechanisms to achieve national consistency in the administration of HACC, coordination with other support programs, and the equitable provision of HACC services between, and within, the individual states and territories.

Mandatory Notification: Child abuse and neglect are broad terms (defined more precisely in State legislation) where a child is in need of care and protection. Notification of child abuse, in keeping with the ‘partnerships/whole of community’ approach, is the responsibility of all members of the community. In other words, any member of the public is able to report concerns of child abuse to the relevant department in that State.

Further to this, most jurisdictions have legislation that mandates certain professions to notify instances of abuse or suspected abuse. In other words, these jurisdictions specify professionals who are legally obliged to notify child protection services when they have formed a belief that there are reasonable grounds that abuse is occurring. At the time of writing, all States except Western Australia have mandatory notification legislation. You will need to check on the status of mandatory notification provisions in your State and, more specifically, who is legislated as a mandated notifier.

Who is mandated to make a notification?

The groups of people mandated to notify their concerns, suspicions or beliefs to the appropriate statutory child protection authority range from a limited number of specified persons in specified contexts (Western Australia, Queensland) through to every adult (Northern Territory).

The relevant Acts and Regulations in the Australian Capital Territory, New South Wales, Queensland, South Australia, Tasmania, Victoria and Western Australia contain lists of particular occupations that are mandated to report. Some states have a limited number of occupations listed, such as Queensland (doctors, departmental officers, and employees of licensed residential care services) and Victoria (police, doctors, nurses and teachers). Other jurisdictions have more extensive lists (Australian Capital Territory, South Australia, Tasmania) or use generic descriptions such as "professionals working with children".
Legal and ethical considerations for working with older people

What are ethics?

Ethics are the standards, beliefs or motivation for behaviours that are valued by you as an individual or valued by a group to which you may belong. Ethics are similar to morals and are 'internal'. However, the law is concerned with prescribing conduct and is 'external' to individuals.

These values, beliefs and attitudes each of us has about:

- How things should be in the world
- How people should act in certain circumstances
- How the important aspects of life are handled (e.g. Money, family, relationships, power, male and female roles).

These beliefs and attitudes are extremely important and personal. Values are formed and absorbed by us all as we develop from childhood and through adulthood. Community service workers are constantly working in a legal and political environment, but sometimes the problems you face in your work are ethically based rather than legally based. It is important for you to be able to understand the difference between ethical and legal problems/issues.

The ethical framework for working in the community services sector has now largely been formally documented through agreed legislative statutes. All work undertaken within the community services sector must reflect an understanding and compliance with relevant local, state, national and international statutory and legislative requirements, including those relating to workplace practices, human and civil rights and specific client service delivery.

Code of ethics

Community service organisations will have a code of conduct (or code of ethics/practice/behaviour), which outlines the ways in which management and staff should conduct themselves at work and when representing their workplace. A code of conduct outlines the organisation’s position on issues such as behavioural standards, equitable service delivery, reporting procedures, complaints management, duty of care and the provision of non-discriminatory work practices, conflict of interest, client interactions, confidentiality etc.

The code provides behavioural guidelines for workers. Managers and supervisors are, therefore, responsible for ensuring that employees understand the organisation’s code, know how to access it and know what to do if they consider that any action on their part or that of other stakeholders might breach the code. To meet the requirements of industrial relations legislation, a disciplinary process should be in place within the organisation. Any breaches of policy, procedures or ethical misconduct should be handled through this disciplinary process.
Bias and discrimination

What is discrimination?

Discrimination toward or against a person or group is the prejudicial treatment of them based on certain characteristics. It can be positive behaviour directed towards a certain group, or negative behaviour directed against a certain group. Every person in the workplace needs to work to eliminate any bias or discrimination against a group or individual. By learning more about your clients or co-workers you can often overcome issues that might arise through personal biases. Some discriminatory behaviour in the workplace can be racist jokes or cartoons, not giving people information in a format that they understand and segregation or stereotyping.

What is normal?

The term 'normal' can end up causing many problems. Normal is a value-laden, excluding concept that often prevents acknowledgement of the diversity of people, their life experiences and situations.

You should avoid using the term 'normal', as it is incorrect and can be offensive.

Avoid or minimise discrimination or bias in the workplace by having...

- Cross cultural work teams and training
- Use of interpreters and/or cultural brokers
- Inclusion policies around decision-making
- Work places free of culturally insensitive literature, posters, signage or cartoons
- Cross cultural employee representation on committees
Duty of care

In all areas of community work, the capacity to exercise a duty of care and operate within a legal and ethical framework is of paramount importance. The term ‘duty of care’ is a legal concept that defines those circumstances where the law will hold that one person is liable to another where, as a result of the first person failing to take reasonable care, that other person is injured. What constitutes ‘reasonable care’? There is no single answer. It will depend upon all the circumstances. Exercising ‘duty of care’ does not mean following a set of prescribed steps. There is no checklist or instruction manual. The legal interpretation of Duty of Care is usually determined when considering breaches of Duty of Care – that is, after the event.

Such determinations on a case–by-case basis are informed by Commonwealth and State legislation and industry and organisational standards including:

- State/Territory legislation, for example, in relation to Mandatory Reporting
- Professional and occupational standards defining responsibilities and limitations of the job role
- Client service standards
- Organisational Codes of Conduct
- Definitions of job roles in position descriptions and industrial awards
- Training and skills of the worker
- Instructions from supervisors.

All community services workers have a duty of care responsibility at a number of levels:

1. **Workers have a duty of care responsibility to themselves as individuals.** They must ensure that all care is taken to remain safe and healthy in the workplace, to comply with accepted practices, codes, procedures and any relevant professional and/or occupational standards.

2. **Workers have a duty of care responsibility to others in their workplace and to their employers.** This usually involves compliance with workplace standards of conduct, and with accepted procedures and practices, including presenting the organisation to the public and to others. Under current WHS legislation, workers have responsibility in accordance with the scope of their job role to identify workplace hazards and to take action to reduce risk of harm.

3. **Workers have a duty of care responsibility to clients.** This can have many interpretations depending on the job role requirements. It could cover issues such as:
   - Confidentiality of information
   - Safety and security
   - The quality of the services provided
   - Taking action in specified situations
   - Reporting, e.g. of child abuse.

Duty of care is a problematic area for community service workers whose clients are particularly vulnerable – for example due to age, disability or illness. While the worker’s first instinct may be to help their client, for example by contacting family members for assistance, the worker may find that they have in fact not exercised a duty of care to their client by breaching their right to privacy.
Roles and responsibilities in aged care work

There are various roles and responsibilities in aged care work, taking into account both seeking extra support and outside assistance. The most important role of an aged care worker is to provide direct care to their clients in order to fulfil their needs to the best of the carer’s ability and within organisational guidelines.

In order to be an effective carer, you need to use your knowledge of aged people and the problems/issues associated with the ageing process. You need to use the skills you have learnt, to assist you to provide the appropriate level of assistance and support to your clients. Through your actions and feelings you can support and assist your clients to live as independently as possible, follow their interests, and exercise their individual rights.

You need to empathise with your clients and listen to their desires. Through the use of effective communication and listening skills and by demonstrating a professional, organised, reliable and flexible approach to your work, you gain the trust of your clients and are more fully equipped to assist them with their daily living tasks. Care workers represent organisations who arrange work for them either on a paid or voluntary basis. It is therefore important for care workers to understand that they have responsibilities to the client and the community services and health sectors.

A multi-disciplinary team, made up of people from a wide range of professions, may include:

- Nursing staff
- Physiotherapists
- Doctors
- Occupational therapists
- Dieticians
- Podiatrists
- Speech pathologists
- Social workers
- Psychologists
- Leisure/recreational coordinators
- Community workers
- Volunteers
- Family members and friends and administration staff.
A carer is responsible for carrying out the instructions that are detailed in the client care plan. A care plan is a comprehensive and individualised document identifying all essential, accurate and relevant information about a client’s needs, personal preferences, and past and current care programs. The care plan identifies what action is required by a carer to fulfil individual client needs and to maintain maximum well-being of the client. All service providers will have access to relevant and accurate information about the client, their response to care and their progress. To achieve continuity of care, all service providers need to refer to and include information on the care plan, thereby ensuring that the care plan provides a common goal or common outcomes through effective communication and team work.

As a carer, you must follow the instructions detailed on the care plan on a daily basis and your responsibility is to ensure that the information provided is accurate and up-to-date. A care plan is a living and continually changing document that needs to respond to the changing care needs of the individual. Your supervisor will re-assess the client and adjust the care plan accordingly. Record any significant changes in your client’s condition or situation that you observe, and report the changes.

**Work role boundaries – responsibilities and limitations**

Support needs to be provided within the context of your role. In particular you need to be clear about what your responsibilities are and what they are not. There are boundaries around your role defined by your skills, knowledge, levels of responsibility and the scope of the tasks you perform. There are times when you will be tested to the limit of these boundaries and beyond, but it is important when this happens to do what you need to do and then pull back and seek expert advice or assistance.

Organisational policies and procedures will also place boundaries around the nature and the extent of the work you do. Workplace health and safety policies limit what you can do to ensure the health and safety of workers and consumers. Information management is bound by the Privacy Act and organisational policies and procedures derived from this. It is important to be confident in performing your role, so do not simply rely on your reading of a position description. Discuss its meaning and scope with your supervisor to ensure that you understand exactly what is expected of you, what you are responsible for and what the limits or boundaries of your work are.

**Standards and Regulations**

**Aged Care standards**

Many community service and non-government organisations rely on government funding, for their existence. This requires them to account for expenditure and to implement public policy in the delivery of their services. In order to receive government funding, organisations need to implement policies and procedures, that adhere to strict standards and which are readily revised and improved on. This is known in the healthcare circles as ‘continuous improvement’. In setting their own standards for service provision organisations must abide by the rules laid down in the quality care principle 1997, including:

**Accreditation Standards: the process to be followed, for organisations, to be recognised**

**Standards for Aged Care facilities:** The Accreditation standards for residential care are made up of four principles, and 44 expected outcomes and are gazetted as part of the Aged care Act 1997 in the Quality of Care Principles. The following standards reflect the quality management and services expected of a residential aged care service. Residential aged care services are assessed against these standards to determine their suitability for accreditation.

**Standard 1: Management Systems, Staffing and Organisational Development**

This standard is intended to enhance the quality of performance under all accreditation standards, and should not be regarded as an end in itself. It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality.
This standard covers:

- Continuous Improvement
- Regulatory compliance
- Education and staff development
- Comments and complaints
- Planning and leadership
- Human Resource Management
- Inventory and equipment
- Information systems
- External services.

Standard 2: Health and personal care

Residents' physical and mental health will be promoted and achieved at the optimum level in partnership between each resident and or his or her representative and the health care team.

This standard covers:

- Clinical care
- Specialised nursing care needs
- Medication management
- Nutrition and hydration
- Skin care
- Continence management
- Behavioural management.
- Mobility, dexterity and rehabilitation
- Oral and dental care
- Sensory loss
- Sleep.

Standard 3: Resident lifestyle

Residents retain their personal, civic, legal and consumer rights and are assisted to achieve active control of their own lives within the residence and in the community.

This standard covers a range of areas related to the individual's lifestyle, including:

- Compliance with regulations
- Emotional support
- Independence
- Privacy and dignity
- Leisure interests and activities
- Choice and decision making
- Resident security of tenure and responsibilities.
**Standard 4: Physical environment**

Residents live in a safe and comfortable environment which ensures the quality of life and welfare of residents, staff and visitors.

This standard covers a range of areas related to an individual's physical environment, including:

- Compliance with relevant guidelines
- Living environment
- Fire, security and other emergencies
- Infection control
- Catering, cleaning and laundry services.

**Continuous Improvement**

What is continuous improvement?

Continuous Improvement is defined as: The Macquarie Dictionary defines the words ‘continuous’ and ‘improvement’ as:

- **Continuous**: Uninterrupted in time; without cessation.
- **Improvement**: A bringing into a more desirable or excellent condition; making more valuable; making or becoming better.

Continuous improvement involves:

- Progressively increasing value to residents and other stakeholders through changes designed to better address their needs and preferences
- Enhancing performance against the Accreditation Standards
- Commitment to identifying needs and opportunities for improvement in a systematic and planned way.

The pursuit of Continuous Improvement means that there is no ceiling to the level of quality. It is not just about meeting standards, even when standards have been met – the quality of service can always be improved. Even when excellent care and services are already being provided – applying the principles of ‘Continuous Improvement’ is a matter of ‘raising’ the bar’.

The system to manage Continuous Improvement would generally involve:

- A set of underlying principles, for example: what is the thinking that lies behind the approach?
- A set of standards
- A self assessment approach to enable ongoing review against the standards and/or the principles.
- An approach to planning and implementing the required or desired improvements
Community Care Common standards: On the 1 March 2011 the Community Care Common Standards (CCCS) replaced the HACC National Service Standards across Australia. The CCCS are part of an ongoing process of reform by the Australian Government and State and Territory Governments that has been underway since 2005 to develop and streamline arrangements in community care. The CCCS are applicable to the Home and Community Care (HACC) Program, Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACHD) and the National Respite for Carers Program.

There are three standards:

1. Effective Management
2. Appropriate Access and Service Delivery and

EACH Standards: The EACH standards are intended to provide a structured approach to the management of quality. They specify care and services to be delivered to the care recipient and provide clear statements of expected performance.

The EACH Standards deal with the following matters:

Part 1: Information and consultation.

Part 2: Identifying care needs.

Part 3: Co-ordinated, planned and reliable service delivery.

Part 4: Social independence.

Part 5: Privacy, dignity, confidentiality and access to personal information.

Part 6: Complaints and disputes; and

Part 7: Advocacy.

DVA Veterans Home Care

DVA has adopted HACC National Service Standards as a basis for the VHC standards. While the title of each objective matches that for HACC and NRCP there are a number of differences in the objective statements and the Consumer Outcomes.
### Comparison of HACC and DVA VHC standards

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<tr>
<th>Objective 1 - Access to Services</th>
<th>Objective 1 - Access to Services</th>
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<tr>
<td>Consumer outcomes include formal assessment for each consumer.</td>
<td>There is reference made to ‘assessed need’ and ‘eligible veterans’ with no direct reference to formal assessment. The underlying Service Standard Principles make direct reference to the assessment tool to be used and how this tool can be used to prioritise services.</td>
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<tr>
<th>Objective 2 - Information and consultation</th>
<th>Objective 2 - Information and Consultation</th>
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<tr>
<td>Consumer outcomes require consumers to be aware of their rights and responsibilities.</td>
<td>Consumer Outcomes make reference to eligible veterans being informed about VHC assistance available and the ability to make informed choices. However, there is no reference made to ‘eligible veterans’ being informed of their rights and responsibilities. The Service Standard Principles make reference to veterans and carers involvement in the development of care plans and service arrangements.</td>
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<th>Objective 3 - Efficient and Effective Management</th>
<th>Objective 3 - Efficient and Effective Management</th>
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<td>Additional Consumer Outcomes that include reference to management views in regard to quality improvement and also direct reference to OHS legislation.</td>
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### Standards and Accreditation:
There are many Industry Standards that are to be adhered to within the community services and health sector. The aged care industry operates within a highly legislated (and by extension, ‘accredited’) context. The primary legislation is the Aged Care Act 1997. From this Act stem a number of accreditation standards and expected outcomes (44 in all). ‘Accreditation’ refers to the formal recognition that explicit standards have been attained by a particular worker, service or agency. The monitoring and administration of accreditation is via the Aged Care Standards and Accreditation Agency (under the Aged Care Act 1997).

**The role of the agency is as follows:**
- Managing the accreditation process
- Promoting high quality care
- Helping the industry to improve quality standards
- Identifying best practice standards
- Liaising with the department of health and ageing where organisations do not meet standards.
Eight

Providing services according to organisation policies, procedures and duty of care requirements

1. What is the purpose of an organisation's policies and procedures?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

2. Explain what regulatory/ accreditation quality standards apply in relation to delivery of services.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

3. What does an aged care worker need to comply with when providing care in the home and community care sector?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
4. What is your understanding of duty of care?

5. You assist an elderly client who lives in their own with activities of daily living. Lately they have become withdrawn. You notice bruising on their arms, but when you mention this, they put it down to ‘old age’. What would you do?

Deliver services within a quality framework

Case Study

The Grange Villa Nursing Home is having a re-accreditation visit. The Accreditation Team has asked to meet with the personal care assistants. At this meeting, one of the Accreditation Team asks the PCA: ‘How do you feel about residents’ rights? John (a resident) has complained about having baked beans for his evening meal on more than three occasions last week. Is this a complaint you feel obliged to address?’

6. Discuss this case study in terms of how the Aged Care Act and Aged Care Standards should frame the Personal care assistant’s response to the Accreditation Team.
Element 3: Support the rights of older people

Assisting the older person to understand their rights and the complaints mechanisms of the organisation

It is important for those of us working with older people to promote the rights of older people to independence, dignity and respect, as well as the right to fair access to services and community resources. When working with older people we need to respect these rights while being aware of some of the more common difficulties older people may experience so that we can adapt our work to meet their needs.

Older people also have the right to:

- Privacy
- Dignity
- Confidentiality
- Freedom of association
- Right to lodge a complaint and to utilize grievance procedures
- Right to express ideas and options
- Right to an agreed standard of care in health services
- Access to services in the community.

Individual’s rights in contributing to care

As a worker in the aged care industry, you must always keep in mind that your clients have not given up their basic rights, just because they have reached a point in their lives where they now need to access care services. The individual client must always be included in the planning of their care, and in the development of their individual care plan. There must be an individual care plan for each client. This plan gives details of all aspects of the care required by the client.

This will include, obviously, medical information, but will extend too to items such as:

- Food preferences
- Medical treatment and/or the refusal of treatment in certain circumstances
- Time of day preferred for shower/bath
- Cultural and/or religious beliefs and practices.

The development of this plan begins from the client’s first contact with the service. Following assessment by an ACAT, the client will be referred for community care services or for admission to a residential facility. From the initial contact, all staff involved must be aware of and observe the clients, their preferences and practices. Before any change or addition is made to a care plan, the client should always be part of the consultative process, or, if the client is not competent to make their own decisions, a relative or guardian should speak for them.
Clients are also able to speak on and participate in the general running of a care facility. As part of the formal agreement that should be in place between residents in a care facility and the organisation, there is a provision that the client has the right to speak on a range of issues affecting the running of the facility, and to participate in residents’ committees, where they exist, or to establish a residents’ committee where they do not.

Likewise, clients of HACC funded and home-based community care services, have the right to provide feedback and suggestions to the organisation/s responsible for providing that care. In government funded facilities, at least, the clients’ rights to this input is protected by various pieces of legislation, not least the Privacy Act and the Freedom of Information Act.

The complaints process

Most aged care providers do their best to provide quality care and services for older Australians. When issues do occur, it’s important that people can raise their concerns in a constructive and safe way.

An effective complaint handling system within an aged care service:

- Allows many issues to be dealt with quickly and effectively
- Can enhance the ongoing relationship between the service provider and the care recipient, their family and representatives
- Contributes to continuous improvement in the service.

The Aged Care Complaints Scheme (the Scheme) supports industry in resolving complaints within their service where possible. Effective resolution of complaints leads to improved aged care services for older Australians. It is also a legislative requirement under the Aged Care Act 1997 (the Act) that your service has an internal complaints resolution process.

The stages of complaint handling

An effective complaint handling process is fair, accessible, responsive, efficient and contributes to continuous improvement in service delivery. The aim is for care recipients, families, representatives and staff to have confidence in the complaint handling system.

Complaints resolved by the Scheme indicate that many cases can be resolved by following five steps:

1. **Acknowledge**: all complaints quickly.
2. **Assess**: the complaint, give it priority, and start to think about which resolution pathway you may take. Where required:
3. **Plan**: the type of information you may need to collect to assess the complaint, and how you will collect it
4. **Investigate**: the complaint to help inform your resolution approach.
5. **Respond**: to the complainant with a clear decision.
6. **Follow up**: any concerns.
7. **Consider**: if there are any systemic issues.

Some complaints may require the service provider to investigate the issues involved. However, most of the time a complaint can be resolved using other means such as conciliation. No matter the approach, and especially when an investigation is required, it’s important to have a plan. Regular contact with the complainant should be maintained throughout the process. It is especially important to keep the complainant informed if their complaint is taking longer to resolve than first advised.
Acknowledgement

A complaint must be acknowledged quickly. This demonstrates that the complainant will be treated with respect, and can be an important tool in managing the complainant’s expectations.

The acknowledgement should:

- Outline the complaint process
- Invite the care recipient and their representatives to participate in the resolution process
- Provide contact details and where possible the name of a contact person
- Reassure that confidentiality will be respected during the process
- Give an estimate of how long it’s likely to take to resolve the complaint and when the complainant will next be contacted.

Written acknowledgement can be beneficial, but is not always necessary. If the complaint is made by telephone and cannot be resolved straight away, it might be more efficient to talk to the complainant about how the complaint will be handled and when they will next be contacted. Ensure this phone call is documented. Similarly, a complaint that is made by letter and can be resolved quickly can sometimes be acknowledged and resolved at the same time.

Assessment and assigning priority

The nature of complaints differs widely. Some complaints can be resolved quickly through open communication or an apology. Sometimes the scope of a complaint is not clear and clarification is needed. More complex complaints may require service providers to investigate the underlying issues or make referrals to other organisations. Early assessment of a complaint is essential for effective complaint handling.

The assessment should include:

- Clarifying the concerns and issues raised by the complainant
- Determining the level of risk to the wellbeing, safety and health of care recipients and staff identified in the complaint
- Deciding whether priority should be given to dealing with one or more aspects of a complaint
- Asking the complainant how they would like to see their complaint resolved.

Often what the complainant is seeking will be straightforward — for example, an apology or small change in services. Some complainants want to raise awareness of a problem or ensure that other people will not find themselves in the same situation. The best way to establish a complainant’s expectation is to ask them what they are trying to achieve. What would resolve this complaint for them? Understanding this may be key to managing a complaint well. Some problems might not be easy to resolve, or the complainant may seek an inappropriate or disproportionate outcome. It’s important to explain why a request cannot be met, and it’s equally important to offer an alternative solution, if possible. Staff should have the authority to resolve straightforward matters. They must also be able to escalate matters that present risks or require more detailed examination.
Service Rights and Responsibilities

HACC Program Statement of Rights and Responsibilities

The HACC Program Statement of Rights and Responsibilities aims to ensure that consumers and agencies are aware of their rights and responsibilities and can be confident in exercising them. The need to promote respect for the rights of clients of HACC services in this way arises from the nature of their relationship with providers.

The HACC Program Statement of Rights and Responsibilities recognises that:

- The program assists people who are at risk of premature or inappropriate long-term residential care and their carers
- The program aims to enhance the quality of life and independence of those at risk people and their carers
- The program is administered within available resources and in accordance with the principles and goals set out in the HACC agreements.

Consumers of HACC funded services retain their status as members of Australian society and enjoy the rights and responsibilities consistent with this status. Providers of HACC services operate under the constraints of relevant law.

Consumer Rights

HACC consumers' key rights within the HACC Program are:

- The right to respect for their individual human worth and dignity
- The right to be treated with courtesy
- The right to be assessed for access to services without discrimination
- The right to be informed and consulted about available services and other relevant matters
- The right to be part of decisions made about their care
- The right to choose from available alternatives
- The right to pursue any complaint about service provision without retribution
- The right to involve an advocate of their choice
- The right to receive good quality services
- The right to privacy and confidentiality, and access to all personal information kept about the consumer.

Clients/consumer responsibilities

Consistent with their status as members of Australian society, consumers of HACC services have a responsibility:

- To respect the human worth and dignity of the service provider staff and other consumers
- To treat service provider staff and other consumers with courtesy
- For the results of any decisions they make
- To play their part in helping the service provider to provide them with services
- To provide a safe work environment for staff and help them to provide consumers with services safely.
HACC Service provider’s responsibilities

In providing services, service providers have a responsibility:

- To enhance and respect the independence and dignity of the consumer
- To ensure that the consumer’s access to a service is decided only on the basis of need and the capacity of the service to meet that need
- To inform consumers about options for HACC Program support
- To inform consumers of their rights and responsibilities in relation to HACC services
- To involve the consumer and carer in decisions on the assessment and service delivery plan
- To negotiate with the consumer before a change is made to the service being provided
- To be responsive to the diverse social, cultural and physical experiences and needs of consumers
- To recognise the role of carers and be responsive to their need for support
- To inform the consumer about the service to be delivered and any fees charged
- To inform the consumer of the standards to expect in relation to services they may receive
- To ensure that the consumer continues to receive services agreed with the provider, taking the consumer’s changing needs into account
- To respect the privacy and confidentiality of the consumer
- To allow the consumer access to information held by the service provider
- To allow the carer access to information held by the provider about the consumer where the carer is the legal guardian or has been so authorised by the consumer
- To deliver services to the consumer in a safe manner
- To respect a consumer’s refusal of a service and to ensure any future attempt by the consumer to access a HACC service is not prejudiced because of that refusal
- To deal with consumer’s complaints fairly and promptly and without retribution
- To mediate and attempt to negotiate a solution if conflict arises between the carer and the elderly person or younger person with a disability
- To accept the consumer’s choice and involvement of an advocate to represent his or her interests
- To take into account the consumer’s views when planning, managing and evaluating service provision.
The Charter of Residents' Rights and Responsibilities

A resident of an Australian Government subsidised aged care facility has the following rights:

[Note: the term ‘residential care service’ means the same as ‘aged care home’]

A. Each resident of a residential care service has the right:

- to full and effective use of his or her personal, civil, legal and consumer rights
- to quality care which is appropriate to his or her needs
- To full information about his or her own state of health and about available treatments
- To be treated with dignity and respect, and to live without exploitation, abuse or neglect
- To live without discrimination or victimisation, and without being obliged to feel grateful to those providing his or her care and accommodation
- To personal privacy
- To live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction
- To be treated and accepted as an individual, and to have his or her individual preferences taken into account and treated with respect
- To continue his or her cultural and religious practices and to retain the language of his or her choice, without discrimination
- To select and maintain social and personal relationships with any other person without fear, criticism or restriction
- To freedom of speech
- To maintain his or her personal independence, which includes a recognition of personal responsibility for his or her own actions and choices, even though some actions may involve an element of risk which the resident has the right to accept, and that should then not be used to prevent or restrict those actions
- To maintain control over, and to continue making decisions about, the personal aspects of his or her daily life, financial affairs and possessions
- To be involved in the activities, associations and friendships of his or her choice, both within and outside the residential care service
- To have access to services and activities which are available generally in the community
- To be consulted on, and to choose to have input into, decisions about the living arrangements of the residential care service
- To have access to information about his or her rights, care, accommodation, and any other information which relates to him or her personally
- To complain and to take action to resolve disputes
- To have access to advocates and other avenues of redress
- To be free from reprisal, or a well-founded fear of reprisal, in any form for taking action to enforce his or her rights.
Each resident of a residential care service has the responsibility:

- To respect the rights and needs of other people within the residential care service, and to respect the needs of the residential care service community as a whole
- To respect the rights of staff and the proprietor to work in an environment which is free from harassment
- To care for his or her own health and well-being, as far as he or she is capable
- To inform his or her medical practitioner, as far as he or she is able, about his or her relevant medical history and his or her current state of health.

Rights of people with disabilities

As well as directly supporting the rights of people with disabilities, the Disability Services Act provided for the establishment of Disability Services Standards for the services funded under the Act. These are readily available in book form, and can assist organisations and individuals in formulating policies and procedures for interaction with their clients with disabilities.

The Disability Services Standards cover all aspects of access to services for people with disabilities and sets down minimum supporting standards for organisations:

- Standard 1 – Service access.
- Standard 2 – Individual needs.
- Standard 3 – Decision-making and choice.
- Standard 4 – Privacy, dignity and confidentiality.
- Standard 5 – Participation and integration.
- Standard 6 – Valued status.
- Standard 7 – Complaints and disputes.
- Standard 8 – Service management.
- Standard 9 – Employment conditions.
- Standard 10 – Employment support.
- Standard 11 – Employment skills development.
- Standard 12 – Protection of human rights and freedom from abuse

It is important that you understand that every individual has the right to freedom and respect. They have the right to be treated fairly by others and these rights are not reduced in any way. A client’s rights remain the same, regardless of his or her physical or mental frailty, or ability to appreciate his or her rights. A positive, supportive and caring attitude from family, friends, and staff, carers and the community will help people who live in care facilities, or with care assistance, to continue as respected and valued members of society.
Nine

Assisting the older person to understand their rights and the complaints mechanisms of the organisation

Case study

Martha and James Baldock live in the neighbouring suburb to their son Phillip, his wife Judy and their children, Jenny aged eight and Matthew aged six years. After much deliberation, Judy has decided to return to her career in Public Relations, which will mean her working long hours and having to travel interstate from time to time.

Martha enjoys good health, apart from arthritis in the joints of both hands which restricts her ability to cook and carry out some household chores. James too is generally healthy, however, the after effects of a stroke four years ago have left him with a slight limp, diminished strength in his left arm and a minor speech impediment which becomes worse when he is tired or upset.

Martha and James are both upset at first when Phillip and Judy reject their offer to take care of the children when they are both working and/or away on business. The parents are aware of the older couple’s right to make decisions about the way they fulfill their role as grandparents, but have to consider other issues and others’ rights in making their own decision.

1. What do you think might be the reasons for Phillip and Judy refusing the offer of help from Martha and James?

2. Whose rights are being protected by the decision? Are anyone’s rights being violated by the decision? Think your answers through very carefully.
Delivering services ensuring the rights of the older person are upheld

All adults possess the right to make their own choices. They can decide for themselves where they live, who they live with, how they spend their money and so on. As they age, so their daily living needs might increase becoming more dependent. In these circumstances, it can be harder to make choices for themselves.

This is exactly what happens to older people who are being abused. They find it difficult to stand up for their rights, to make choices for themselves, particularly to the people who are abusing them. Assisting the older person to identify which of their rights has been abused is often the first step to take. An important right is the right 'to live in dignity and security and to be free of exploitation and physical or mental abuse'.

Sometimes those responding to an abusive situation may find it difficult to uphold the rights of the older person, particularly if the older person decides to do something that they don't agree with. For example, an older person might decide to still see the relative who visits them most often, even though they know this person only insults them whenever they do visit.

Tensions like these can be resolved by referring to the older person's right to make their own choices. This right is the most important in all circumstances where the older person has the capacity to make their own choices. So if it is the older person's wish to continue seeing the person who abuses them, it is their right to do so, and they should be supported. The home's stance in these circumstances is one of minimising the risk, or ameliorating the situation.

What are the ways that we can ensure client rights are upheld?

Keep clients informed: Clients need to be as informed as possible about their rights and responsibilities. Comprehensive information about the service should be provided at the referral and assessment stage, including information about the eligibility criteria (who can use the service), the assessment process, service rules, services offered, staff qualifications, confidentiality exclusions, client rights and responsibilities, complaints procedure and any fees involved. This can be in the form of an information handbook or pamphlet and should be in a format accessible to clients. For example, translated into relevant languages or in simple format for a client with an intellectual disability.

Client participation forums: Agencies need to have a structure in place for clients to have a say about the services being offered and what needs to be improved. This may be through representation on management committees, holding focus groups and surveying regularly to seek client feedback.

Monitoring by funding bodies: This varies across government departments and funding programmes; however funding bodies should play a role in ensuring that services are fulfilling their legislative and funding responsibilities in the area of upholding client rights. This may be through visiting agencies occasionally or written reports provided every year as part of the accountability process.

Making sure that clients know how to complain: Basic human rights include the right to be heard—better still, some rights, like legal rights, mean being able to take action to recover any lost rights or even seek compensation. Legitimate client complaints also provide valuable feedback to the service, so that services and staff can improve. Legitimate client complaints also provide valuable feedback to the service, so that services and staff can improve.
Advocacy
Advocacy: what is it?
An advocate is a person who speaks, argues or stands up for the rights and opinions of another.

To advocate is to stand up for or argue on behalf of and for the benefit of another.
To ensure people’s rights are maintained and upheld, sometimes advocating on their behalf or with them is necessary. Consent of the client is required to legally and ethically represent them in an advocacy role.

Understanding consent: Consent is a very important issue when dealing with advocacy. The client has the right to make decisions that affect their own lives. Most adults will automatically make such decisions. However, as they get older or become unwell, people sometimes begin to question their right to make important decisions, while others may assume that once a person becomes physically frail or unwell, their mental ability is diminished. As a result, friends, family and others involved in a care situation, may become more protective of the person, and attempt to begin to influence their decision-making, or to try to protect them.

Consent to advocacy: It is important that your decisions as an advocate are in the best interests of your client. Your client needs to be able to play some role in their own decision-making. It is important that your client gives their consent to any advocacy that is undertaken on their behalf. It is also important that they understand the specific actions that will be undertaken and that they give their consent to this as well. By gaining consent from your client for advocacy you are allowing them to play a role in the decision-making processes of their lives.

Informed consent: When your client gives consent for something to happen that means that they agree with it and support it. The concept of informed consent is slightly different. Informed consent means that your client would fully understand the situation, the possible consequences of the decision and agreeing to that decision. When your client agrees to something that they haven’t really understood, it is not informed consent. It is therefore very important that you, as an advocate, make sure that you get informed consent from your client before you take any action.

To make sure your client has given their informed consent you need to ask yourself certain questions, including whether the client can be expected to fully understand what the decision means. You might conclude that your client will need more information in order to understand any decisions or any actions.

National Aged Care Advocacy program
The advocacy support services funded under the National Aged Care Advocacy program provide independent advocacy for, and information to, older Australian recipients or potential recipients of aged care. The services also provide an important educative role for aged care recipients and government approved providers on the rights and responsibilities of aged care recipients including the Charter of Residents’ Rights and Responsibilities and the Charter of Rights and Responsibilities for Community Care contained in Schedules 1 and 2 of the User Rights Principles 1997 (Cth).

As advocacy and educative services, they have a particularly important role to play as a social accountability mechanism. Through their advocacy and educative roles, there is the potential for the community based organisations, aged care clients and their carers to be involved in monitoring the implementation of the reforms. This participatory monitoring should be encouraged, not only because of the principle of participation but also because of the particular vulnerability of Australia’s older population.

As part of the right to seek, receive and impart information, social accountability mechanisms such as the advocacy support services, working with aged care recipients and their carers together with civil society organisations, could undertake this monitoring role. There are many places where this external monitoring is taking place, either cooperatively with government or independently.
Identifying breaches of human rights and respond appropriately

Empowerment and disempowerment

Change in attitude towards ageing and affirmation of the rights of older people is necessary for empowerment of people as they age to become the norm. Empowerment links to inequality, because inequality tends to become more pronounced at both ends of the life course. The negative impact of inequality is a barrier to reducing absolute poverty and hinders the fulfilment of a variety of human rights, including the capacity to be heard. Empowerment also determines ability to extend opportunity and to enhance capabilities.

Disempowerment is closely connected to the denial of human rights, which is linked to loss of autonomy. The diminishing capacity to take decisions for oneself, either because of infirmity or because younger generations may assume that older people are incapable of taking decisions, is one of the defining features of (very) old age and is a key concern for older people’s human rights. Dealing with the autonomy question is therefore critical to any discussion of how to empower older people and ensure that even the oldest old and the most frail are empowered. Research suggests that the biggest threat to an older person’s autonomy (regardless of income levels) may come from family members who begin to make decisions on behalf of the older person and thereby disempower them.

Relevant international conventions on civil and human rights

Human rights

Human rights are rights that apply to every individual regardless of race, creed, ability, gender or age. The most famous declaration on Human Rights is that put forward by the United Nations in 1948, and known as The Universal Declaration of Human Rights. This is one of four documents that together are often called ‘The International Bill of Rights’.

These documents include:

- The Universal Declaration of Human Rights 1948
- The International Covenant on Civil and Political Rights 1966
- The International Covenant on Economic, Social and Cultural Rights 1966
- The Optional Protocol to the International Covenant on Civil and Political Rights.

The United Nations Declaration of Human Rights is based on the following principles:

- Physical integrity
  - This includes the right to life, liberty and freedom of movement
  - Individuals should be free from torture or punishment of any form

Mental and moral integrity:

- This includes freedom of thought, conscience and religion. It also includes the freedom to express your own opinion and form your own relationships.
Socio-economic rights:

These include the right to participate in and have access to:

- Work, leisure, education, health care, owning property, social security and a reasonable standard of living
- The right to have a family. This includes the right to be allowed to marry and to start a family
- Legal integrity and civil rights. This includes the right to have an elected Government and to have a fair trial before the courts.

(It should be noted that such documents are not legally binding until they are adopted by a nation’s Parliament.) The key point to be remembered in working with community services organisations is that everyone has the same rights. A person’s rights are not dependent on their age, the colour of their skin, their level of knowledge or education, their ability or disability.

Human Rights and diversity

Human rights require that aged care health services are respectful of difference and diversity. Health workers, for example, should be sensitive to issues of ethnicity and culture. This is not only a matter of human rights but it also makes sense. Thoraya Ahmed Obaid, Executive Director of the United Nations Population Fund has observed that ‘cultural sensitivity ... leads to higher levels of programme acceptance and ownership by the community, and programme sustainability’. A number of special groups are defined in the Aged Care Act and the Allocation Principles 1997 (Cth).

Special needs groups recognised in the aged care system

The Aged Care Act, section 11-3 specified the following special needs groups:

- People from Aboriginal and Torres Strait Islander communities
- People from non-English speaking backgrounds
- People who live in rural or remote areas
- People who are financially or socially disadvantaged
- People of a kind (if any) specified in the Allocation Principles 1997 (Cth).

The Allocation Principles 1997 (Cth), part 2A specifies the following groups as special needs groups:

- People who are veterans
- People who are homeless or at risk of becoming homeless
- People who are care-leavers.

Sources: Aged Care Act 1997 (Cth) and Allocation Principles 1997 (Cth).

The aged care reform package includes a total of $192 million over five years to better support people with special needs. The reforms focus on ensuring culturally appropriate aged care services for Aboriginal and Torres Strait Islander peoples and older people from culturally and linguistically diverse communities, more aged care support for veterans, and more assistance for older people who are homeless or at risk of homelessness.
Aboriginal and Torres Strait Islander peoples

The estimated resident population of Aboriginal and Torres Strait Islander peoples at 30 June 1991 was 351,000 people. In 2006, there were 517,000 people, representing 2.5 per cent of the total Australian population. Between 1991 and 2006 the population increased by 2.6 per cent per year on average, compared with 1.2 per cent for the total Australian population.

The population of Aboriginal and Torres Strait Islander peoples is projected to increase to between 713,300 and 721,100 people in 2021. This is an average growth rate of 2.2 per cent per year, compared with between 1.2 per cent and 1.7 per cent per year for the total Australian population over the same period. The number of older Aboriginal and Torres Strait Islander people (55 years and over) is projected to more than double over the period, from 40,000 in 2006 to between 82,000 and 86,600 in 2021.

Culturally appropriate care is essential for aged care services delivered to all older Aboriginal and Torres Strait Islander peoples and is particularly crucial for Aboriginal and Torres Strait Islander people with dementia. Though there are no national studies on the prevalence of dementia in Aboriginal communities, small studies suggest that the rate is much higher than that in the general population and that the onset is earlier. Access Economics noted a small study in the Kimberley region of Western Australia which sampled 400 members of the community aged 45 years and over finding a prevalence rate of 12.4 per cent (compared with 2.6 per cent in the Australian population generally). The study revealed that not only was there a much higher prevalence rate, but the onset was also much earlier than for other Australians. The impact of this disease on the individual, the family and Aboriginal communities is potentially devastating.

Aged care services for Aboriginal and Torres Strait Islander peoples are delivered through mainstream services, for example the Home and Community Care program (HACC) and also through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. The HACC program has a special advisory body, the National Aboriginal and Torres Strait Islander HACC Forum that provides input to policy and planning on Indigenous matters.

The Social Justice Report 2005 recommended that a human rights approach be adopted to address the health of Aboriginal and Torres Strait Islander peoples. This includes older Aboriginal and Torres Strait Islander people. Since that time the ‘Close the Gap’ campaign has been designed and implemented. The federal government should ensure that the provision of aged care services to older Aboriginal and Torres Strait Islander people is coordinated with this campaign.

Culturally and Linguistically Diverse older people

At 30 June 2010, data on the estimated resident population of Australia (22.3 million people) revealed that 27 per cent of the population was born overseas (6.0 million people). Over the past 60 years the overseas-born population has increased from about 1.3 million to 6 million.

One in five older Australians comes from a non-English speaking country, and the size of this group is growing faster than other segments of the older population. Although people from non-English speaking countries made up only 15 per cent of the very old population (85 and over) they represented 21 per cent of those aged 75–84 years and 23 per cent of those aged 65–74 years.

Over the coming decades, immigrants from non-English-speaking European countries, who arrived in Australia during the peak of post-war immigration up to 1971, will become a more significant part of the very old (85 and over), and Asian immigrants from countries such as Vietnam, Malaysia and the Philippines will become a more significant part of the younger old, with implications for provision of health and aged services.

While older people born overseas in non-English speaking countries are generally healthier than the rest of the older population, they can face barriers in accessing appropriate health and aged care services such as accessing information and services that are sensitive to their backgrounds, circumstances and language. Indeed, older members of culturally and linguistically diverse backgrounds (CALD) frequently revert back to their first language as a result of the ageing process. In the case of older people with dementia from CALD communities, culturally appropriate aged care
services with first language support are particularly crucial as the language most recently acquired is lost first.

To address the situation of access to services and to information, the aged care reform package includes funding to improve the accessibility of information materials as well as the skills and knowledge of aged care providers and their staff to meet the care needs of their clients. To assist with the implementation of aged care services that address the needs of older CALD Australians, the federal government has recently announced plans for the development of a specific CALD aged care services strategy to be developed before the end of 2012.

**Older Veterans**

Statistics show that an estimated 394,516 Australians received some form of assistance from the Department of Veterans Affairs (DVA) at 30 June 2007 of which 78 per cent were aged 65 years and over. It is also estimated that DVA clients make up at least 17 per cent of permanent residents of aged care services and 16 per cent of the packaged care (community aged care package, extended aged care at home, extended aged care at home – dementia) population.

In 2007, approximately 143,000 DVA clients had some experience of mental health concerns. The most common conditions are generalised anxiety disorder, depression, alcohol dependence and post-traumatic disorder. While the Veterans and Veterans’ Families Counselling Service provides counselling and group programs there is currently no additional funding provided for veterans with mental health problems that are in receipt of home care packages. The aged care reform package redresses this through the provision of additional funds to introduce these services to veterans in receipt of home care packages and to provide better services to veterans in residential aged care.

**Lesbian, gay, bisexual, transgender and intersex people**

The reforms will also work to improve the provision of aged care services for older lesbian, gay, bisexual, transgender and intersex (LGBTI) Australians through their inclusion as a special needs group under the Aged Care Act. This will assist members of the LGBTI community to access acceptable and appropriate care suitable to their needs.

Sexual orientation, sex and/or gender identity have important implications for the provision of aged care services as many LGBTI people have experienced unlawful discrimination over the course of their lives. It is thus imperative to ensure that this discrimination does not continue into the provision of aged care services.

Additionally, there are no comprehensive projections of the number and distribution of older LGBTI people. Nevertheless, it is anticipated that consistent with the ageing Australian population, there will be a large increase in the demand for aged care services by older LGBTI people.

**Women**

Ageing is gendered, with women tending to live longer than men. In 2010, just over 50 per cent of people aged 65–74 years in Australia were women. In the same year, women comprised 65 per cent of those 85 years and older. Women 65 years and over require more assistance than men for activities such as property maintenance, housework and transport. In 2004–05, home and community care services were provided to over 744,000 people, 75 per cent of whom were 65 years and over. Two thirds of these clients were women.

Additionally, there are clear gender differences amongst informal carers. Women make up over 69 per cent of primary carers of older people. Older men, particularly those aged 75 years and over, are more likely to be cared for by an older female carer and women in this age group are more likely to be cared for by a female carer.

The Australian Institute of Health and Welfare has noted that this sex composition of the older population has implications for aged care policy. The survival of women to more advanced ages means they will have higher levels of severe disability and are less likely to have a spouse carer. In 2010, women comprised 56.5 per cent of the 2.16 million recipients of the Age Pension, making it less likely for older women to afford private aged care services. The gendered nature of ageing also has implications for the human rights of women.
Women are not listed as a special needs group in the Aged Care Act. However, due to the multidimensional nature of the discrimination experienced by many women throughout their lives together with the gendered nature of ageing, it is essential to ensure the accessibility (including economic accessibility) and acceptability of aged care services delivered to older women.

The federal government and aged care providers need to ensure that the human rights of older women in receipt of aged care services are protected and respected. Monitoring of the accessibility and acceptability of aged care services to older women will assist this process. Monitoring will require the development of data indicators, disaggregated at least by age, sex, race, place of abode and geographical location, in order to better assess the situation of older women as recipients of aged care services and as carers.

**Other special needs groups**

Homeless people and those at risk of homelessness, care leavers and people who are financially or socially disadvantaged have also been acknowledged as special needs groups. It is important that this is the case. Due to their diverse circumstances, frequently resulting in discrimination on multiple grounds, these groups are particularly susceptible to having their human rights violated.

In addition to and also overlapping with these groups is a section of the older population with substance misuse problems. As the number of older Australians increases, so too will the number of older Australians with substance misuse problems. As with alcohol misuse, there is Australian evidence of misuse of prescribed drugs such as pain relief drugs, particularly among older Australians. Acceptable aged care services tailored to the specific needs of this group will require a health workforce with the competence to recognise and manage substance misuse. The federal government could consider planning for the demand that will arise with the ageing of this population group to ensure non-discrimination in access to aged care services. The human rights of special needs groups can be better respected and protected through the inclusion of disaggregated indicators in the national quality indicators. The indicators should measure access to services and be disaggregated, at least, on the grounds of age, sex, race, ethnicity, sexuality, place of abode, and socio-economic status.

**Human rights challenges for this area**

- Development of disaggregated indicators to better assess the situation of all older people with special needs. These indicators will need to be disaggregated, at least on the grounds of age, sex, sexuality, race, ethnicity, place of abode, socio-economic status
- Ensuring that amendments to the Aged Care Act are compatible with the human rights contained in the seven core treaties to which Australia is a party.

**Accountability and the Aged Care Sector**

The principal focus of human rights accountability is the degree to which the human rights of older Australians are respected. Accountability requires mechanisms that provide the opportunity for government and the community to identify what has been done well, to identify mistakes and to implement change. The provision of remedies for violation of human rights is important as it is the remedies that help make human rights real. Within the current aged care sector there are several accountability mechanisms.

**These mechanisms are:**

**The Aged Care Standards and Accreditation Agency**

The Standards and Accreditation Agency manages the accreditation of aged care homes in accordance with the Accreditation Grant Principles 2011. The accreditation process is linked with the quality of services as it provides the opportunity to identify what has been done well and to implement change where mistakes have been made. Homes found to have not met the Accreditation Standards are placed on a timetable for improvement, providing them with an opportunity to meet the Accreditation Standards.
Recognising the signs consistent with financial, physical or emotional abuse or neglect of the older person and report to an appropriate person

Elder abuse is a term referring to any intentional or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult. While elder abuse does not receive has much attention as the issue of child abuse, and while the incidence rate is lower, older people can be abused physically, emotionally, sexually and financially.

The reasons why people abuse older people are complicated and often there is more than one cause. It is not always obvious, or easy to understand why some people abuse others. However, things such as carer stress, which is the result of increased frustration and isolation that occurs because of the constant demand to meet the older person’s needs, tiredness and physical strain can sometimes be the cause.

A lack of carer support, poor self-esteem, a lack of money, the abuse/misuse of drugs and alcohol and a sense of powerlessness, or not having control over other things, are often seen as some of the other reasons, which contribute to a person’s likelihood to abuse others. Abuse may also be a continuation of domestic violence, which has existed in the relationship, for many years. These issues can make it hard for carers, care workers and other people in trusting relationships; however they never justify, or excuse abuse. Being abused affects the whole well-being of the older person – both their physical and emotional well-being, often for sometime after the abuse, has occurred.

Unfortunately abuse is difficult – not only for the older person but also for family members, friends and personal care workers. People close to the person may feel helpless and frustrated and may find it difficult to know what to do, or how to react and behave, especially if they are close to the older person and the person, causing the abuse. While it is essential that the safety and rights of the older person are maintained it is also important that the person causing the abuse has their rights respected and is supported in addressing their needs and concerns.

Types of abuse

Neglect: Neglect is a failure to provide the basic physical and emotional necessities of life. It can be wilful denial of medication, dental or medical care, therapeutic devices or other physical assistance to a person who requires it because of age, health or disability. It can also be a failure to provide adequate shelter, clothing, food, protection and supervision, or to place persons at undue risk through unsafe environments or practices and thereby exposing those people to risk of physical, mental or emotional harm. Neglect includes the failure to provide the nurturance or stimulation needed for the social, intellectual and emotional growth or well being, of an adult or child.

Physical abuse: Physical abuse is assault, non-accidental injury, discomfort, or physical harm to a person by any other person. It includes, but is not limited to, inflicting pain or any unpleasant sensation, causing harm or injuries by excessive discipline, beating or shaking, bruising, electric shock, lacerations or welts, burns, fractures or dislocation, female genital mutilation and attempted suffocation or strangulation.

Restraints or restrictive practices: Restraining or isolating an adult for reasons other than medical necessity or to prevent self-harm is considered abusive. This may include the use of chemical (e.g. medication) or physical means or the denial of basic human rights or choices such as religious freedom, freedom of association, access to property or resources or freedom of movement. These practices are not considered to be abuse if they are applied under a restricted practice authorisation.
Sexual assault: Includes any sexual contact between an adult and child 16 years of age and younger or any sexual activity with an adult who lacks the capacity to give or withhold consent, or is threatened, coerced or forced to engage in sexual behaviour. It includes non-consensual sexual contact, language or exploitative behaviour and can take the form of rape, indecent assault, sexual harassment or sexual interference in any form.

Psychological or emotional abuse: Psychological or emotional abuse includes verbal assaults, threats of maltreatment, harassment, humiliation or intimidation, or failure to interact with a person or to acknowledge that person’s existence. This may also include denying cultural or religious needs and preferences. Also included are the inflictions of psychological or emotional suffering or fear, including actions that lead to fear of violence, to isolation or deprivation, feelings of shame, loss of dignity, humiliation, intimidation or powerlessness.

Financial abuse: The illegal or improper use of the person’s property, resources, finances and other assets without their informed consent or where consent is obtained by fraud.

Recognising signs of abuse

Staff and management play an important role in protecting clients from further harm by recognising the indicators of abuse and responding to them. The presence of one or more indicators does not mean that abuse has occurred but does require staff to be vigilant on the client’s behalf. Indicators of abuse are not always obvious, and while clients or others may suspect that abuse has occurred there might not be any evidence to confirm the suspicion. Indicators are variable, and people who are familiar with clients and have a strong positive relationship with them are best placed to recognise behavioural changes that may suggest a client is being abused.

Reporting abuse

- All staff has a duty to report abuse, assault or neglect immediately in accordance with their organisation’s documented procedures
- All incidents and allegations of abuse are to be documented and reported to a manager
- Any concerned person can make a report or an allegation without fear of reprisal
- Services must respond promptly and appropriately to allegations in accordance with documented procedures
- Where the person provides consent, the relevant person responsible/ guardian/ support person is informed of the allegation of abuse
- Privacy and confidentiality must be assured
- Access to information, legal support, advocacy and counselling are to be provided.
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Identifying breaches of human rights and respond appropriately

1. What would constitute a breach of human rights in the aged care sector?

2. What are some indicators of elder abuse?

3. Describe the principles of access and equity.
Assisting the person to access other support services and the complaints mechanisms as required

Making complaints accessible

Making a complaint should be easy.

An effective complaint handling system is accessible to care recipients and relies on complainants:

- Knowing how to complain and who to complain to, and
- Being able to complain.

A complaint handling system needs to be available to anyone who wishes to make a complaint. Complainants need to be informed that they have a right to complain and how they can complain. Service providers should ensure that their complaints policy is well publicised and freely available to care recipients and their representatives.

This can include:

- Providing a ‘how to complain’ information sheet to care recipients and their representatives
- Advertising the complaints policy and staff contact details on posters, publications and websites
- Actively seeking feedback as part of ongoing conversations
- Frequent reminders in different formats that complaints are welcome.

Care recipients and their representatives should be encouraged to raise concerns with:

- Any staff member at any time
- A nominated staff member who handles complaints when the complaint cannot be resolved immediately
- A resident representative
- The scheme, if a resolution cannot be found within the service.

Better practice complaints handling allows complaints to be made in a variety of ways.
This can include informal and formal ways, such as:

- Using a suggestions box
- Using a ‘quick fix’ complaints book where staff and care recipients can write down simple problems and how they were fixed
- Using forms to capture complaint details
- Accepting anonymous complaints
- Having an internal appeals system for dissatisfied complainants
- Having a senior member of staff available to hear complaints at all times
- Having regular care and family conferences
- Regular reminders that service management and staff value feedback
- Training staff to be proactive in listening to potential and actual complaints
- Promoting the scheme
- Promoting local advocacy services
- Providing all information in plain, friendly language.

**Assisting complainants**

It’s important to assist complainants with accessibility needs where required.

This can include providing assistance related to:

- Literacy and language skills
- Cultural and linguistic backgrounds
- Physical, mental, cognitive and sensory abilities.

Some complainants may have difficulty making a complaint either verbally or in writing and should be offered help from staff to communicate their concerns. Where English is not the first language, a family member, friend or professional translation service can be used to facilitate complaint handling. The National Relay Service (NRS) provides a free service to assist conversations with people who are deaf or have a speech or hearing impairment.

The NRS can enable conversations over the internet using web browser technology (including on smartphones, PCs and tablet computers) and over the telephone. Aged care advocacy services can assist any care recipient or representative to make a complaint, including complainants with mental or cognitive impairments. The Scheme can also facilitate assistance.
Eleven

Assisting the person to access other support services and the complaints mechanisms as required

1. Where would you find information about resident’s rights and responsibilities?

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2. What would you do if you became aware that resident’s rights were not being upheld?

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3. What are your organisation’s policy and procedures for managing complaints from clients/family/carers? If you are not working, your trainer will provide you with access to a complaints policy. You can then discuss how complaints are managed based on the policy you have

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Element 4: Promote health and re-ablement of older people

What are health and wellness and reablement?

**Wellness:** is a term that describes an approach to community care delivery that focuses on whole of system support for clients’ independence, by changing the way that all people involved in service delivery work with people receiving services.

A **wellness approach:** involves redesigning the model of service delivery in community care, starting from the premise that people who are frail or disabled as a result of chronic disease or injury, have the capacity to make gains in their physical, social and emotional well-being and can continue to live autonomously and independently in the community if positively supported to do so.

It involves reorienting the practice of people involved in service delivery and the management of services, so that those services can be tailored to respond to individual needs and goals. More flexible and responsive approaches to service delivery present challenges to the way service delivery is organised through service providers.

**Dimensions of wellness**

There are eight dimensions of wellness that influence a person’s ability to function at a healthy level.

The dimensions of wellness are:

1. **Physical Wellness:** a lack of illness and/or disability
2. **Emotional Wellness:** an ability to cope and manage stress
3. **Intellectual Wellness:** the ability to think, reason and remember
4. **Social Wellness:** the ability to connect with a support system of family and friends
5. **Occupational Wellness:** the ability to work and/or volunteer
6. **Spiritual Wellness:** a sense of purpose and meaning beyond one’s self
7. **Environmental Wellness:** feeling safe at home and around the community
8. **Financial Wellness:** having sufficient money to meet basic needs.

When interacting with older people, consider how reduced levels of wellness may put them at risk and how you can help keep their life in balance.
For example:

- A person facing physical, emotional or intellectual challenges may struggle to live independently and meet basic needs.
- A person who is alone and isolated may face social and emotional challenges, increasing the risk for neglect and abuse.
- If you sense an older person needs additional support, consider which dimensions of wellness are being most affected. This can help you determine his or her specific needs and how to respond. For example, an older person needing emotional or social support may need a hand to hold and a heart to understand. A person with physical challenges may need help with daily living activities and transportation.
- Many older people find it difficult to ask for or accept assistance because of pride or stubbornness. If you sense someone has unmet needs or is neglecting him or herself, call your local agency on aging.

Reablement: refers to short term targeted interventions pitched at tertiary prevention for people who already have a well established level of frailty or disability as a result of age, chronic disease or both. General, these interventions are low intensity and low in cost. In the UK, reablement has been defined as:

> ‘Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living.’

Both terms are used to distinguish the approaches they describe from a medical model of rehabilitation.

Reablement programs: tend to be led by allied health professionals, particularly physiotherapists and occupational therapists but can be delivered by vocationally qualified workers. They are highly goal focused and time limited. The goals, however, are not so much clinical goals but goals meaningful to the person/client that then motivate them to engage. The interventions tend to be functionally specific programs of exercise, adjusted tasks and physical activity, geared around the activities of daily living that, over a defined period, will increase the person’s strength, balance and physical condition, with consequential and collateral benefits for their ability to continue to perform the activities of daily living without assistance.
Encouraging the older person to engage as actively as possible in all living activities and provide them with information and support to do so

Encouraging the older person to engage

Although ageing may lead to new lifestyles and create new needs the essence of a person remains very much the same. We do not stop being one person and suddenly become someone else once we reach later life and the way we cope with the changes that accompany growing older will very much depend on our personal values and beliefs and our life experiences. Being able to maintain contact with neighbours, friends, local groups and people generally in the community are all ways in which people maintain a sense of purpose, identity and connectedness which are important for social and emotional well-being.

Older people who are able to contribute in a meaningful way to the running of the community, whether it be through paid or voluntary community activities or helping younger and/or older family members, have a sense of purpose and meaning in their lives and are more likely to feel they are valued and respected members of society. Older people who cannot maintain strong family and community relationships can be socially isolated and can experience feelings of being ‘left-out’ or excluded.

In order to develop effective relationships with older people, care workers need to understand and imagine what it would be like for the older person at this particular point in their life. While all these things are very important, perhaps the most important thing that care workers can do is to remember that each person ages differently and that no two people experience ageing in the same way. It is important to listen carefully to older people so that you can find out about their desires and preferences and then try and fulfill these to the best of your ability.

Let’s look at some of the interests or needs that older may have or experience to enhance their quality of life:

**Lifestyle and Leisure:** The choices older people make regarding their use of their time has implications for both their health and their wellbeing. According to the Australian Bureau of Statistics older people spend more time on passive leisure activities such as reading, watching television and relaxing. On average older people spend 1 hour per day more watching television, than the rest of society. They only spend 10% of their time on social and community interaction. This includes entertainment such as the theatre, religious activities and sporting events.

**Leisure and recreational needs:** Older people have the same leisure and recreational needs as other age groups. The need to meet and socialise with other people does not diminish with age and as you learnt earlier many older people view later life as an opportunity to travel and pursue hobbies and interests that they have not had time for previously because of family and work responsibilities. People who are involved in activities outside the home tend to be more positive about ageing and gain much enjoyment and satisfaction from being able to interact, and maintain relationships with other people.
Exercising voting rights, and other social responsibilities for the older person: An older person has just as much right to vote or drive as any other individual in society. Each individual a carer will come across in their profession will have varying needs for assistance in the following matters:

- Maintaining voting rights
- Maintaining a valid driving licence
- Registering vehicles (especially for those clients still living at home)
- Paying rates and taxes- if living at home.

Access to transport: Transport is very important in maintaining independence and quality of life. Not being able to access transport can lead to social isolation and a general deterioration in social and emotional well-being. An older person's ability to access transport depends on a number of different things, including where they live, how much they are able to pay for the transport and their physical health.

Maintaining family and community relationships: Family life and relationships with family members are very important to older people. Families are often the largest source of emotional, practical and financial support. Close family relationships, the giving and receiving of support, having fulfilling family roles and caring for family members is very important to most people. Many older people feel that a full family life has a positive impact on their overall self-esteem and sense of well-being. Contact with grandchildren can help older people maintain a youthful outlook and provide a sense of belonging and a means by which family and cultural history can be passed on.

Being able to continue to learn: Research has shown that older people who participate in adult education classes experience feelings of achievement and self worth which have a positive effect on their social and emotional well-being. Continuing to learn throughout life can enable older people to keep up-to-date with social changes; which means they are more likely to maintain meaningful relationships with younger people in the community.

Learning can also assist older people with the use of new technologies, such as new communication equipment, which can prevent isolation by enabling them to maintain contact with family members and friends if they have limited mobility or are separated because of distance. New technologies, such as internet shopping, automatic teller machines (ATMs) and equipment that can assist with completing everyday living activities can also assist them to remain independent. There is a growing movement in many countries including Australia known as the University of the Third Age. ‘University of the Third Age’ is an organisation providing low-cost educational opportunities for people in active retirement. The elderly also are participating in mainstream courses such as TAFE colleges and Universities.
Twelve

Encouraging the older person to engage as actively as possible in all living activities and provide them with information and support to do so

1. How would you encourage older people to attend social and recreational activities of choice?

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2. How would you promote the older person’s esteem and confidence?

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Providing the older person with information regarding relevant support: Coordinators should provide a range of opportunities for their clients to obtain information and develop skills. They should keep in mind individual differences and needs in the types of information provided and how it is provided.

Information and skill may be provided by:

- Direct contact with clients as a groups or individually
- Group training
- Providing brochures and information packs
- Referring clients to other sources of information such as websites or community groups
- Information sessions provide by other health professional, organisations, or agencies
- Helping clients to access information from government organisations, such as Centrelink.

Providing information in a suitable format: Relying on print media or verbal communication only to get your message out will place many people with a disability at a disadvantage. Presenting your material in a range of formats allows a wide range of groups in the community, not just people with a disability, to access information. Some formats cater to the needs of more than one disability group, and some will be of benefit to the community in general. The following is a brief description of suitable formats for different disability groups.

People with vision impairment:

Effective ways of providing information to people who are blind, or have a vision, impairment, include:

Large print: Text can be produced in a variety of sizes to meet individual needs. Printed material should ideally be in a sans serif font and 16 point, with a minimum size of 11 point. Use a text colour that contrasts with the background (avoid red and green type as they have poor contrast and make it difficult for people to read). Black type on white or off-white background is optimal. Use style devices such as underlining, italics and hyphenation sparingly.
**Information and communication technology:** Providing information electronically, either on a website, through email or an electronic file/document, can be a good option if the information is prepared in an appropriate format. Unlike sighted people, most computer users who are blind or vision impaired do not use a mouse. Many use a screen reader or, in some cases, a Braille keyboard. A screen reader is software that works with a speech synthesiser to read aloud everything on a computer screen, including icons, menus, and text, punctuation and control buttons. It reads across the screen from left to right, one line at a time.

Because this software will attempt to ‘read’ any formatting — for example, instead of reading columns from top to bottom it will read the first line of text in the first column and then jump across to read the first line of the next column. For this reason, it is best to keep formatting (including tabs and tables as well as columns) to an absolute minimum in your document. Information provided electronically should also be able to be enlarged by users to suit their needs. Advice and guidelines for creating accessible websites are available from the World Wide Web Consortium website (www.w3.org/WAI).

**Audiotape/CD•ROM:** Newsletters, books and reports can be produced on audiotape or CD-ROM. It is best to use an organisation that specialises in the production of audio material for people with a print disability.

**Braille:** Braille is used by a small proportion of people who are blind. Documents on computer file can be converted into Braille using Braille conversion software and printed out by a Braille embosser.

**People with a hearing impairment:** Effective ways of providing information to people who are deaf or have a hearing impairment include:

- **Written/printed information:** Printed information should be written in plain English and include cartoons, diagrams, photographs and pictures to help communicate your message clearly.

- **Captioning:** Captioning films, videos and television programs and advertisements assists viewers who are deaf or hearing impaired to understand what they are not able to hear.

**TelephoneNumber typewriter (TTY) and/or National Relay Service (NRS):** Organisations can communicate with people who are profoundly deaf through the use of a TTY or the NRS.

- **Sign language:** Skilled sign-language interpreters are available for seminars, meetings, conferences and other community events.

- **Audio loop:** An audio loop in public meeting places such as halls, churches, seminar rooms, lecture theatres and schools will allow people who use hearing aids to participate.
Health care approaches /Models of care and support

A number of models of care may be referred to in relation to provision of appropriate support.

**What is a model of care?**

A "model of care" broadly defines the way health services are delivered. It outlines best practice care and services for a person or population group as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place.

**The model describes:**

- Types of activities to be delivered to clients by a provider, health professional, or care team
- Types of services to be provided by an organisation
- The appropriate stage for an activity or service to be delivered
- The location or context that the activity or service will be provided in
- The health care team and community partners that will provide the service
- The policy framework for the model of care.

**Consumer Directed Care (CDC):** Consumer directed care (CDC) empowers the consumer to have more control over their own life and be in charge of decisions about their lifestyle and support matters. It focuses on the person’s life goals and strengths, placing their needs at the centre of the services and support (including aged care and health services). The person makes choices and/or manages the services they access, to the extent they can and wish to do so, including who will deliver the services and when.” (COTA Australia, 2014)

**What does CDC mean - to consumers?**

“CDC is about the fact that most people have managed their lives all their life and want to go on doing so, despite challenges they face.” (COTA Australia, 2013). Consumer Directed Care essentially enables individuals requiring home care packages to determine how they will be supported through the provision of services that are designed around what they believe will help them live independently at home.

**Positive ageing**

Positive Ageing -is a philosophy built around the concept that ageing is ‘part of life’s journey’ and that the elderly should be recognised as active, valued members of our society who can continue to contribute, learn and develop themselves. National Strategy for an Ageing Australia is based on the principles of ‘positive ageing’ and was released by the Federal Government in October 2001.
The Principles Guiding the National Strategy are:

- The ageing of the Australian population is a significant common element to be addressed by governments, business and the community. All Australians, regardless of age, should have access to appropriate employment, training, learning, housing, transport, cultural and recreational opportunities and care services that are appropriate to their diverse needs, to enable them to optimise their quality of life over their entire lifespan.
- Opportunities should exist for Australians to make a life-long contribution to society and the economy.
- Both public and private contributions are required to meet the needs and aspirations of an older Australia.
- Public programs should supplement rather than supplant the role of individuals, their families and communities.
- A strong evidence base should inform the policy responses to population ageing.
- The delivery of services and pensions for our ageing population is affordable so long as we have a well managed economy and growth.

The United Nations have also embraced the concept of ‘Positive Ageing’ and have developed Age-friendly Standards. They suggest the development and implementation of standards that can be utilised by policy makers to restore function and expand the participation of older people in all aspects of society.

Such standards could include:

- Making the environment accessible to all through “universal design”
- Setting standards for traffic regulation, transport systems, quality of street lighting and pavements
- Supporting the implementation of devices that increase capacity (for example door handles suitable for use by the elderly and disabled)
- Supporting the adoption of a more holistic model of care in health and social care provision to include social, environmental and economic factors.

Activity Theory: explains that older people who continue to seek activity in their older age are more motivated and able to function fully in their older life.

Validation Theory: relates to the recognition and “validation “ of each individual as a person of worth , with a history of life experiences and belief, philosophies and networks.

Disengagement Theory: relates the powerlessness and social isolation felt by older people as they leave active employment. The theory is based largely on the effects of capitalism and its influence of our role and status within society. As we get old, younger people in society expect us to fade away or not be functional in retirement. Therefore older people feel powerless and often worthless because of society’s views.

Social Construction Theory: Relates to influence that ageism has on the status of older people and how the younger people in society view older people. This influences the way older individuals value themselves, perceive their worth and develop motivation and positive ageing.

The Active Ageing model of care

The World Health Organisation ‘Active Ageing’ framework (WHO, 2002) has been developed to overcome key criticisms of previous models. The term ‘active ageing’ was chosen in order to emphasise the valuable contribution older people make to their families, communities and society. It is defined as “the process of optimising opportunities for physical, social and mental well being throughout the life course, in order to extend healthy life expectancy, productivity and quality of life in older age (WHO, 2002, p. 12.) It emphasises the value of continued involvement across six life domains: social, economic, civic, cultural, spiritual and physical.
The WHO definition of Active Ageing comprises three key pillars:

1. **Participation**: lifelong learning, paid and unpaid work;
2. **Health**: achieving and maintaining good physical and mental health in later life; and,
3. **Safety**: ensuring the “protection, safety and dignity of older people by addressing the social, financial and physical security rights and needs of people as they age”.

There are some similarities between an Active Service Model and the WHO ‘Active Ageing Framework’; they both aim to keep older adults “engaged in life” for as long as possible. They both emphasise a focus on the quality of older people’s lives and their engagement in the community (Wistow, Waddington, & Godfrey, 2003).

They are consistent with an ecological approach to wellness, which suggests that well being comes from family, community and social engagement, stepping outside ourselves and becoming enmeshed in a web of reciprocal relationships and interests (McMurray, 2007). From this perspective, improvements in a person’s health and functional capacity are necessary but not sufficient. Measures to (re)connect people into community involvement and social relationships are essential.

**Victorian HACC Active Service Model (ASM)**

The Victorian HACC Active Service Model (ASM) is characterised as a quality improvement initiative that explicitly focuses on promoting capacity building and restorative care in community care service delivery. It has taken as its point of departure the work on wellness undertaken in WA with some elements of reablement programs in the UK and NZ.

The Victorian HACC Active Service Model is based on the premise that all clients have the potential to make gains in their wellbeing and that Home and Community Care services can support improvement. Our approach is to strengthen good practice and build capability through quality improvement. The goal of the Active Service Model is for people in the HACC target group to live in the community as independently and autonomously as possible. In this context, independence refers to the capacity of people to manage the day to day activities of their daily life. Autonomy refers to making decisions about one’s life.

Not all HACC clients will be able to live independently and autonomously, but the goal of this initiative is to ensure that clients are able to gain the greatest level of independence they can and want to achieve, and equally, that they can be as actively involved in making decisions about their life as they can and want to be – such as the type of services they receive and the goals they wish to achieve.

**The principles underpinning the Active Service Model are that:**

- People wish to remain autonomous
- People have the potential to improve their capacity
- People’s needs should be viewed in an holistic way
- HACC services should be organised around the person and his or her carer, that is, the person should not be simply slotted into existing services, and
- A person’s needs are best met where there are strong partnerships and collaborative working relationships between the person; their carers and family; support workers and between service providers.

**Person-centred care:** Traditionally, decisions regarding the type of support to be provided to an individual were made primarily by health professionals. These models of care focused on the impairments and inabilities of a client, creating a negative psychological framework from the beginning. A person-centred care approach to care delivery however, is designed to empower an individual by emphasising self-determination and independence.

Care plans are developed with an emphasis on what is important to the individual client, now and in the future. In provision of person-centred care, a client’s talents, skills and abilities are identified; with workers listening to what is really important to the individual. The principles of human rights, independence, choice and social inclusion underpin this model.
**Strength-based practice**: Strength-based practice is a solution focused theory, again emphasising the individual’s self-determination and strengths. This model also focuses on the client, their choice of future outcomes and their individual strengths, to ensure they are well placed to deal with any problem or crisis.

Strength-based practice increases the capacity of individuals, groups, families and communities to respond to their own challenges. Clients are empowered by being treated with respect and having their strengths acknowledged and enhanced. They are actively listened to, so individual strengths and resources can be identified and future goals and ambitions fully understood. Support can then be provided to address difficulties or obstacles to the client achieving these goals.

**Current best practice service delivery models**

There are several current theories or ideas that drive the basic principles behind organisation policies and legislation.

**Examples of these include:**

- Least restrictive alternative
- Social justice
- Equity.

It is important that you understand each of these current theories in order to fully understand the philosophies of organisations that work within this field.

**Least restrictive alternative**

The least restrictive alternative expresses the idea that if freedom and dignity of an individual is important, then the control over that individual’s life by government or organisations should be limited. The statement and idea of least restrictive alternative applies to people with disabilities, specifically those with intellectual disabilities. The least restrictive alternative principle may be translated into practice whereby individuals are provided with the level of support they require without it intruding unnecessarily into their lives.

The aim of this idea is to provide individuals with greater levels of independence. A couple of good examples are that people with disabilities are encouraged and empowered to move away from institutionalised residence and children with disabilities are enabled more access and more integration within mainstream schools.

Several organisations in Australia that work with and provide services to people with disabilities have adopted the least restrictive alternative principle. In other words, they aim to provide services that assist people with disabilities in gaining greater levels of independence without restricting their freedom. If employed by an organisation that has adopted the least restrictive alternative principle, you will find yourself continually balancing the worker’s duty of care towards their clients against the client’s right of choice and dignity of risk.

**Social justice**

There are three key issues that make up the principle of social justice: access, equity and participation. Social justice is concerned with ensuring every member of society has equal rights, equal access to resources and equal participation in decision-making, that is, each member of society should have equal rights, equal opportunity and equal access to the resources provided by society as a whole. The principle of social justice has relied heavily on changing attitudes through legislation such as the **Disability Discrimination Act 1992**.

**Equity**: Quite simply, equity means having equal rights with every other person in society, regardless of background, gender, age, culture, status, colour, disability or sexual preference.
A Palliative Approach

Palliative care provides clients with relief and comfort when there is no cure for their illness and measures to extend the person’s life are discontinued. A person receiving palliative care has an active, progressive and far-advanced disease such as cancer, dementia or Alzheimer’s disease, with no prospect of cure. Palliative care is the specialised care of people who are dying.

The World Health Organisation defines palliative care as ‘an approach that improves the quality of life of clients, their family and carers facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual’. The NSW Department of Ageing, Disability & Home Care defines palliative care as ‘the active total care of people whose disease is not responsive to curative treatment’.

The aim of palliative care is to:
- Control and provide relief from pain and other distressing symptoms
- Neither hasten nor postpone death
- Integrate the psychological and spiritual aspects of client care
- Offer a support system to help clients live as actively as possible until death
- Offer a support system to help clients’ families cope during the clients’ illness and in their own bereavement
- Regard dying as a normal process.

Understanding grief and loss

Although not always named, grief is central to the experience of mental illness — for people diagnosed, their families and their friends. Grief is the emotional, spiritual, physical, mental and behavioural response that we have to loss. This loss may be the loss of someone through death, but it can also refer to other losses such as the loss of a homeland for migrants or refugees, the loss caused by the end of a relationship, the loss of a job, one’s health, a pet or the loss of innocence. The loss may be through giving up something highly valued. There is a loss to be grieved when a child or a partner is diagnosed with mental illness.
Kubler-Ross' stages of grief

Elizabeth Kubler-Ross looked at grief in relation to people facing death and dying, however it was soon realised that this framework could apply to other losses that people experience. Mental illness, like any other illness, implies a loss of health and this may progress to other major losses that can affect every area of a person’s life and those who have been near to them, eg: through marriage breakup, loss of income and career.

The loss of the sense of being in control can be devastating for someone whose life is disintegrating around them. This is where the Kubler-Ross stages of grief framework give some comfort, turning the grieving process into an opportunity to refresh hope. The following stages suggested by Kubler-Ross will be examined in the light of those affected by mental illness. Also, the stages are not to be seen as progressive. The person may skip a stage or revert to an earlier stage.

Denial: In this stage, the person is unable or unwilling to accept their loss. In the early stages of grief and loss, this may seem a safe place to be. Some professionals believe that people with major mental illnesses lack insight into the fact that they are ill and therefore denial may be seen as another symptom of how unwell they are. Denial can shows that a person is in shock about the seriousness of their loss or change in health and that they are not prepared to accept a hope destroying view of the future.

Anger: Anger can be experienced by family, friends and carers, as well as the person with the condition. Statements such as, ‘Why me? I don’t deserve this,’ or ‘What has our family done to deserve this?’ may be used. Although such statements are often said in anger, they can also indicate the commencement of a search for meaning. Finding meaning is fundamentally linked to the concept of ‘hope’. You may have heard the saying, that without ‘meaning’ there is no ‘hope’ and without ‘hope’ there is no ‘meaning’.

Bargaining: Therese Rando (1993, Treatment of complicated mourning, Research Press, Champaign, IL, USA) considers that losses force a person to review their beliefs and the resources they can confidently draw upon. When there appears to be no possible means of overcoming the loss alone, appeals to a ‘higher power’ and promises of a changed life in return can dominate this stage, eg: ‘if you make my illness go away, I promise I will become a better person’.

Depression: When a person gives up on being angry and trying to bargain, the frustration of lost expectations lays the ground for depression. This is the danger stage where sleep is disturbed, diet is ignored and general withdrawal from friends occurs. Since these behaviours are already involved in major mental illnesses, it can be difficult to sort out the grief associated with the losses involved in mental illness from the illness itself.

Acceptance: The final stage is the acceptance of loss and a re-engagement with life. This does not mean that the individual has been ‘cured’, but that acceptance has provided them with a renewed hope that life can be lived to the full within the bounds of their capabilities. They are less likely to be focused on what they can no longer do.

Rando’s framework

Therese Rando a researcher and clinical psychologist has framed the grief process using six Rs:

1. Recognise the loss.
2. React emotionally to the loss.
3. Recollect and re-experience.
4. Relinquish (ie: let go).
5. Readjust.
6. Reinvest.

This framework emphasises the grief process as an opportunity to reprioritise a person’s direction and to rebuild their life with renewed hope.
Showing compassion

True compassion lies at the heart of comforting. However, compassion can run dry like a well without some understanding of the grieving process. We show our compassion for others by recognising their suffering and desiring to relieve them of it. We can be compassionate people by helping them with the tasks at hand. How do we know what to do? We can simply ask. We might help notify family and friends of the death. We might prepare the home to receive the many visitors who may arrive. We could organise the collection of food that others will bring. We might ask if we could watch the children for the family to give parents some time to themselves. We can help in everyday, practical ways.

Listening with compassion

Almost everyone worries about what to say to people who are grieving. But knowing how to listen is much more important. Oftentimes, well-meaning people avoid talking about the death or mentioning the deceased person. However, the bereaved need to feel that their loss is acknowledged, it’s not too terrible to talk about, and their loved one won’t be forgotten.

While you should never try to force someone to open up, it’s important to let the bereaved know they have permission to talk about the loss. Talk candidly about the person who died and don’t steer away from the subject if the deceased’s name comes up. When it seems appropriate, ask sensitive questions – without being nosy – that invite the grieving person to openly express his or her feelings. Try simply asking, “Do you feel like talking?”

- **Accept and acknowledge all feelings**: Let the grieving person know that it’s okay to cry in front of you, to get angry, or to break down. Don’t try to reason with them over how they should or shouldn’t feel. The bereaved should feel free to express their feelings, without fear of judgment, argument, or criticism.

- **Be willing to sit in silence**: Don’t press if the grieving person doesn’t feel like talking. You can offer comfort and support with your silent presence. If you can’t think of something to say, just offer eye contact, a squeeze of the hand, or a reassuring hug.

- **Let the bereaved talk about how their loved one died**: People who are grieving may need to tell the story over and over again, sometimes in minute detail. Be patient. Repeating the story is a way of processing and accepting the death. With each retelling, the pain lessens.

- **Offer comfort and reassurance without minimising the loss**: Tell the bereaved that what they’re feeling is okay. If you’ve gone through a similar loss, share your own experience if you think it would help. However, don’t give unsolicited advice, claim to “know” what the person is feeling, or compare your grief to theirs.

(Adapted from Segal, Smith and Jaffe, Helpguide.org 2009)
Activity

Thirteen

Loss and grief

1. What do you think impacts on an older client’s experiences of loss and grief?

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Assisting the older person to recognise the impact that changes associated with ageing may have on their activities of living

Impacts that changes associated with ageing may have on their activities of living

Key issues that affect function:

I.M.P.A.C.T.

I is for IMPAIRMENT: Conditions such as dementia, Alzheimer’s and depression, may cause people to think or act unreasonably. As a result, they may not be safe living alone.

Suggestion: If you are concerned a person’s mental well-being and overall safety is at risk, consult your management and/or your local agency on aging.

M is for MEMORY: It is normal to occasionally forget someone’s name or where you put the car keys, but people with memory problems often find it difficult to express their thoughts, solve problems and make decisions. They may struggle when they are in a strange place, faced with new issues or feeling pressured.

Suggestion: Slow the pace and try to calm the situation. Stress from feeling hurried tends to make things worse. Break tasks down into smaller parts and deal with issues one at a time. Look and listen for feedback.

P is for PHYSICAL: A person’s independence is threatened when mobility becomes a challenge. Stiffening joints, arthritis and reduced flexibility and muscle tone can make movement painful, difficult and unsafe. Stroke and other illnesses may also present mobility challenges.

Suggestion: If you see an older person struggling to get around or fumbling for his or her belongings, offer assistance by asking if you can hold or carry something, open a door, or get a chair or motorized scooter, such as those available in many grocery and retail stores. Take the person’s lead and do not force anything.

A is for ACCESS: Whether an older person is at home or in the community, the environment can present challenges and safety risks. From pets and area rugs to steps, curbs and uneven surfaces, hazards are everywhere. Slips, trips and falls can lead to serious injury, loss of independence, disability and even death.

Suggestion: Look for possible safety risks, such as poor lighting, spills, shiny floors that might appear to be wet, and possible hazards that may cause a person to trip or stumble. Wherever possible, take action to create a safe environment by addressing or removing potential dangers (e.g., poor lighting, insecure handrails, trip hazards such as extension cords, clutter).

C is for CLARITY: Many older people have reduced hearing and vision, making it difficult to participate in activities and conversations. For example, the higher-pitched tones of women and children can be difficult to hear, and lighting changes (e.g., from bright light to dim lighting) can make it difficult for aging eyes to adjust and see details.

Suggestion: If a person is hard of hearing, reduce background noise, speak louder and slower, and pronounce words more carefully. Ask questions to see if the person you are speaking with is following the conversation. You might also share written information that people can refer to. If vision is a problem, increased lighting and print size can make a difference.

T is for TIME: As people age, they tend to take longer to think and perform tasks. Whether due to natural causes, illness or disability, this can be extremely frustrating for them and for others.

Suggestion: When people are stressed, their ability to function, think clearly and make decisions is reduced. Be patient! Don’t rush or give them too much, too quickly. When you meet someone, start the conversation with a friendly comment and/or general question to help them relax. Talk and share information in ways older people can participate.

“I’m 80 years old, and I can’t do what I used to. I don’t want people to help or hurry me. I want to do it on my own so please be patient.” – Frederick, age 80.
Look for ways you can ‘IMPACT’ independence and help safeguard older people. Do not judge someone by his or her appearance, an illness or injury. Determine what types of services and support older people can benefit from by recognising potential limitations. Also important is recognising and focus on a person’s capabilities. What someone CAN do is equally important to what they can’t do.
Activity

Fourteen

Assisting the older person to recognise the impact that changes associated with ageing may have on their activities of living

You will need to base the answer of this activity on one older person you know, ie: a client, a friend or a relative.

1. Describe the mental health of the person, the physical health of the person and also your own abilities as a care worker.

2. Briefly explain what types of assistance the person may need and what you can do to assist them to meet their needs in their situation. Give examples or describe a case scenario of a client who needs varied information to maintain independent living.
3. Mr Jackson is an older person with impaired vision. He has Type 2 diabetes, high blood pressure and an inner ear problem.

How might a support worker take into account these physical changes and other changes associated with ageing when commencing care, taking Mr Jackson to the shower, or assisting Mr Jackson with personal care?
Identifying strategies and opportunities that maximise engagement and promote healthy lifestyle practices

Health promotion

Conceptual model for healthy aging

Promoting health and preventing disease and injury—enabling people to increase control over and improve their health. Health promotion focuses on enhancing the capabilities and capacities of individuals, families and communities to make healthy choices and develop healthy and supportive environments.

- **Optimising mental and physical function**: enabling people to remain as independent as possible in carrying out the routines of daily living.
- **Managing chronic conditions**: enabling people to effectively manage conditions caused by injuries or diseases, by facilitating self-care and independence and using collaborative approaches with professionals and caregivers.
- **Engaging with life**: enabling people to have meaningful relationships with others and be involved in activities that are satisfying and purposeful.

Healthy ageing depends on genetic, environmental and behavioural factors, as well as broader environmental and socio-economic determinants. Some of these factors are within the control of the individual, usually referred to as lifestyle factors, and others are outside the individual’s control. Social determinants of health, such as income and education, influence the choices that individuals can make and create life circumstances which limit opportunities for healthy lifestyle and create health inequalities.

WHO’s Active Ageing Framework provides a useful model for understanding how social, personal and behavioural determinants interact with the physical environment and access to health services to enable or prevent active ageing. A key component of WHO’s active ageing framework is the consideration of how the broad determinants of health affect the process of ageing. Gender and culture are listed as two ‘cross-cutting’ determinants which shape the way we age and influence all the other determinants of active ageing.

Other determinants of health identified in this framework include:

- Health and social service system determinants (for example, health promotion and disease prevention, curative services, long-term care, mental health services)
- Behavioural determinants (for example, tobacco use, physical activity, nutrition, alcohol, oral health, medications)
- Physical environment determinants (for example, housing, safety of home environment, clean water/air, safe foods)
- Social environment determinants (for example, social support, violence and abuse, education)
- Personal determinants (for example, biology, genetics, psychological factors)
- Economic determinants (for example, income, social protection, work).

At all stages of the life course the adoption of healthy lifestyles and actively participating in one’s own care are of great importance. The WHO’s active ageing framework states that ‘engaging in appropriate physical activity, healthy eating, not smoking and using alcohol and medications wisely in old age can prevent disease and functional decline, extend longevity and enhance ones quality of life’. There is evidence to suggest that the determinants of health are good predictors of how well both individuals and populations age.
Supporting a clients health

In order to support a client’s health, it is important to have an understanding of the basic requirements for good health. Such requirements include diet, exercise, lifestyle, hygiene and oral health.

Diet: A healthy diet is integral to health and well-being. The Dietary guidelines for Adults in Australia (endorsed by the NHMRC (National Health and Medical Research Council) April 2003) promote good health and nutrition for all Australians. It is important that when we eat we include a wide variety of nutritious foods in our diet. Energy requirements vary depending upon age, gender, body mass and activity. The energy intake should reflect the amount of activity.

Care should be taken to:

- Limit saturated fat and moderate total fat intake
- Choose foods low in salt
- Limit alcohol intake
- Consume only moderate amounts of sugars and foods containing added sugars.

Australian healthy eating guidelines

The Dietary Guidelines for Australian Adults (2003) are:

- Enjoy a wide variety of nutritious foods
- Eat plenty of vegetables, legumes and fruits
- Eat plenty of cereals (including breads, rice, pasta and noodles), preferably wholegrain
- Include lean meat, fish, poultry and/or alternatives
- Include milks, yoghurts, cheeses and/or alternatives
- Reduced-fat varieties should be chosen, where possible
- Drink plenty of water.

Take care to:

- Limit saturated fat and moderate total fat intake
- Choose foods low in salt
- Limit your alcohol intake if you choose to drink
- Consume only moderate amounts of sugars and foods containing added sugars
- Prevent weight gain: be physically active and eat according to your energy needs
- Care for your food: prepare and store it safely.
- Encourage and support breastfeeding.
Healthy weight

A convenient way to assess whether weight is in the healthy range is by using the **Body Mass Index (BMI)**. BMI is calculated by dividing weight in kilograms by height in metres squared. For example, a woman who is 1.67m in height and weighs 65kg would have a BMI of 23.3 which falls within the healthy weight range. Overweight is measured as 25 or more with obesity determined as 30 or more. These cut-off points are based on associations between chronic disease and mortality and have been adopted for use internationally by the World Health Organisation.

**Body Mass Index (BMI) table**

<table>
<thead>
<tr>
<th>BMI</th>
<th>Waist less than or equal to 40 in. (men) or 35 in. (women)</th>
<th>Waist greater than 40 in. (men) or 35 in. (women)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.5 or less</td>
<td>Underweight</td>
<td>N/A</td>
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<tr>
<td>18.5 - 24.9</td>
<td>Normal</td>
<td>N/A</td>
</tr>
<tr>
<td>25.0 - 29.9</td>
<td>Overweight</td>
<td>High</td>
</tr>
<tr>
<td>30.0 - 34.9</td>
<td>Obese</td>
<td>High</td>
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<tr>
<td>35.0 - 39.9</td>
<td>Obese</td>
<td>Very High</td>
</tr>
<tr>
<td>40 or greater</td>
<td>Extremely Obese</td>
<td>Extremely High</td>
</tr>
</tbody>
</table>

Maintaining a healthy body weight means balancing the energy going into the body [types and amounts of food and drink] and the energy being used by the body (physical activity). To keep weight at a steady level, the energy from the things you eat must balance the energy used by your body for growth and repair, for physical activity, and to keep your bodily functions working. Healthy eating habits throughout life can help reduce the risk of health problems such as heart disease, cancer, diabetes and obesity. To avoid the consequences of an unhealthy lifestyle we need to think about the choices we make about our own lifestyle right now. Choices such as choosing not to smoke, choosing to be more active, choosing to eat better. To achieve these we may need to think about setting some goals.
Factors that affect food intake

Some of the more common factors that may affect an individual’s ability to meet their nutritional needs follow.

Environmental/lifestyle factors

- Poor mobility can lead to issues with people in their own home obtaining and preparing their own food.
- Living and eating alone makes it more difficult for the person to be motivated to eat nutritious food at regular intervals. Feeding one person is often more expensive.
- Recent hospitalisation can impact on a person's ability to enjoy their food as they may also be emotionally or physically affected by the event.
- The food that is available may not be culturally or spiritually appropriate if the provision and availability of food is changed due to health, lifestyle or residential factors.
- The person may not have the skills or knowledge to shop and prepare their own food.
- Change in living conditions (eg: moving to a relatives’ home, retirement village, residential accommodation) often result in a change in diet and lack of control over what is available and the timing of meals.

The food that is available may not be culturally or spiritually appropriate if the provision and availability of food is changed due to health, lifestyle or residential factors. The person may not have the skills or knowledge to shop and prepare their own food.

Personal factors: The side effects of some medications include those relating to appetite and gastrointestinal function. They may cause loss of appetite, nausea, vomiting, constipation and/or diarrhoea. Gait and balance disorders make it difficult to shop and prepare and cook meals. Swallowing disorders can be caused by a number of chronic illnesses and make it difficult for a person to eat food that is not soft or cut into small pieces. Choking is also a risk.

Dentures, particularly if they are a poor fit affect the person’s ability to chew food and may cause pain and ulcers to the mouth. Cognitive impairment affects the ability to plan, so making shopping and cooking difficult. People with visual impairment may have difficulty in the shopping, food preparation and cooking. The actual feeding may also be difficult. Injuries, particularly to the hand arm or shoulder make shopping, food preparation and cooking and the actual feeding process difficult.

Some nutritional concerns: Some issues that individuals experience can benefit from a change in diet. Dietary advice from a dietician or nutritionist may also be needed.

These include:

- Dehydration
- Being overweight and obese
- Weight loss and/or poor food intake.
- Chronic health disorders such as anaemia, diabetes, kidney and heart disease.

If you are aware of the presence of any of these you should document and report this to your supervisor.
Special considerations for people in residential facilities

**Vitamin D:** helps to metabolise calcium and sunshine is the main source of Vitamin D. Many individuals, particularly those in residential care facilities, do not receive sufficient exposure to the sun. A lack of vitamin D can lead to Osteoporosis which is a disease where bones become fragile and break easily. Fractures of the hip, leg and wrist are common. Once the calcium is lost in the bones it is difficult to replace, but a diet high in calcium which is found mainly in milk, yoghurt and cheese helps to prevent this. The low fat variety of these is a better choice.

**Hygiene:** Personal hygiene refers to the activities a person takes to keep their body clean. If a person neglects their personal hygiene it can have a detrimental effect on their physical and psychological health and can cause them discomfort.

Many factors influence a person’s ability to attend to their personal hygiene needs and these include:

- Personal preference
- Cultural values
- Religious beliefs and values
- Lifestyle
- Level of independence
- Physical capabilities
- Intellectual capacity
- Emotional state
- Economic status
- Knowledge of the significance of hygiene
- Climate
- Environment
- Availability of facilities such as water and infrastructure.

Many people are able to attend to their own hygiene needs, however some may require partial or total assistance from a carer. When assessing a person for their hygiene needs and formulating a care plan, it is important their usual routine is followed as closely as possible. If the person prefers a bath to a shower, or wishes to shower in the evening or every other day, these preferences should be accommodated as closely as possible.

When assessing the person’s hygiene needs the team leader should take into account the following:

- Limitations in mobility
- Poor vision
- Dizziness and loss of balance
- Decreased sense of touch
- Ability to remember how to attend to their hygiene needs.
A number of aids such as shower stools, mechanical lifters and handheld showers can be used to assist with personal care. It may be necessary to arrange for the addition of support rails, handheld showers, toilet lifters and other aids to be installed in the person’s home by a home maintenance service.

It is important for the carer to remember that it can be very embarrassing for a person if they are unable to meet their own hygiene needs without assistance. There is a lack of privacy and the loss of independence can be very demoralising and depressing. If the person is receiving care support in their own home, they may also feel that this is an invasion of their personal space and the sanctity that their own home provides. A calm sensitive and caring approach can help to reduce these fears. The person must give their consent to receive assistance with their hygiene needs. The meeting of personal hygiene requirements includes care of the skin, hair, nails and mouth.

If the skin is not washed regularly dirt, sebum, dried sweat and dead skin cells collect, providing an ideal medium for the growth of bacterial and fungal infections. Hair should be washed regularly. If it is not, it may become oily or dry and can become lank or brittle. Some people wash their hair daily, while others prefer to have it washed every two or three days and up to weekly.

**Oral health**

**The most common issues that affect a person's oral health are:**

- **The buildup of plaque**: This is a problem as it is responsible for dental cavities. Plaque corrodes the tooth enamel and causes inflammation of the gums (periodontal disease). It is caused by the build-up of micro-organisms from food debris left for too long in the mouth. If the teeth are not regularly brushed and flossed, plaque will build up. Another factor that increases the build-up of plaque is sugar. All sugars and sweet foods, such as cordial, soft drinks, flavoured milks, honey and dried fruits increase the risk of cavities.

- **Dry mouth (xerostomia)**: Production of saliva may be slowed by some medications and as people age. This affects the person’s ability to chew food. An adequate fluid intake and the chewing of raw vegetables can assist this. If the person is not able to do this, specific toothpastes and gels are available to assist with saliva production.

- **Tooth wear and damage** – Cracks and rough edges on teeth can cause ulcers, pain and discomfort. This is causes poor mastication and a reluctance to brush and floss the teeth.

- **Tooth loss**: This can impact on a person’s bite and swallowing and the person may need partial or complete dentures.

- **Poor mastication (ability to chew)**: Chewing of food is the first part of the digestive process. Poor mastication may slow the process of digestion and reduce the absorption of vital nutrients.

- **Ill fitting dentures**: If dentures do not fit properly they can cause pain and ulceration, poor mastication and changes to the appearance of the person, which can affect their self-esteem and mental and social health.

For the person at a higher risk of oral hygiene problems, additional strategies include:

- Regular tooth brushing and cleaning of dentures
- Having assistance to perform oral hygiene
- Reviewing medication (in consultation with an appropriate professional) to identify if the person is taking medications which have ‘dry mouth’ as a side effect
- Using an electric toothbrush or a modified toothbrush and dental equipment to assist the carer to access the person’s mouth.

A person with cognitive impairment may have difficulty in understanding the need for oral hygiene and resist attempts to maintain this. Communication and behavioural management may be needed to assist the carer with this process.
**Exercise:** Exercise is of immense benefit in improving health and well-being and reducing the risks of premature death, illness and disability. Regular exercise burns kilojoules, builds muscle mass and increases metabolism.

**The benefits of exercise:** Regular exercise reduces the risk of heart disease, stroke and some cancers. It helps to maintain and increase joint movement, to keep bones healthy and strong and helps to prevent falls and injury. It also helps to prevent weight gain and if associated with a healthy diet, can help to reduce weight.

Regular physical activity can help those people with chronic, disabling conditions to maintain at least some muscle and joint function and perform some activities of daily living, as well as helping to manage pain. Rehabilitation and early mobilisation with weight-bearing exercises following injury or other events that affect mobility, promotes optimal physical and emotional health. It also encourages the person to regain some independence and increase the opportunities for social contact. Regular exercise in a shared environment, eg: walking group, aerobics, leisure or fitness centre, team games such as bowls, golf, carpet bowls, invites social interaction. Physical activity also helps to improve mental health. It can reduce stress and anxiety and improve concentration.

**Lifestyle:** Lifestyle choices relate to:

- Health and well-being
- The environment
- Maintaining independence
- Accommodation.

These components are interrelated, each impacting the others. Making good lifestyle decisions can help a person to maintain their health status and increase their physical, mental and emotional health. As we address each of these aspects, we will follow a number of case studies to see how they impact within the framework of an individual's life.
Fifteen

Identifying strategies and opportunities that maximise engagement and promote healthy lifestyle practices

1. What is the meaning of healthy ageing?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

2. Outline strategies that the older person can adopt to promote healthy lifestyle practices.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

3. State six of the positive benefits that an elderly person may gain from undertaking regular exercise.

1. ______________________________________________________________________________________

2. ______________________________________________________________________________________

3. ______________________________________________________________________________________

4. ______________________________________________________________________________________

5. ______________________________________________________________________________________

6. ______________________________________________________________________________________
Identifying and utilising aids and modifications that promote individual strengths and capacities to assist with independent living in the older person’s environment

An aid is something that helps a person to do something more easily. The aim of any aid is to maximise the abilities and independence of the person. This type of support can mean the difference between the person managing their daily living skills or having to move into a supported accommodation arrangement. We all have a number of aids in our own homes. It is important that the client is aware of the equipment and aids available to them so they can make informed choices about how best to meet their personal care needs whilst maintaining a level of independence.

Below is a brief outline of the various types of equipment and aids that can be used to make life more comfortable for the client and easier for the carer.

**Wheelchairs**

A person may experience mobility impairment as a result of accident or injury, chronic medical condition or congenital disability. For example, from paralysis, multiple sclerosis, cerebral palsy, muscular dystrophy, Spina bifida, poliomyelitis, spinal cord injury, back injury, arthritis, broken or sprained limbs, loss of limbs, stroke or brain tumour. Mobility impairments vary—a person may have difficulty with balance, gait and coordination, and experience dizziness, weakness, pain and paralysis. They may use crutches, a walking stick or a wheelchair. People who use wheelchairs have varying degrees of difficulty with mobility. Some may use their arms to propel the chair, others may use an electric wheelchair, which is usually heavier and cannot be easily folded to be placed in a car.

**Mobility aids**

Mobility aids, commonly walking aids, are tools that are designed to assist walking or enable mobility. Walking aids vary, from those providing some support for those who can walk independently but need aid in stability, to greater support for those who need help to walk, to those providing maximum support and designed to aid those people who are unable to walk even with help.

Walking aids include walking sticks and canes, crutches; various walking frames such as walkers or Zimmer frames, wheeled (rolling) walkers, and wheeled mobility devices such as wheelchairs and power chairs, and scooters. Scooters are a common mobility aid that allows people to access what the community has to offer such as libraries, shops and leisure venues. Many businesses that provide mobility aids can be found on the internet. Mobility Aids is one such business, specialising in providing electric scooters, power and manual wheelchairs, lift and recline chairs, nursing beds and a range of other mobility aids. Their website is: <www.mobilityaids.com.au>
Lifting and transfer aids

Lifting and transfer aids assist people with some weight-bearing capacity to transfer between one surface and another. This may include standing or seated transfer aids, transfer boards or vehicle transfer aids.

Standing transfer aids

Standing transfer aids assist people who can bear weight to actively participate as they transfer from one seated position to another. This eliminates almost all lifting requirements of the carer and reduces risk of injury.

Aids available include:

- Rotating discs allowing an individual to move into a standing position, and then with assistance turn towards the alternative seat and lower without having to move their feet
- Standing aid which has rotating discs on which the person stands using a steel frame which includes handles and knee supports, allowing an individual to transfer independently without carer support
- Walking belts that are worn by the person and allow two carers to hold onto attached handles and support the person as they walk
- Transfer pads, with handles sewn in on either side, which sit under the persons buttocks and can be used by carers to assist the person to move from sitting to standing.

Lying transfer aids:

- Sliding sheets with handles that when placed under a person lying on their back allow carers to move them up and down the bed, onto their side or even into a sitting position
- Air moving elevating lift chairs, or cushions, to transfer a person lying on the floor that has fallen to a seated position using a pump mechanism.
Vehicle transfer aid

Vehicle transfer aids can include:

- Mobile battery operated hoists which can be dismantled and transported
- Swivel car seat adaptation where a swivel mechanism is attached to the base of the existing vehicle seat and allows it to rotate 90° to assist with transferring (can be either manual or power operated)
- Swivel discs that rest on the car seat and allow easy turning as the top moveable disc rotates on the base stationary disc (can also be wedge shaped)
- Transportable steel handles that are used on the ‘V’ shaped door striker plate of most vehicles with grab handle to assist with getting out of a car
- Adjustable straps that can attach to the vehicle grab rail or door to assist with transferring
- Sliding pads/sheets to assist with moving, turning and transferring with models available for aircraft transfers
- Automatic seat lifters which enable a car passenger seat to lift out of a van and swivel 90°
- Curved transfer boards which accommodate for shape of car doors and allow transfer from mobility aid to/from car.

Seated transfer aids and transfer boards

Transfer boards come in a range of materials, designs and lengths and generally have a non-slip surface on the base, with a slippery top surface which may be moveable. The board is placed between two surfaces such as a bed and wheelchair and the individual slides across the board. Transfer boards are also available which have a toilet opening to allow transfer and use of the toilet without removal of the board.
Hospital Beds

Nursing or hospital beds differ from traditional beds as:

- Hospital beds ensure safety as most have side rails to keep the client in the bed. Safety rails or side rails are used for people who may fall out of bed, are prone to confusion or are unsteady on their feet when climbing out of the bed.

- Some hospital beds are electronic or have a foot lever to pump the bed manually up and down. When making a bed, bed bathing, rolling a person, performing a dressing or helping a person to dress, it is important to have the bed at the carer’s height to avoid back injury.

- Some hospital beds have equipment attached such as IV poles to allow for a bag of fluid or blood products to be hung.

- Hospital beds have brakes to ensure safety. The bed is unable to move when the brakes are on and the brakes can be disengaged to move it around the room, to another room or outside.

Breathing devices

Continuous positive airway pressure machines (CPAP machines) give a continuous flow of oxygen or air, usually overnight, for the patient who has sleep apnoea or respiratory disease. There are different devices used for CPAP such as nasal prongs which fit snugly in each nostril and deliver a certain amount of continuous air or oxygen. Another device is a mask which again fits snugly over the nose and mouth.

Nasal prong or mask oxygen is used for patients who have respiratory diseases such as emphysema, chronic obstructive airway disease or asbestosis. People who require oxygen usually have a low flow metre to adjust the amount of oxygen necessary. Ventilator—some people require a ventilator if they are unable to breathe on their own. These patients may have had a spinal injury and in this case the position of the injury in the spine determines the type of ventilation required.
Continence aids

Incontinence occurs when there is an inability to control the passage of urine or faeces, causing a social or hygienic problem. For clients who are mobile and continent you may just need to remind them to go to the toilet. These clients should have easy access to a toilet and have facilities to wash their hands afterwards.

Other clients may have continence problems these may include:

- **Stress incontinence:** Loss of urine when the client sneezes, coughs or laughs
- **Urgency incontinence:** They experience an urge to go to the toilet and must go straight away or they immediately lose the urine
- **Total incontinence:** Constant loss of control of urine and faeces.

The person's care plans may include a regular toileting regime to promote continence. For clients who have stress or urgency incontinence there are a range of absorbent pads which are available to insert into underwear to protect skin condition and clothing. You will need to check with clients if they need to be changed on a regular basis. Once again ensure your clients have easy access to the toilet and if they indicate they wish to go to the toilet and you must assist them straight away.

If the client is incontinent, ensure wet clothing is removed straight away and the skin is washed and dried, this is to ensure the skin is cared for and the client's dignity is maintained. Clients may also be given exercises by a physiotherapist to perform during the day, to help strengthen their pelvic muscle to help improve their continence. You may need to remind and encourage your clients to do these exercises.

Some clients may be incontinent of urine and faeces. Bowel management plans for clients should be in place. These management plans aim at developing regular bowel habits. Clients with no control may have a regular time in the day where they are given a suppository to help empty the bowel and establish a routine. You would need to discuss this situation with your supervisor and follow policies and procedures. To prevent constipation a well-balanced diet, high in fibre with an adequate fluid intake, is important. You can help and encourage your clients to choose a well-balanced diet to help prevent bowel problems. There is a range of products available to protect the client's skin, clothing and dignity. These include pads, liners, disposable briefs and protective underwear, which need to be changed as required. Ask your supervisor about the range of products your organisation makes available.
Toileting a resident

There are several methods used when toileting a resident:

- **Commodes**: commode is a portable chair or wheelchair with an opening for a pan. When using a commode chair to transport a resident, use a modesty or dignity gown. Some can be placed over the toilet. This is used for residents who have difficulty walking to the toilet.

- **Bedpans and urinals are used when residents cannot get out of bed**. Males use a bedpan for bowel movements and use a urinal for urination. A fracture pan has a thinner rim and is only about a centimetre deep at one end. They are used for residents who have limited range of motion in their back.

Personal audio-visual aids

The Independent Living Centre of Victoria has a huge range of aids for people with a disability. They are a generalist service in that they display a range of aids for people with any type of disability. They have a great website which provides a listing of the various aids, plus costs, suppliers and so on. You can even see what some of the aids look like—all without leaving home. Personal audio-visual aids can help a person read, write, and manage daily living tasks.

Some examples are:

- Magnifying aids
- Audio tapes
- Electronic reading machines
- Computers that use large print and speech
- Braille
- Spectacles
- Hearing aids.

**Modified feeding aids**: Some care recipients may require feeding due to weakness, paralysis, casts, confusion and behavioural problems. There is a vast range of feeding aids including specialised eating utensils, plate guards, non-slip plates, sip cups, two-handled mugs and rocker knives.
Discussing situations of risk or potential risk associated with ageing

Why are older people at greater risk?

All of us have accidents, some of which result in injury. Often we should have been aware of the consequences of our actions and taken steps to avoid these consequences. Most accidents are small, such as paper cuts to the hand, a scald on the arm when lifting a hot item out of the oven or knocking a knee or elbow on a piece of furniture. They are often the result of inattention to what we are doing and it just proves how easily we can damage ourselves if we fail to pay attention to our safety needs.

The ability to be able to protect ourselves from harm depends on many different things including:

- Our ability to monitor the environment using our senses, such as seeing, hearing, and feeling
- Our ability to recognise and remember risks in our environment
- Our desire and willingness to avoid risks
- Our ability to think of ways to avoid risks and to be able to put these ideas into action.

Everyone has safety needs and although age itself is not a factor the physical and often lifestyle changes that occur as we grow older make older people, as a group, more prone to accidents and injury.

What risks do older people face?

A risk can be defined as a situation that has the potential to create a hazard to a person’s health, safety and wellbeing. Risks that happen because of the ageing process can be physiological, psychological, emotional and environmental. You probably thought about lots of reasons why older people are more likely than younger adults to have accidents and why these accidents can often result in more serious injuries. Let’s just look at some of the more important ones in a little more detail.
Identify situations of risk, or potential risk, and report to supervisor

What are the possible risk factors in the client's environment?

There are risk factors in everyone's living environment. However, for the client, risk of injury from physical factors in their environment may increase due to increasing frailty or the inability to process thought patterns required to organise a task. How the client copes with their surroundings influences the potential risks that they will face.

Areas for activities of daily living include:

- Bathroom and toilet
- Laundry
- Kitchen
- Living room and bedrooms
- Garden and exteriors.

Bathroom and toilet

Bathroom and toilet fixtures and fittings may present risks if they are old and worn. However, new facilities can also present potential risks.

Hazards in the bathroom and toilet:

- Slippery floors due to water or powder on the floor
- If the bathroom does not have a steam outlet, the floor may become slippery with condensation
- Toilet floors may become slippery due to Incontinence
- Hot/cold water control taps may be poorly maintained or too tight. The client may have difficulty manipulating the control taps, which puts them at risk of burns from hot water or the risk of wet floors due to flooding
- Cupboards may be too high or low, making access difficult
- The client may injure themselves from trying to get to the cupboards
- The bath or toilet may be too low, making their use very difficult, especially when there are no support rails on the walls or bath
- Support rails, if present, which are loose or placed at inconvenient heights may cause risk of injury
- The incorrect use or disposal of continence aids can cause hygiene problems
- Free standing heating devices, such as kerosene or electric heaters can increase the risk of burns or possible electrocution if they fall into a bath.
Laundry

In the laundry the client may wash and iron their clothes and linen and store household cleaning products. If they are able to continue these functions without assistance, you need to think about the potential hazards.

Consider that:

- Floors may become slippery due to wet surfaces from water spillage, wet clothes or dripping taps
- Poor or exposed wiring from electrical appliances together with water increases the risk of electrocution
- Loose tiles, poor flooring or obstacles on the floor such as wet clothes may cause a client to trip and fall over
- The drying area may be too high or some distance from the home environment.
- Carrying or lifting heavy, wet clothes to the area may cause injury
- Household cleaning products are potentially dangerous if ingested or used incorrectly in interactions with other solutions, ie bleach and cleaning fluid. Any out-of-date products might contain toxic fumes
- Poor and/or high access to laundering products may cause the client injury as they try to reach things
- The client may be at risk of burns from ironing.
**Kitchen**

The area where food is prepared and stored contains a number of potential hazards, particularly due to the number of utensils and appliances that a client may use when preparing and serving food.

**Some hazards to consider are:**

- Boiling water, hot food or hot ovens and stove tops may cause burns. Carrying heavy saucepans and appliances may cause the client to injure or burn themselves, especially if the saucepans are hot.
- Loose tiling or loose mats may cause a client to trip and fall over.
- Floors may become slippery from water, spilt food or other liquid.
- Poor knowledge of how to safely use appliances such as food processors may cause injury. The ability to use the appliances may also decrease as the client ages.
- Poorly maintained electrical cords increase the risk of electrocution.
- Malfunctioning equipment may increase the risk of health and safety. For example, a malfunctioning refrigerator may cause food to spoil.
- Sharp utensils such as knives and vegetable peelers can cause serious cuts if not used carefully.
- Gas leaks from the delayed lighting of burner or oven can increase the risk of injury from fire or gas inhalation.
- Cluttered areas, poorly stored food and inadequate pest control can increase the number of pests in the area and cause risk to the client’s health.
- Food products which are out-of-date increase the risk of food poisoning.
- Storage areas that are too high or low may cause the client injury as they try to reach them.
Living rooms and bedrooms

These are the areas in which clients spend their time. The bedroom is used for sleeping and dressing. The living room can be where the client eats their meals, talks with others, is entertained or where they simply sit and enjoy their day.

Potential risks in these areas are many and varied:

- Cluttered floors and walkways increase the risk of falling over, especially if the client is unfamiliar with the layout of rooms, furniture or obstacles
- Poor lighting in walkways and other areas can increase the risk of falling over obstacles or knocking into furniture. The glare of bright lighting can have an effect on the diminished eyesight of clients
- Support handrails in walkways need to be properly attached or at the correct height to avoid the risk of the client falling over
- Furniture with sharp edges may increase the risk of bruising or injuring their skin
- Lots of noise, such as a loud TV, vacuum cleaners or loud conversation can affect the client
- The bed may be too low or too high, making it difficult for them to get in and out
- If bed rails are required and are poorly attached or poorly maintained; they may increase the risk of the client injuring themselves when trying to use them
- Inappropriate use of hot water bottles, heating pads, ice packs can cause risk to the client’s health, e.g. burns
- Coarse bed linen may cause skin irritations.
Garden and exteriors

This is an area of enjoyment for many clients throughout their lives. They may have actively worked in a large or very small garden over many years and it may have served many functions such as for barbecues or growing fruit. Gardens and outdoor areas can quickly become neglected and hazardous if the client is no longer able to maintain them.

You should consider some of the following hazards:

- Overgrown footpaths, uneven concrete, loose boards, bricks and hoses, wet ground. These can all cause a client to trip and fall
- Poorly maintained garden equipment may cause a client to injure themselves when using it
- Poorly lit entrances and steps may increase the risk of the client falling over an obstacle that they didn’t see
- Poorly placed or maintained ramps may lead to falls
- Poorly maintained fences and gates can make accessibility difficult and reduce security.

Other environmental risk factors

There are two other aspects of a client's environment which can be a risk to the client's health and safety.

These are:

- Clothing and accessories
- Temperature.

Clothing and accessories

As we've mentioned, ageing can affect a client's ability to effectively dress themselves. Decreased ability for dressing themselves has been identified as a risk to the client's health and safety. The clothes and accessories themselves can also be a risk.
It is possible that:

- Clothing can be too tight, making it difficult for a client to dress and undress themselves. Tight clothing can also damage the skin and restrict the flow of blood, causing oedema (swelling). It can also restrict the client’s movement, making mobility even more difficult.

- Clothing that is too long or too big, or articles such as trailing scarves, can increase the risk of the client tripping and falling over.

- Ill-fitting shoes, or shoes which are too big, can increase the risk of the client falling over.

- Shoes which are too small can make walking very difficult and painful and can also increase problems with feet such as bunions and calluses.

- Shoes with slippery soles can cause a client to slip and fall on some surfaces.

- Clothing that is inappropriate for the season may put the wearer at risk. If a client wears heavy woollen jumpers in the middle of summer, they risk heat-related problems. If the client wears light cotton clothing in winter, they risk contracting chest infections.

- Jewellery which is too tight can restrict the flow of blood causing oedema (swelling). For example, rings that are too tight may need to be cut off to prevent the metal digging into edematous, ‘puffy’ fingers.

**Temperature**

When the climate changes clients can change their indoor living temperature by using equipment: like heaters and air conditioners. The temperature of the environment around the client is important. If the temperature is too hot or too cold it can affect their health.

**The client may be at risk of temperature related illnesses due to:**

- Their inability to adjust the controls on heating or cooling equipment due to immobility and loss of fine motor control skills.

- The body’s ageing process and reduced or impaired cognitive reasoning affecting the client’s ability to differentiate between temperature changes. This may cause them to dress inappropriately for the climate or set temperature control equipment at inappropriate levels.

This is not an exhaustive list of potential risks. You should always continually observe the client’s environment to assess the possibilities for injury.

**Falls:** Falls among older people are common and can result in serious injuries that can affect their quality of life. Falls can result in older people experiencing lacerations (damage or breaks to the skin), muscle and joint injuries, head injuries and fractures (broken bones), especially bones in the arms, wrists, legs and hips. While these injuries can, and often do cause immediate pain and discomfort they can also lead to long periods in hospital and ongoing pain and discomfort. Some older people can also develop a loss of confidence, making them less likely to keep active and independent which may lead to a decreased quality of life.
Dignity of risk

Your clients have the right to make decisions that may include the acceptance of personal risk. As a care worker it is your responsibility to ensure that safety hazards and situations of risk are minimised for your clients, however, it is not possible for you to protect them from all potential hazards. It is important however that you understand the difference between the clients' rights to live with risk and staff neglect. It is important that you carefully consider all of the implications when considering preventing clients from fulfilling personal preferences or independence because of possible risk situations. The freedom that an individual is given should be balanced with stability and security.

Whilst allowing clients to maintain their independence and fulfil personal preferences, it is essential that their own safety and the safety of others, is taken into consideration. The most perfect example to illustrate this is that of smoking. A client who lives in a residential care facility will have the right to smoke. However they will only have the right to smoke in designated areas. This means they may not be allowed to smoke in public areas, their bedroom or in their bed. This rule will have been introduced in order to protect the safety of all residents and all staff rather than just to limit the freedom of the individual. In order to support and encourage your clients in fulfilling personal preferences you need to acknowledge the rights of the person and respect the person’s need for independence.

It is not an easy task to respect the person’s needs and personal preferences while trying to ensure that they are safe. There will be many situations where encouraging the individual’s independence or fulfilling personal preferences may in fact expose them to a risk situation. If you are faced with a client who wishes to maintain their independence or personal preferences that may place them at risk or others at a safety risk, it is essential that you discuss these safety risks directly with the client. It may be possible that the client is happy to receive assistance in performing these tasks. It may also be possible, through discussion, to provide your clients with alternative approaches to fulfilling this level of independence and personal preferences. It may be that only a small change in routine or the way in which a person performs this task is all that is required to eliminate the risk.

Referral

As community service workers you will often find yourself in situations where you can't provide an appropriate or on-going service to your clients. This might be because your agency policies state that you can only assess clients, or work with clients for a specified timeframe. It also might be because you don’t have the skills necessary to deal with certain issues such as child abuse, sexual assault, marital issues, loss and grief and so on.

It is important to realise that acknowledging you haven’t the necessary skills isn’t a sign of failure but rather a professional assessment of your strengths and weaknesses. By referring a client on to someone who can help them with their particular issue you are effectively meeting your client’s need and thus helping them move a step closer to resolve whatever is troubling them.

As a general principle regarding when to make referrals, make them if:

- You are in doubt of your own capabilities,
- You’re over-identifying with your client
- You know or suspect that another agency or professional is more appropriate for a particular client.

Referral means putting people in touch with services that have the resources to help them achieve their goals. It is not just about handing out a number. You are responsible for bringing the person and the service together.

When we make a referral, we are basically sending a person to another professional who specialises in working with particular needs or problems. Referring a client to another professional doesn’t mean that we stop working with that client but rather that we work as part of a team to best meet all that person’s needs.
Professionals to whom we might refer a client

Examples of professionals to whom we might refer a client are:

- **Doctors** are trained to assess symptoms and make a diagnosis based on their knowledge and ability to understand the signs and symptoms that a patient is experiencing. Many doctors focus on particular areas of medicine and are called specialists. Specialists who often work with people with a disability are neurologists (brain and nervous system), ear nose and throat (ENT) specialists, ophthalmologists (eyes), orthopaedic specialists (bones), psychiatrists (mental health) and paediatricians (children).

- **Occupational Therapists** work with people on activities of daily living, and develop treatment plans to help people gain skills. They also assess what equipment and modifications to the environment might help people to go about their daily activities more easily.

- **Physiotherapists** help people to gain more physical control of their bodies so that they can move more easily or improve their muscle control or strength. Helping people to use aids such as walking frames and crutches is another focus of physiotherapists as is teaching people how to prevent further damage to muscles.

- **Social workers** work with individuals, couples, families, groups and communities. They work to empower people who are disadvantaged or marginalised in and by society. They provide specialist counselling, help people to learn new skills and strategies, and they attempt to make changes to policies and systems that traditionally disempower people.

- **Psychologists** are trained in psychometric testing—which means that they can assess (using certain tests) a person’s intelligence or where they may be experiencing some damage to the brain. Some psychologists work in special schools and can provide educational assistance to children with a disability. Other psychologists specialise in counselling.

- **Podiatrists** look after people’s feet. They treat feet problems as well as assess why people have certain problems affecting their feet. They may suggest (and make) orthotics (inserts that go inside shoes) unique to their patient’s foot or feet.

- **Orientation and mobility instructors** teach people with a visual impairment the skills necessary to move safely about their physical environment. They may teach people how to use a white cane or a guide dog as well as how to use other mobility aids.

- **Audiologists** assess whether or not someone has a hearing loss, what type of hearing loss they have and the degree of loss.

- **Employment consultants** assist people to locate and maintain employment.

- **TAFE teacher/consultants** support students to access and complete their studies at TAFE.

As a worker in this industry it is vital to get to know the range of agencies out there so that you can give the best possible service to the person you are working with.
Sixteen

Discussing situations of risk or potential risk associated with ageing

Scenario
Mrs Brooks, 82 years, live with her pet cat in a three bedroom home. There are stairs to the front and back of the house and a large yard and garden area. She has lived in the same area for 60 years, is widowed and has no family in the immediate area. Mrs Brooks:

- Has arthritis in her hands and knees
- Is diabetic – diet controlled
- Has some vision impairment.

Identify and list the risks there may be for Mrs Brooks.

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Bibliography


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